



HIV/AIDS in Haiti:

A Literature Review

February 2004

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Acronyms

AAA	Agro Action Allemande
ADIIH	Association des Industries d'Haïti
AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	Acquired Immune Deficiency Syndrome Control and Prevention Program
ART	Anti-retroviral Therapy
ASON	Association de la Solidarité Nationale
AOPS	Association des Oeuvres Privées de Santé
BCC	Behavior Change Communication
BID	Banque Interaméricaine de Développement
CCP	Johns Hopkins University Center for Communication Programs
CDC	Centers for Disease Control
CECOSIDA	Centre pour la Communication sur le SIDA
CDS	Centre de Développement Sanitaire
CHASS	Centre Haïtien de Service Social
CPCO	Centre de Promotion des Femmes Ouvrières
CRS	Catholic Relief Services
CSW	Commercial Sex Worker
DOTS	Directly Observed Therapy – Shortcourse
DSSE	Département Sanitaire du Sud-Est
EMMUS	Enquête Mortalité Morbidité et Utilisation des Services
FEBS	Fondation Esther Boucicault Stanislas
FHI	Family Health International
FP	Family Planning
FOSREF	Fondation pour la Santé Réproductive et l'Education Familiale
GHEKIO	Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes
GIPA	Grande implication des personnes affectées et infectées par le VIH/SIDA
GLAS	Groupe de Lutte Anti-SIDA
GRASADIS	Groupe de Recherches et d'Action Anti-SIDA et Anti-Discrimination Sexuelle
HAART	Highly Active Anti-retroviral Therapy
HAS	Hospital Albert Schweitzer
HCP	Health Communication Partnership
HHD	Health and Human Development
HIV	Human Immunodeficiency Virus
HS-2004	Health Systems 2004
IEC	Information, Education, and Communication
IHE	Institut Haïtien d'Enfance
MAEC	Maison Arc en Ciel
MAST	Ministère des Affaires Sociales et du Travail
MHDR	Mouvement Haïtien pour le Développement Rural
MSH	Management Sciences for Health
MSPP	Ministère de la Santé Publique et de la Population
MTCT	Mother-to-Child Transmission
NGO	Non-governmental Organization
PAHO	Pan-American Health Organization
PALIH	Projet d'Apui à la Lutte contre les IST-VIH/SIDA
PAP	Port-au-Prince
PECAS	Programme Education Civique Anti-SIDA
PLWHA	Person/People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
POZ	Promoteurs Objectif ZeroSIDA

PROFAMIL	Association pour la Promotion de la Famille Haïtienne
PROMESS	NGO for centralized drug distribution funded by PAHO and WHO
PSI	Population Services International
RH	Reproductive Health
SCF/UK	Save the Children UK
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASCAD	Union des Amis Socio-Culturels d'Action en Développement
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	Voluntary Testing and Counseling
VDH	Volontariat pour le Développement d'Haïti
WHO	World Health Organization
YDI	Bassin Bleu Youth Initiative

Literature Review on HIV/AIDS in Haiti

1. Background – Literature review

1.1 Methods:

This literature review was conducted using the PubMed database, the Center for Communication Programs (CCP)'s Popline service, and the Google search engine. Smaller, HIV/AIDS-specific databases were also searched, although few articles were drawn from them. Additional documents were provided by Elsie Laudent and Nafissatou Diop-Sidibé of CCP. Sources included in this review were limited to those published after 1990 in English or French.

2. Background - Haiti

2.1 General background and demographic information about Haiti:

The population of Haiti is currently estimated at 7,527,817. (USAID/PHNI, 2003, p. 1). Of this number, about 40% are under the age of 15, while only about 5% are over 64. (Cayemittes et al., 2001, p. 1) The proportion of children and adolescents is especially large in rural areas, where high fertility has resulted in a very young population. There are about 1,789,178 women of childbearing age in Haiti. (USAID/PHNI, 2003, p. 1).

The country is primarily rural; only 36% of its population lives in urban areas. (Cayemittes et al., 2001, p. 1). Due to rural-urban migration, however, the rate of population growth in urban areas is three times faster than that in rural areas. This rapid urban growth has resulted in the development of shantytowns around many urban areas, particularly that of Port-au-Prince. (Cayemittes et al., 2001, p. 1). It should be noted that urban populations in Haiti tend to be disproportionately female. This may be attributed, in part, to the fact that women tend to migrate from the countryside to urban areas, while men tend to migrate overseas. (Cayemittes et al., 2001, p. 9).

Although Haiti's economy was traditionally agriculture-based, in the course of the last two decades it has shifted towards a market economy with a heavy emphasis upon the informal sector. Due to this emphasis, it is difficult to accurately gauge the state of the country's economy. It is estimated that 70% of the population lives below the poverty line. (Cayemittes et al., 2001, p. 2). As of 2000, more than one-third of the adult population was unemployed. (IHE, 2002).

Despite improvement efforts in recent years, Haiti's infrastructure is not well developed. It is noted in the 2000 Enquete Mortalite, Morbidite et Utilisation des Services (EMMUS III), for example, that the energy and telecommunications sectors are deficient, the road system does not meet the population's needs, international transport capacity is limited to two ports and two airports, and agricultural land use is inefficient. (Cayemittes et al., 2001, p. 2).

As of 1990, approximately 46% percent of school-age girls and 49% of school-age boys were enrolled in primary school. These percentages diminished considerably (to 20% and 21%) at the secondary school level. As of 1997, the national literacy rate was estimated to be 49% for adult males and 45% for adult females. (UNAIDS/WHO, 2002, p. 3).

Access and exposure to the media is relatively limited in Haiti. At the national level, 47% of all households own a radio, while 23% own a television and 4% own a telephone. Ownership of these goods is particularly limited in rural areas, where 31% of households own a radio, 3% own a television, and 0.2% own a telephone. Exposure to the media is somewhat broader than ownership of media-related durable goods such as radios and televisions. For example, more than 60% of both men and women report listening to the radio at least once a week. About 1/3 report watching television at least once a week. Like ownership of goods, exposure to the media is most limited among older people, people without formal education, and residents of rural areas. (Cayemittes et al., 2001, p. 22).

2.2 Healthcare, health-seeking behavior and use of services (including reproductive health care):

As of 1998, PAHO estimated that only 60% of Haiti's population had access to health services. (UNAIDS/WHO, 2002, p. 8). Cost, distance, and lack of transportation are often cited as major barriers to accessing care, particularly for women. (Cayemittes et al., 2001, p. 123).

A medical anthropologist working in Haiti in the mid-1990's found that health-seeking beliefs and behavior in the country were based upon multiple belief systems and therefore highly complex. By his account, illnesses are categorized as either natural ("illnesses of God") or supernatural ("illnesses of Satan"). Natural illnesses are thought to be curable with biomedicine, which is preferred by most people if they have the resources to access it. If biomedical care is unavailable, comparable traditional or informal healing (from herbalists, bonesetters, and itinerant medicine sellers, for example) is employed. Supernatural illnesses, which cannot be cured with biomedicine, are addressed using a variety of strategies rooted in Catholicism, Protestantism, voodoo, or some combination thereof. (Corbett, retrieved July 20, 2003, from www.webster.edu).

Nearly 80% of the women who gave birth during the EMMUSS III survey period had received some prenatal care from a trained professional in the course of their pregnancy. (Cayemittes et al., 2001, p. 125). Forty-four percent of the women surveyed had attended all four recommended prenatal appointments, while 29% had attended two or three and 7% had attended only one. (Cayemittes et al., 2001, p. 127). Overall, the total percentage of women who received prenatal care was 10 percentage points higher in 2000 than it had been during the EMMUS II survey in 1994. This increase in prenatal coverage is particularly evident among women without formal education and women resident in rural areas. (Cayemittes et al., 2001, p. 126).

As of 2000, it was estimated that less than 25% of births in Haiti occurred in health facilities. (Cayemittes et al., 2001, p. 131). Nearly 70% of births were attended by traditional birth attendants, half of whom were not equipped with birthing kits, indicating that they had not received any formal training. (Cayemittes et al., 2001, p. 132). In keeping with this, only 24.2% of births were attended by skilled health personnel. (UNAIDS/WHO, 2002, p. 8). An assessment of reproductive health service delivery sites conducted in 2001 further indicated that many healthcare institutions did not collaborate with traditional birth attendants in their catchment areas, resulting in limited coverage of pregnant women. (HS-2004, 2001).

Family planning services have been available in Haiti for more than 25 years. Despite this fact, the rate of modern contraceptive use in the country is still among the lowest in the Western Hemisphere (15% as of 2000). (Cayemittes et al., 2001, p. 76). This low contraceptive prevalence appears to be related to religious beliefs, strong pronatalist values, "the plurality and looseness of unions," high levels of illiteracy, and the economic value attached to children. Efforts to educate the public about family planning have also been hampered by the country's poor physical infrastructure and transport, political unrest, poverty, and lack of funds. (Maynard-Tucker, 1996, p. 1379-80).

EMMUS III respondents cited a number of reasons for not using contraception. The most common were desire for additional children, perceived sterility, health problems associated with contraceptive use, fear of side effects, and opposition to contraception. (Cayemittes et al., 2001, p. 88). According to surveys conducted in 1990 in Port-au-Prince, Leogane, and Pignon, reasons for discontinuation of contraceptive use included side effects, desire for additional children, method failure, and inconsistent supply of methods (particularly injectables). (Maynard-Tucker, 1996, p. 1385). Observations of healthcare facilities and community-based distribution programs during the same study period indicated serious quality of care issues, including long wait times, insensitivity to cultural norms (such as the frequent use of male health agents to promote and distribute family planning to women), and poor counseling and interpersonal skills on the part of providers (Maynard-Tucker, 1996, p. 1385).

The EMMUS III found that 48% of women and 59% of men had seen or heard a message about family planning on the television and/or radio in the month preceding the survey. (Cayemittes et al., 2001, p. 89). Among both men and women, exposure to messages via the radio or the radio and the television in

combination was much more likely than exposure via the television alone. Written messages do not appear to have reached much of the population, as is evidenced by the fact that only 24% of individuals surveyed had seen or read a printed message about family planning in the month preceding the survey. (Cayemittes et al., 2001, p. 89-92).

2.3 Sexually transmitted infections (STIs):

Current estimates place adult STI prevalence in Haiti above 10%. (IHE, 2002, p. 4). This figure is consistent with the prevalence rates produced by studies and sentinel surveillance during the past decade. Ongoing issues in the prevention and treatment of STIs include: limited access to testing services; costs associated with examination-based diagnosis; the weakness of syndromic management as a diagnostic tool among women; inconsistent availability of drugs for treatment; and poor diagnosis follow-up and partner referral. Behavior change communication, with a particular emphasis on the promotion of dual protection, has been recommended as the most feasible way to address the problem of STIs in Haiti. (Brutus, 1996, p.46-7).

Four percent of the women surveyed during the EMMUS III reported having had an STI during the twelve months preceding the survey. (Cayemittes et al., 2001, p. 226.) It seems likely that this percentage is an underestimate of true STI prevalence, given that STIs are often asymptomatic in women and that women who are infected may hesitate to admit it for social reasons. A second estimate of STI prevalence based upon self-reports of STI or STI symptoms in the twelve months preceding the survey indicated that prevalence among female respondents might actually have been as high as 15%. (Cayemittes et al., 2001, p. 227). Four percent of male EMMUS III respondents reported having had an STI during the twelve months of the survey. (Cayemittes et al., 2001, p. 227). The second, broader estimate indicated that STI prevalence in male respondents could have been as high as 9%. Of the women who had been diagnosed with an STI during the twelve months before the survey, 63% reported having sought care and 56% had informed their partners of their status. Of the men who had been diagnosed with an STI, 81% had sought care and 62% had informed their partners. (Cayemittes et al., 2001, p. 227).

The EMMUS III revealed that a large proportion (66%) of surveyed women had not heard of STIs other than HIV/AIDS. (Cayemittes et al., p. 223). Half of surveyed men were similarly uninformed. Among people of both sexes, adolescents (15-19), residents of rural areas, and those lacking formal schooling were the least likely to have heard of STIs. Among female respondents who had heard of STIs, 89% were able to name a sign of such an infection in women. (Cayemittes et al., p. 223). Eighty-eight percent were able to name a sign of STI in men. Of male respondents who had heard of STIs, 96% were able to name at least one sign of STI in men. (Cayemittes et al., p. 223). Only 87%, however, were able to name such a sign in women.

Although STI care-seeking behavior has been little studied, it is thought to be dominated by self-medication (with antibiotics, which are readily available without a prescription) and treatment by traditional healers. (Desormeaux et al., 1996, p. 502).

STI/HIV services in Haiti tend to be integrated with primary health care rather than family planning services. As recently as 1995, the Association pour la Promotion de la Famille Haïtienne (PROFAMIL) was cited as the only organization in the country with an integrated STI/HIV/FP program. (Brutus, 1996, p. 46). In 1996, GHESKIO began to offer integrated STI/HIV/FP services, and with the recent expansion of PMTCT services in Haiti, other organizations have begun to follow suit. (CDR, 2002, 6).

According to the Haitian government, less than half of the healthcare sites in the country currently provide STI-related services. In addition to the problem of access created by this lack of coverage, the cost of medications for treating STIs is a barrier for many potential patients. Furthermore, the quality of care at those sites that do provide services is not entirely adequate. Frequently cited quality of care issues include lack of provider competence in the areas of syndromic management and treatment, and supply problems. (IHE, 2002, p. 14; HS-2004, 2001, p. 19).

A study conducted in 1992 found that “voluntary partner referral for STI treatment was possible [in Haiti] without major drawbacks.” (Desormeaux et al., 1996, p. 505). As a result of this study, a number of Haitian organizations institutionalized partner referral as part of their STI treatment plans. Some programs have provided treatment for partners free of cost at the time of initial contact (as with, for example, men who accompany their female partners to antenatal care appointments). Although this strategy appears to be successful, it is prohibitively expensive for many institutions. (Desormeaux et al., 1996, p. 506).

A 2001 assessment of USAID-funded STI programs suggested that STI services in Haiti should include: effective use of syndromic management; syphilis screening and treatment at antenatal clinics; improved mechanisms for partner notification and treatment; effective monitoring and surveillance of STIs; targeted services for high risk groups, and high-quality counseling services. (Synergy, 2001).

3. HIV/AIDS in Haiti

3.1 HIV/AIDS in Haiti – Overview:

HIV/AIDS has impacted Haiti more severely than any other country in Latin America or the Caribbean, attaining prevalence rates of nearly 5% in the general population. It is estimated that 85% of the seropositive adults in the Caribbean live in Haiti or the Dominican Republic. (Putnam et al., 2002, p. i). Primary factors in the development of the HIV epidemic in Haiti include: socio-political instability, poverty, limited access to healthcare and health-related information, stigmatization of people living with AIDS and their families, social norms promoting multiple sexual partnerships, and poorly developed mechanisms for the control and treatment of STIs. Many authors also agree that a lack of consistent commitment to HIV/AIDS prevention and control on the part of both the government and Haitian society as a whole has been instrumental in the development of the epidemic. (Brutus, 1996; Cayemittes et al., 2001; Putnam et al., 2001). Finally, the fact that “Haiti has been isolated from international participation in AIDS forums and dialogue” for much of the last decade may have hindered efforts to combat the epidemic. (Putnam et al., 2001, p. 4).

3.2 The response of the government and multilateral organizations to HIV/AIDS:

“Historically, national leadership in the battle against HIV/AIDS in Haiti has not been strong.”(Putnam et al., 2001, p. 4). Much of the progress that has occurred on this front during the last decade may be attributed to the efforts of various NGOs, through which international funding was channeled during the politically turbulent 1990’s. Flawed parliamentary elections in 2000 exacerbated political tensions in Haiti, which led to the reduction or suspension of millions of dollars in health sector funding by some governments and multilateral organizations (including the World Bank, the Inter-American Development Bank, the European Union, Holland, Germany, France, and Japan). (Putnam et al., 2001, p. 4-5; Haiti: USAID Support, retrieved June 20, 2003, from www.usaid.gov). Despite these difficulties, many remain hopeful about president Jean-Bertrand Aristide’s government’s ability to turn the tide of the HIV/AIDS epidemic in Haiti. The current government is the only one in the country’s history to have incorporated HIV into its platform and to have provided on-going support for HIV prevention efforts. (Deibert, 2002, p. 3-4). It is now in the process of implementing a new national strategic plan for HIV/AIDS, which focuses upon STI/HIV prevention, prevention of mother-to-child transmission (PMTCT), ensuring the safety of the country’s blood supply, vaccine research, and care and support for people living with AIDS. (HIV/AIDS in Haiti and USAID Involvement, retrieved May 7, 2003, from www.synergyaids.com). In keeping with current international trends, the program also recognizes that “the health sector alone cannot achieve or finance an expanded, comprehensive response to HIV.” (Putnam et al., 2001, p. 5).

Several United Nations programs are involved in HIV/AIDS-related work in Haiti. UNAIDS has mobilized technical working groups to develop its strategic priorities, which include expanded access to voluntary testing and counseling (VCT), improving the national surveillance system, mitigating HIV transmission, improving care for people living with AIDS, and promoting the empowerment of women. UNFPA has funded a number of programs targeting youth, including POZ (Promoteurs Objectif ZeroSIDA), FOSREF (Fondation pour la Santé Reproductive et l’Education Familiale), and VDH (Volontariat pour le Développement d’Haiti). UNICEF is currently working with 21 NGOs to prevent vertical transmission,

including provision of antiretroviral medications. (Putnam et al., 2001, p. 12-13). UNDP has sponsored research into community responses to HIV/AIDS. (FHI/IMPACT, 2000, p.27-8).

The Pan-American Health Organization (PAHO) is also active in HIV/AIDS work in Haiti. In recent years the organization has collaborated with the CDC to improve HIV/AIDS surveillance systems and with the NGO POZ to support a reproductive health hotline. (Putnam et al., 2001, p. 13).

USAID has been active in HIV/AIDS programming in Haiti for more than a decade. The agency has provided support to wide variety of organizations in the areas of prevention, services and treatment, advocacy, and community mobilization. Specific projects are described in greater detail in the Programmatic Interventions section of this document.

3.3 Clinical trials:

In 2001, the Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO) launched a Phase II HIV vaccine trial in Haiti. Other sites for the trial are Brazil and Trinidad and Tobago. Many researchers see the trial as a building block that will increase Haiti's capacity to sustain a comprehensive national AIDS program. Some also feel that the vaccine trial may encourage non-participants to get tested for HIV by giving them a sense of hope for the future. Both GHESKIO director Dr. Jean Pape and Dr. Paul Farmer of Zanmi Lasanté remain optimistic about Haiti's capacity to host vaccine trials in the future, including, they hope, a Phase III efficacy trial. (Adesky, 2001).

3.4 Epidemiological data on HIV/AIDS in Haiti:

There have been efforts to "initiate and sustain HIV/AIDS surveillance at the national level" since 2001 in Haiti. Estimates of national HIV prevalence are currently based upon sentinel surveillance among pregnant women. The most recent surveys were conducted in 2000 at twelve sites throughout the country. (UNAIDS/WHO, 2002, p. 2).

Questions have been raised, however, regarding the accuracy of the current surveillance system. It may be argued that the sample sizes used are not large enough to produce valid results, and that sample sites are not sufficiently numerous or representative. Notably underrepresented are certain vulnerable populations, such as young people and commercial sex workers. (Putnam et al., 2001, p. 6).

Sentinel surveillance carried out among pregnant women in 2000 suggested seroprevalence rates of 4.5% in the general population and 6.1% in adults. This represents a decrease from the 1996 survey, which indicated that the national prevalence rate was around 5.9%. This reduction should be interpreted with caution, however, as it offers little information about trends in behavioral or attitudinal change. (UNAIDS/WHO, 2002, p.2). Furthermore, the rate of HIV infection in the 15-24 age group actually increased between 1996 and 2000, indicating that incidence of the disease may be on the rise. (Putnam et al., 2001, p. 6).

As of 1999, AIDS was the leading cause of death in Haiti, accounting for as much as 20.5% of all deaths in certain age groups. UNAIDS estimates that 30,000 adults and children died of AIDS in Haiti during 2001. (UNAIDS/WHO, 2002, p. 2).

In 1998, a Futures Group/Policy Project team modeled the HIV/AIDS epidemic in Haiti and developed estimates of infection and disease prevalence for the years to come. At that time, there were estimated to be between 260,000 and 365,000 people living with AIDS. That number is expected to reach 263,000 to 375,000 in 2010. (FHI/IMPACT, 2000, p. 6).

Estimates released by the U.S. Census Bureau in 1998 illustrated some of the potential effects of the HIV/AIDS epidemic in Haiti, including: a 20% increase in infant and child mortality, a 10% increase in maternal mortality, a doubling of adult mortality, increases in adult and child morbidity, a 20% decrease in fertility and consequent reduction in population growth, and a change in population structure resulting in an increased dependency ratio. (FHI/IMPACT, 2000, p. 9).

Since the identification of the first AIDS cases in Haiti in the late 1970's, a shift has occurred in the pattern of transmission seen in the country. In the early stages of the epidemic, many cases appeared to be concentrated in the same groups that were heavily affected in the United States and Europe. (Desvarieux and Pape, 1991, p. 271). In 1983, for example, 50% of the AIDS patients in Haiti were bisexual, 25% were heterosexual, and 25% had received blood transfusions. (Pape and Johnson, 1993, p. S342). By 1986, however, the percentage of AIDS patients who were bisexual had dropped to 10%, while the percentage who were heterosexual had increased to 80%. (Pape and Johnson, 1993, p. S342). In keeping with this shift, the last twenty years have seen an enormous increase in the proportion of female AIDS patients (15% in 1982 to 46% in 1992). (Pape and Johnson, 1993, p. S342). As a result, the number of infections among infants and children has increased dramatically as well.

Heterosexual transmission of HIV is now thought to account for more than 90% of the AIDS cases in Haiti. (Deschamps et al., 1996, p. 324). A 1996 study of seroconversion among discordant couples found that the rate of conversion among sexually active couples was 5.4 per 100 person-years. (Deschamps et al., 1996, p.324). The incidence of seroconversion varied according to sexual activity, STI, use of condoms, and duration of cohabitation at study entry. The authors suggested that the rate of seroconversion in the study cohort might actually have been lower than that in the general population, due to selection criteria for entry into the study. (Deschamps et al., 1996, p. 329).

Seroprevalence rates have historically been higher in urban areas than in rural, although this disparity is diminishing over time. In 1982, 80% of the AIDS patients in Haiti were from Port-au-Prince, 10% from other major cities, and 10% from abroad. By 1990, only 65% of new AIDS cases came from the Port-au-Prince area. (Desvarieux and Pape, 1991, p. 274). The socio-political instability that prevailed in Haiti during the 1990's is thought to have contributed to this shift by promoting out-migration from the cities to rural areas, thereby bringing urban populations with high HIV seroprevalence rates into contact with lower-prevalence rural populations. (Brutus, 1996, p. 46).

Ironically, it has been suggested that Haiti's poor infrastructure, which is frequently depicted as a culprit in the delivery of prevention and care services, has actually helped to maintain the lower seroprevalence rates in rural areas by preventing people from traveling as much as they might otherwise. Four of Haiti's provinces are more seriously affected by the epidemic than the rest of the country: the Center, the Northwest, the West, and the North. (FHI/IMPACT, 2000, p. 6).

Despite the barriers to travel noted above, Haitians have continued to migrate within the country and abroad in search of work, a trend that may have contributed to the development of both the country's HIV/AIDS epidemic and its deepening poverty (St. Cyr-Delpe, 1995).

3.5 HIV infection in Haiti: natural history and disease progression:

In a study conducted from 1985 to 2000, Deschamps et al. found that HIV disease progression in a Haitian cohort was nearly twice as fast as that in developed countries before the widespread use of antiretroviral therapy. The reasons for this rapid progression may include poor nutrition (EMMUS II found that nearly 10% of urban women were malnourished), high prevalence of community-acquired infections (such as respiratory tract infections and acute diarrhea), and high prevalence of active tuberculosis. (Cayemittes et al., 2001, p. 168; Deschamps et al., 2000).

HIV-associated infections (preceding AIDS) and symptoms common in Haiti include esophageal candidiasis, cryptosporidiosis, prurigo, tuberculosis, herpes zoster, and weight loss. (Pape and Johnson, 1989, p. 227-9; Desvarieux and Pape, 1991, p. 276).

3.6 HIV/AIDS and Tuberculosis (TB):

Haiti has one of the highest rates of TB infection in the world (500 cases per 100,000 persons). (GHESKIO Projects, retrieved June 20, 2003, from www.haitimedical.com/gheskio.project.htm). The risk of TB in

tuberculin-positive individuals is 50 to 100 times greater in HIV-positive individuals than in their seronegative counterparts, and HIV-positive individuals are efficient transmitters of TB. (Desormeaux et al., 1996, p. 2). Furthermore, active TB is thought to affect HIV replication and illness progression, as is reflected by high mortality rates seen among HIV-positive individuals who have been successfully treated for TB. TB prevention and effective HIV/AIDS care are, therefore, inextricably linked. (Gordin et al., 2000, p. 1449).

A 2000 study indicated that a two-month course of preventive rifampin/pyrazinamide chemotherapy was as effective as the standard twelve-month isoniazid regimen in preventing the development of active TB in HIV-positive individuals with a positive tuberculin skin test. This finding is significant in that the shorter regimen could improve adherence and cost-effectiveness while saving time for health workers and preventing further development of drug-resistant TB. (Gordin et al., 2000).

The Boston-based organization Partners in Health (Zanmi Lasanté) sponsors a large medical center in Cange, Haiti. Among the center's many innovative programs is a "DOTS (directly observed therapy – shortcourse)-Plus" strategy, which has been used to combat multi-drug resistant TB in the center's catchment area. The program, which uses second-line TB drugs in individually tailored regimens and provides patients with support groups and individual *accompagnateurs* to ensure adherence to medication, has been very successful. In 2000, for example, 90% of all registered TB cases in Zanmi Lasanté's catchment area were cured, compared to 26% in the rest of the country. (Adesky, 2001, p. 3).

TB screening and control programs have been suggested as a "nonthreatening setting for HIV counseling and testing activities serving large numbers of people." A study demonstrating the effectiveness of this type of interventions is described in the Services and Treatment section of this literature review. (Desormeaux et al., 1996, p. 2).

In the inverse of the interventions described above, GHESKIO has successfully integrated TB screening into voluntary counseling and testing (VCT) services. When GHESKIO clients presenting for VCT report a cough, they are screened for active TB. This appears to be sound practice, as about 27% of these patients have been found to have active TB. (Burgess et al., 2001, p. 1879).

Despite the efforts of organizations like GHESKIO, linkages between TB and HIV/AIDS services remain weak. Referral systems between service provision sites are limited, as is coordination of programs by organizations working in prevention. As of 2001, Haiti still lacked national treatment guidelines for HIV-TB co-infection. (Putnam et al., 2001, p. 27).

3.7 Pediatric HIV/AIDS:

Given the growing proportion of HIV infections among Haitian women over the last two decades, vertical transmission has become an increasing problem and the number of pediatric HIV/AIDS cases has risen. In 2000, it was estimated that about 20,000 Haitian children under the age of 15 (0.7%) were infected with HIV. It is estimated, however, that this number will drop to 15,000 (0.6%) by 2010. (FHI/IMPACT, 2000, p. 11).

As early as 1987, a study found that 8% of patients at the University Hospital Rehydration Unit were HIV-positive, as were 16% of the patients at a pediatric tuberculosis hospital, 33% of the residents of an urban orphanage, and less than 1% of the residents of a rural orphanage. By 1989 the seroprevalence rate in the same orphanages had risen to 54.5% and 4.5%, respectively. (Desvarieux and Pape, 1991, 275-6).

In their study of HIV disease progression in Haitian children, Jean et al. noted that seropositive children were more likely to suffer from recurrent diarrhea, pneumonia, failure to thrive, pyoderma, and otitis than seronegative children. The high rate of infant mortality in Haiti (131/1000) may make it difficult to accurately attribute infant deaths to AIDS, but the authors suggests that as many as 20% of the infant deaths in Haiti may be attributable to HIV/AIDS. (Jean et al., 1997, p. 606)

3.8 AIDS orphans and other vulnerable children:

UNAIDS estimated that 200,000 Haitian children under the age of 15 had lost one or both parents to AIDS by the end of 2001. (UNAIDS/WHO, 2002, p.2). This number represented more than 7% of the under-15 age cohort at that time. (FHI/IMPACT, 2000, p. 11). Very little research has been done on AIDS orphans or other children who are touched by the disease. A report on AIDS orphans in Haiti carried out by Family Health International (FHI) notes that “although some data indicate that the pandemic may recently have plateaued, the economic and social problems faced by the children and families affected by HIV/AIDS will not diminish for at least another 15 years.” (FHI/IMPACT, 2000, p. 2).

Qualitative research conducted by CARE in 2003 in the Northwest indicated that AIDS orphans suffered from public humiliation, inadequate care, and low school enrollment. Study participants identified lack of knowledge and fear of HIV/AIDS, the financial strain of fostering orphaned children, and lack of training for foster parents as primary causes of these problems, and sexual exploitation and juvenile delinquency as their secondary consequences. (CARE/Intell, 2003, v-vii).

There are a number of programs serving AIDS orphans and other vulnerable children in Haiti, including those supported by CARE, Save the Children, Catholic Relief Services, Management Sciences for Health (through the HS-2004 project), the International Labor Organization, UNICEF, and a variety of local NGOs. These programs provide institution-based care, fostering services, community-based care, or a combination thereof. An estimated 200,000 children lived in institutions full or part-time in 2000. (FHI/IMPACT, 2000, p. 24). More than half of the orphans and vulnerable children in Haiti are absorbed into families and communities, however the stigma, economic strain, and organizational challenges of caring for these children limit this response. (FHI/IMPACT, 2000, p. 21). Although the number of children reliant upon institutions and targeted programming continues to grow, funding for interventions targeting AIDS orphans and other vulnerable children has diminished in recent years. (FHI/IMPACT, 2000, p. 2).

Fostering is common in Haiti, as is evidenced by the fact that 25% of Haitian families include a child whose parent is not resident in the household. (FHI/IMPACT, 2000, p. 20). Anecdotal evidence indicates that, in the case of orphans, much of the fostering is done by maternal grandparents, aunts, or uncles. Without the proper resources, however, fostering may have detrimental effects. “The health and nutrition of HIV-negative children and children who are not orphaned are likely to be stressed as families assume responsibility of care for additional orphans.” (FHI/IMPACT, 2000, p. 15). This is of particular concern in light of the already-poor level of vaccination coverage and limited access to healthcare in much of Haiti. Many NGOs working with community programs in Haiti have indicated that “families are willing to maintain HIV/AIDS patients and their children at home if they receive training, assistance with organization, contact, and psychosocial assistance.” (FHI/IMPACT, 2000, p. 21). At present, the lack of resources and support for families providing care for orphans or other vulnerable children makes institutions an attractive option. (FHI/IMPACT, 2000, p. 23).

Another group of children impacted by the HIV/AIDS epidemic in Haiti are *restavèks*, or child domestic laborers. Research indicates that these children often exist in a state of semi-slavery, without access to education or other basic services. They are also extremely vulnerable to abuse, much of which is sexual in nature, as is evidenced by the fact that female *restavèks* are commonly referred to as *la pou sa*, or “there for that.” (United Nations Commission on Human Rights, 2002, retrieved August 10, 2003, from www.antislavery.org). In 2000, there were estimated to be 250, 000 *restavèks* in Haiti. (FHI/IMPACT, 2000, p. 14).

3.9 Commercial Sex Workers:

Commercial sex is legal in Haiti. A study of female condom use among commercial sex workers (CSW) conducted in 2002 found that most commercial sex was, not surprisingly, motivated by financial need. Most CSWs surveyed indicated that they were aware of the risks associated with commercial sex, including HIV infection. Nearly all the CSWs surveyed reported systematic condom use, although 40% said they would have sex with a client without a condom if he was a repeat customer, paid more, or requested it. The study

recommended that prevention activities targeting CSWs focus heavily upon outreach activities and include ongoing promotion of both male and female condoms. Organizations currently working with CSWs in the area of HIV prevention include FHI, FOSREF, PSI, and the Haitian Red Cross. (PSI, 2002).

3.10 Men who have sex with men:

Homosexuality is not, for the most part, socially accepted in Haiti. Men who have sex with men (MSM) are obliged to conceal their sexual orientation, a fact that promotes clandestine sexual encounters and limited condom use. Organizations currently working with MSMs in Haiti include FHI and the Groupe de Recherche et d'Action AntiSIDA et Antidiscrimination Sexuelle (GRASADIS). (IHE, 2002, p. 7).

3.11 HIV/AIDS-related knowledge, attitudes, and practices:

The EMMUS III indicated that 97% of surveyed individuals, regardless of gender, age, place of residence, or educational attainment, knew of the existence of AIDS. (Cayemittes et al., 2001, p. 201). Despite this high level of general awareness, misconceptions persisted. For example, 24% of women and 13.5% of men surveyed believed that HIV/AIDS could not be prevented. (Cayemittes et al., 2001, p.203-5). Thirty-five percent of the women surveyed knew of HIV/AIDS, but could not name any method of prevention. (Cayemittes et al., 2001, p. 206). Nearly 19% of the men surveyed were similarly ill informed. (Cayemittes et al., 2001, p. 207). Given that knowledge of three specific methods of HIV prevention – abstinence, faithfulness, and condom use - is often considered essential from a programmatic point of view, the prevalence of these misconceptions is troubling. When asked to name methods of prevention, young adults, residents of the Port-au-Prince area or Grande Anse, and those who had attended secondary school were more likely to cite condoms than were members of other groups. In contrast, older people, women living with their partners, urban residents, and women who had attended secondary school were more likely to cite faithfulness than members of other groups. (Cayemittes et al., 2001, p. 204).

It has been suggested that the spread of HIV in Haiti is related, to some degree, to local conceptions of illness and health. More than half of female EMMUS III respondents and 43% of male respondents stated either that HIV/AIDS could be transmitted by sorcery or that they did not know if this kind of transmission was possible. (Cayemittes et al., 2001, p. 209). As noted above, for many rural Haitians, there are two types of illness – the natural and the supernatural. Supernatural illnesses, which are directed at a specific individual, are not thought to be transmissible to others, a fact that may explain some of the difficulties encountered by behavior change programs in Haiti. (Desvarieux and Pape, 1991, p. 275). The Haitian conception of illness may also promote the spread of HIV by encouraging people to seek ineffective treatment for STIs, thereby prolonging their illness and increasing their risk of contracting HIV. (IHE, 2002, p.8).

The practice of dry sex is thought to be common in Haiti. This supposition is supported by the results of a 1999 qualitative study of Haitian immigrants in the Dominican Republic, which found that dry sex was nearly universal within the study group. (Halperin, 1999, 445). Female respondents reported using herbs, plants, and chemical products such as alum to increase vaginal dryness or tightness. In the same study, many male respondents noted that during dry sex, the prepuce of the uncircumcised penis sometimes ruptured and bled noticeably, a fact that points to a possible connection between dry sex, lack of male circumcision, and heterosexual HIV transmission. This is particularly significant given that circumcision is thought to be uncommon in Haiti. (Halperin, 1999, 446).

A study conducted in Port-au-Prince and Leogane in 2002 suggested that circumcision was rare outside of the capital city. While 20% of participants from Port-au-Prince were circumcised, only 2% of those hailing from areas outside the city had had the operation. (PSI, 2002, 4). In total, less than 10% of study participants were circumcised. (PSI, 2002, 4). It should also be noted that more than half of the circumcised men who participated in the study had been circumcised as adults. (PSI, 2002, 10). Despite the apparent rarity of circumcision within the study group, most participants were familiar with the practice and expressed positive attitudes towards it.

A significant proportion of the EMMUS III's respondents (29% of female respondents, 20% of male respondents) was not aware that a person who appeared to be in good health could be seropositive. (Cayemittes et al., 2001, p.208-9).

One third of EMMUS III respondents knew a person living with HIV/AIDS or someone who had died of the disease. (Cayemittes et al., 2001, p. 209). Respondents in the age group 20-24 were the most likely to have had personal experience with seropositive individuals. Male and female respondents were equally likely to report that they knew a person living with HIV/AIDS or someone who had died of the disease.

The majority of EMMUS III respondents (81% of female respondents and 84% of male respondents) reported that they were not at any risk of contracting HIV. (Cayemittes et al., 2001, p. 210). Nearly half of the respondents who believed they were not at risk justified their perception on the basis of the fact that they only had one sexual partner at the time of the survey. (Cayemittes et al., 2001, p.212). About 25% of the respondents who said they were not at risk justified their perception because they were abstinent. Smaller proportions of respondents claimed that they were not at risk because they used condoms or did not patronize commercial sex workers. Among respondents who believed they were at risk, reasons for the perceived risk varied by sex of the respondent. While female respondents cited infidelity on the part of their partners as the primary reason for risk, men were more likely to cite having had multiple partners. (Cayemittes et al., 2001, p. 214). Both men and women cited failure to use condoms as a risk. The perception of risk increased significantly with increased number of reported sexual partners in the twelve months preceding the survey. (Cayemittes et al., 2001, p. 212).

More than half (56%) of female EMMUS III respondents who had heard of HIV/AIDS said that they had not changed their sexual behavior since learning of the virus' existence. (Cayemittes et al., 2001, p 214). This proportion was particularly high among women who considered themselves at moderate or high risk of contracting HIV, women in rural areas, and women resident in the Arbonite, the Southeast, the North, and the South. Of female respondents who reported having changed their behavior since learning of HIV/AIDS, the most commonly reported changes were faithfulness, abstinence, and requests that their partner be faithful. Only 3% of the women surveyed reported using condoms after learning of HIV/AIDS. (Cayemittes et al., 2001, p. 214). One-third of male respondents who had heard of HIV/AIDS reported that they had not changed their behavior after learning of the virus. (Cayemittes et al., 2001, p. 214). As with the female respondents, the proportion of men who reported no change in their behavior was higher among men who considered themselves at moderate or high risk than among those who considered themselves at low risk. Other groups of men among whom there was less reported behavior change were: men who were divorced or separated, men from rural areas, and men resident in the Northwest and Grande-Anse. Among men who did report changing their behavior, faithfulness was the most commonly reported change, followed by condom use, and abstinence.

A study conducted in 2000 in Cap-Haïtien and Port-au-Prince found that, among young men aged 15-19 who were sexually active in the twelve months preceding the survey, more than 12% reported sex with a commercial sex worker. This percentage was only slightly lower among men aged 20-24. Of young men in either age group, only about 70% reported using a condom during the encounter. (CERA/FHI, 2000, p. 6-7).

Most EMMUS III respondents were familiar with the condom as a method of family planning and/or disease prevention. Despite this fact, 18.5% of male respondents and 35.5% of female respondents said that they would not be able to procure a condom if they needed one. (Cayemittes et al., 2001, p. 233-4). Less than 5% of female respondents and less than 15% of males reported that they had used a condom during their last sexual encounter. (Cayemittes et al., 2001, p. 235). Younger people (15-19) of both sexes were more likely to have used a condom during their last encounter than were older people.

A large proportion of EMMUS III respondents (49% of female, 62% of male) said that young people between the ages of twelve and fourteen should be taught how to use condoms. (Cayemittes et al., 2001, p.

217-220). Particularly large proportions of young (20-29) people, single people, those with secondary school education, and those resident in urban areas supported teaching young people about condom use.

A study conducted in Port-au-Prince and Cap-Haïtien in 2000 found that nearly 75% of girls aged 15-19 had heard of the female condom, although only 1.6% had used it themselves. (CERA/FHI, 2000, p. 13). Among young people aged 20-24, more than 85% had heard of the female condom, and about half the young women in this age group knew where to procure it. (CERA/FHI, 2000, p. 14).

Very few of those surveyed during the EMMUS III (4% of female respondents and 6% of male respondents) had ever been tested for HIV. (Cayemittes et al., 2001, p.220). Of those who had been tested, a large proportion were tested in private sector facilities. About half of the respondents who had not been tested wished to know their serostatus. More than half of these people did not know, however, where they could receive testing services. (Cayemittes et al., 2001, p. 220-3). Young people (15-19), people over the age of 40, people resident in rural areas, and those without formal instruction were particularly ill-informed about where to find testing services.

Of the women in union surveyed during EMMUS III, 96% reported having had only one sexual partner (including their primary partner) during the twelve months before the survey. An additional 4% reported that they had not had any partner during the twelve months before the survey, and 0.4% reported that they had had more than one partner. (Cayemittes et al., 2001, p. 230). Of the women surveyed who were not in union, 76% reported that they had not had a partner during the twelve months before the survey. (Cayemittes et al., 2001, p. 230). Twenty-three percent reported having had one partner, and 0.6% reported having had two or more partners. (Cayemittes et al., 2001, p. 230). Of men in union, 73% reported having had only one partner during the twelve months preceding the survey. (Cayemittes et al., 2001, p. 231). Twenty-five percent reported having had two or more partners. (Cayemittes et al., 2001, p. 231). Respondents under the age of 25 were more likely than those in other age groups to report multiple sexual partnerships in the twelve months preceding the survey.

In a 1996 study of seroconversion among discordant couples, almost half of the couples (all of whom received counseling and free condoms) adopted safer sex practices. Despite these encouraging results, a significant proportion of the study cohort did not change their behavior, a fact that underscores the need for further research into other means of prevention, such as vaccines and microbicides. (Fowlkers, 1996, p.1).

In a study conducted in Port-au-Prince and Cap-Haïtien in 2000, less than half of respondents aged 15-24 were aware of any HIV/AIDS-related programming in Haiti. When asked to name programs with which they were familiar, young people between the ages of 15 and 19 were most likely to cite educational programs on radio and television and condom distribution programs, while older respondents more often named educational programs affiliated with health clinics and peer education programs. (CERA/FHI, 2000, p. 32-33).

3.12 Stigma:

During the 1980's, Haiti was linked to HIV/AIDS when it was hypothesized to be the virus' point of origin. Haitians were included in the CDC's "4H" list of risk groups for HIV in the United States (the other groups included in this list were homosexuals, heroin users, and hemophiliacs). The resulting stigma contributed to the development of widespread denial surrounding HIV/AIDS in Haiti. (St. Cyr-Delpe, 1995).

Nearly 90% of EMMUS III respondents believed that a seropositive person was obligated to disclose their serostatus to others. (Cayemittes et al., 2001, p. 217). Only 20% percent of female respondents and 25% of male respondents said that a seropositive person should be allowed to continue to work with others. (Cayemittes et al., 2001, p. 217-20). Among both men and women, the belief that a seropositive person should not be allowed to work was more common among the young, the uneducated, and those from rural areas.

35% of female EMMUS III respondents and 42% of male respondents claimed that, if a member of their family contracted HIV/AIDS, they would be willing to care for that person in their home. (Cayemittes et al., 2001, p. 217-20).

Research conducted in 2000 in Grande Anse suggested that fear of infection through casual contact with PLWHA was still relatively common. In keeping with this, a number of study participants suggested that PLWHA should be physically isolated from others, or at least provided with separate eating utensils, blankets, and clothing. (Vilgrain, 2000, 34, 42).

People living with HIV/AIDS in Haiti may be treated as less than human, as is evidenced by frequent comparisons between infected individuals and animals, and by the widely held belief that the souls of infected individuals have been stolen and replaced with those of the dead. (Fitzgerald and Simon, 2001, p.303).

Women living with HIV/AIDS are often the subjects of more severe stigma than their male counterparts. (St. Cyr-Delpe, 1995). In discordant couples, it is more common that the man abandons his female partner than vice versa. This is particularly true if the woman is pregnant. (IHE, 2003, p. 8).

A 1995 qualitative study conducted at four sites in Haiti found that HIV/AIDS resulted in social isolation of the infected person's entire family, not just the individual themselves. (FHI/IMPACT, 2000, p. 17). The same study revealed that communities did not feel responsible for assisting AIDS-affected families, and thought that care was the responsibility of outside organizations. (FHI/IMPACT, 2000, p. 17).

Interviews with people recently diagnosed with HIV in the Artibonite valley reflected a widespread mistrust of health care staff and denial regarding the accuracy of HIV tests. The authors note that they have encountered similar mistrust in conducting community education activities. They remark that "church leaders, school directors, voodoo priests, continually suspect ulterior motives for AIDS education." (Fitzgerald and Simon, 2001, p. 304).

In focus groups conducted in 1992 in Port-au-Prince, male respondents indicated that they were afraid to attend local health clinics, lest members of their community think they had AIDS. (Desormeaux, 1996, p.504). Similar fears were expressed by participants in a 2002 evaluation of GHESKIO's PMTCT services (CDR, 2002, 21).

3.13 Gender:

A 1990 qualitative study of Haitian relationships and contraceptive practice found that, in general, "unions and sexual relationships are loose, promiscuity is practiced by both sexes, and both men and women are involved in serial monogamy or in polygamous sexual relationships which produce many children." (Maynard-Tucker, 1996, p. 1386).

In a 1995 qualitative study, most female respondents indicated that, although both partners could initiate sex, women did not have the right to refuse their male partners' advances. (Ulin et al., 1995, p. 61). Most female respondents also believed that it was a man's prerogative to have more than one sexual partner. A majority of both men and women surveyed in another study indicated that condom use was the man's prerogative during a sexual encounter. (Adrien, 1993, p. 241).

It has been suggested that the extreme poverty that prevails in Haiti has contributed to the current HIV/AIDS epidemic by forcing women to make their sexual debuts early and seek multiple sexual partners in order to meet their most basic financial needs. (IHE, 2003, p.11). Most authors agree that, due to cultural and economic factors, Haitian women have little power or ability to negotiate condom use or other safer sexual behavior.

The age of sexual debut appears to be dropping in Haiti, as is evidenced by the fact that, in 1994, 8.4% of young women between the ages of 15 and 19 had had sex, while five years later this percentage had risen to

12%. (IHE, 2003, p. 11). It has been suggested that the instability and poverty that have plagued Haiti in recent years may have promoted sexual activity among young people by limiting their activity options – in terms of job opportunities, school enrollment, and extracurriculars. (Aldebron, 1993, p. 23) It should also be noted that Haitian women tend to seek male partners who are several years their senior. The EMMUS III indicated that, on average, women were partnered with men who were 5.8 years their senior. (IHE, 2003, p. 11). This age difference is greatest among women between the ages of 15 and 24, who are, on average, more than seven years younger than their partners. This practice may put women at increased risk of STI, including HIV.

The EMMUS III found that communication among couples was limited, with 1/3 of respondents “rarely” or “never” discussing even the most basic matters with their partners. (Cayemittes et al., 2001, p. 243). This pattern was especially pronounced among younger women, and became less so with increasing age and duration of relationship.

Violence against women appears to be relatively common in Haiti. The EMMUS III found that 30% of women had been the victims of violence. (IHE, 2002, p. 2). Much of this violence is sexual in nature, thereby exposing women to STIs, including HIV.

Haitian women have long been discriminated against in the legal arena. The Minister of Justice has admitted that national legislation in general, and the Civil Code in particular, is discriminatory against women. Only in recent years have women ceased to be considered as minors under Haitian law. (Country Specific Information on Women and AIDS for Four Nations Targeted by Bush AIDS Initiative, retrieved August 10, 2003, from www.icrw.org).

4. Programmatic Interventions

The presentation of interventions in this literature review follows the conceptual framework developed by the Health Communication Partnership (HCP), which is based upon a USAID model. In this framework, interventions are categorized according to four approaches: prevention, services and treatment, advocacy, and community mobilization. Clearly, many organizations implement multiple interventions, and a single intervention may include more than one approach (as with, for example, the many programs that combine prevention and community mobilization). For the sake of clarity, organizations are described most fully in their area of concentration, with programs in other areas outlined in the tables that follow each section. Certain smaller organizations about which there is little available information appear only in the tables. The exception to this rule is the Ministère de la Santé Publique et de la Population (MSPP), whose activities are described in all four sections. It should be noted that the majority of the organizations described in this literature review either collaborate directly with USAID or with its implementing agencies.

HIV/AIDS-related programming in Haiti has been ongoing for well over a decade. Although progress has been made in the field in recent years, certain weaknesses remain. In the past, donor agencies and NGOs have often failed to coordinate their efforts. As a result, activities, materials, and messages have been duplicated unnecessarily and mistakes frequently repeated. This problem is particularly evident among behavior change communication programs and has been compounded by the fact that few programs have been well documented or evaluated. Another problem frequently cited in the literature is the fact that most activities have historically been concentrated in Port-au-Prince and other large cities. This issue is of particular concern in light of the increasingly rural focus of the HIV/AIDS epidemic in Haiti. (Putnam et al., 2001; Faulkner and Maynard-Tucker, 2002).

USAID has been active in HIV/AIDS programming in Haiti since 1990. Through its AIDSTECH and AIDSCAP projects in the 1990's, the agency “introduced and encouraged a focus on HIV/AIDS in the country and prompted coordination among the different partners and programs.” (Faulkner and Maynard-Tucker, 2002, p. 1). In more recent years, USAID has funded HIV/AIDS and reproductive health programs through the IMPACT project (managed, like AIDSCAP, by FHI) the Health Systems 2004 project (spearheaded by Management Sciences for Health), and HCP, among others. (Haiti: USAID Support,

retrieved June 20, 2003, from www.usaid.gov). In 2001, USAID/Haiti commissioned the Synergy Project to develop a program strategy for USAID's work in HIV/AIDS. The report recommended that USAID work to provide decentralized prevention and care throughout the country, while insuring extra coverage of high-risk communities and those most in need. (Putnam et al., 2001, p. 21). A CHANGE Project team carried out a second, more narrowly focused, analysis of USAID-funded programs in 2002. Selected recommendations of these two reports are described here.

In addition to supporting the work described above, USAID/Haiti has convened a working group of experts on behavior change communication and HIV/AIDS, which includes representatives of both the agency's cooperating agencies and local NGOs. Members of this group, which is known as the *Groupe Technique*, include among others FHI, Population Services International (PSI), FOSREF, POZ, CARE, and CCP.

4.1.1 Prevention – general:

Ministère de la Santé Publique et de la Population (MSPP)

The Ministry of Public Health and Population (MSPP) has spearheaded a number of HIV prevention activities in recent years, including: the development of a Family Life Education curriculum; youth conferences; condom distribution and management of stock; information kiosques at festivals; and a traveling youth prevention “caravan,” which is described in greater detail in the Youth and Peer Education section of this literature review. (IHE, 2000, p. 11-12). One MSPP office that is particularly involved in HIV prevention is the Unité Centrale de Coordination (UCC), which is responsible for the development of BCC strategies for STI/HIV/AIDS, norms for counseling and VCT, and health communication messages pertaining to STI/HIV/AIDS.

Family Health International (FHI)

FHI's AIDSCAP project provided technical and material support to organizations working in HIV/AIDS prevention from 1992 to 1996. The overall project comprised several strategic areas, which were: implementing targeted behavior change interventions; increasing condom access through social marketing; increasing access to STI care; enhancing the social and policy environment to support behavior change; strengthening the technical, management, and evaluation capacity of Haitian NGOs; and improving the care of AIDS patients. Participating organizations included: IMPACT/Interaide (peer education and condom distribution targeting commercial sex workers and their clients); the Groupe de Lutte Anti-SIDA (workplace-based education on HIV transmission and prevention); the Centre de Promotion des Femmes Ouvrières (educational activities targeting female factory workers); the Volontariat pour le Développement d'Haiti (peer education and social marketing targeting youth); the Centre Haïtien de Service Social (peer education and condom social marketing targeting urban youth); PSI (condom social marketing); the Centre de Développement Sanitaire (clinic-based services and home visits to the urban poor); and GHESKIO (clinician training and research on HIV/AIDS and STIs). The project period saw significant changes in the general public vis-à-vis HIV/AIDS, such as greater awareness of transmission, prevention, and personal risk, and increased access to and use of condoms. (Final Report for the AIDSCAP Program in Haiti, retrieved June 20, 2003, from www.fhi.org). Since 1997 FHI has worked primarily through the IMPACT project, which focuses on supporting local organizations to promote behavior change among young people, commercial sex workers, men who have sex with men, and the media. IMPACT provides technical and material assistance to its grantees. IMPACT works with FOSREF, VDH, POZ, CARE, Maison Arc-en-Ciel and a variety of media organizations. FHI is also working with the MSPP and other partners to implement a national anti-stigma campaign. Finally, FHI is currently spearheading a USAID-funded behavior surveillance survey. (Putnam et al., 2001).

Promoteurs Objectif ZeroSIDA Foundation (POZ)

“The Promoteurs Objectif ZeroSIDA (POZ) Foundation was created in 1995, in part to compensate for the closing of the USAID-funded AIDSCAP project.” (Putnam et al., 2001, p. 14). POZ is involved in a wide variety of prevention activities, which include counseling services in Port-au-Prince, a newsletter for groups working in HIV/AIDS and the Telephone Bleu hotline, which targets adolescents. (Putnam et al., 2001). POZ is also active in the areas of advocacy and community mobilization. In recent years, for example, the

organization has coordinated nationwide activities on the day of the International AIDS Candlelight Memorial (May 21). POZ was also recently awarded a Pact/USAID Community Reach grant to address stigma and support people living with HIV/AIDS. The funds will be used to create and strengthen self-help groups for PLWHA and to increase the capacity of such groups to advocate for HIV prevention and care. (Mott, retrieved June 20, 2003, from www.afronets.org). POZ receives support from FHI/IMPACT, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and the HS2004 project.

Population Services International (PSI)

Since the early 1990's, PSI has managed a successful condom social marketing project in Haiti. The unusually broad level of national coverage achieved by the project is due in large part to the fact that PSI trains outreach workers from its partner NGOs throughout the country to act as wholesale distributors of the condoms. Part of the profits from these NGO-initiated sales are returned to the partner organizations, a tactic that serves to expand the range of the social marketing program while strengthening the smaller partner NGOs. NGO-initiated sales account for about 1/3 of the project's total sales. In addition, more than 100 independent and commercial vendors sell the project's Panté condoms. (Dadian, 1997). As of 2001, PSI's social marketing program sold 15 million condoms annually in Haiti and was the primary nationwide source of mass communication on HIV and STIs. (Putnam et al., 2001, p. 11). PSI also markets female condoms under the brand name Réyalité. In addition to its social marketing activities, PSI is also heavily involved in peer and community education through its Club Cool project. Launched in 1997, the project "promotes access to information and health products concerning reproductive health and HIV/AIDS prevention" through a network of youth social clubs. (How Does YouthAIDS Fight AIDS? retrieved June 20, 2003, from www.youthaids.org). The clubs, of which there are now more than 25, are largely autonomous and organize social and educational events for their peers and other community members. The clubs stress the role of abstinence, condom use, and faithfulness in HIV prevention. "PSI and Club Cool also disseminate their message through "Jounal Jenn Yo," a youth magazine which provides information about HIV/AIDS prevention." (How Does YouthAIDS Fight AIDS? retrieved June 20, 2003, from www.youthaids.org). PSI also works with CSWs, for whom it develops educational materials and conducts outreach activities. Finally, PSI is heavily involved in prevention of mother-to-child transmission (PMTCT) programming through its AIDSMARK project. Through AIDSMARK, PSI is currently implementing a USAID-funded mass-media campaign and a referral network for providers working in PMTCT. In this project, PSI partners with service providers to ensure that pregnant women have access to VCT, and that those women found to be HIV-positive receive the support they need. (Pregnant Women Seek HIV Testing in Haiti, retrieved June 20, 2003, from www.usaid.gov).

Konesans Fanmi

Konesans Fanmi is an umbrella organization that encompasses NGOs, women's groups, and private sector groups concerned with community-level health promotion. Konesans Fanmi focuses upon gender equity and sensitizing communities to the needs of people living with HIV/AIDS. It has achieved positive results through its outreach program, which trains young people as volunteers. (Putnam et al., 2001). Current activities include community education and mobilization, school-based and distance education for young people on sexuality and HIV/AIDS, and training in BCC, community mobilization, and gender equity for health staff.

World Vision

World Vision is an international Christian relief and development organization that has been active in HIV/AIDS work in Haiti since Spring 2003. Thus far, the organization's activities have focused upon raising awareness of HIV/AIDS. World Vision's target populations include orphans and other vulnerable children, adolescents, pregnant and lactating women, and Christian leaders. Recent activities include a training on community mobilization and a survey of PLWHA in World Vision's intervention areas. Results of this survey are expected to be available by the end of 2003.

Pan-Caribbean Partnership against HIV/AIDS

Efforts have been made in recent years to promote greater collaboration between Haiti and other Caribbean nations in the fight against HIV/AIDS and other STIs. One example of such an effort is the Pan-Caribbean Partnership against HIV/AIDS, which was created in 2001 to enhance and complement existing national programs. The Partnership is coordinated by the Caribbean Community Secretariat (CARICOM). (HIV/AIDS in Haiti and USAID Involvement retrieved May 7, 2003, from www.synergyaids.com). Smaller-scale partnerships between organizations in Haiti and the Dominican Republic are also developing. In 2002, GHESKIO, VDH, and two Dominican NGOs organized a workshop to develop strategies to protect young people and commercial sex workers in the two countries from HIV/AIDS. (SIDA: Rencontre de travail des ONG, retrieved June 20, 2003, from www.haitipressnetwork.com).

Prevention best practices:

UNAIDS suggests a number of guidelines for successful HIV/AIDS prevention programming. First and foremost, there must be political will and government support for HIV/AIDS prevention. Second, programs should promote community mobilization and involvement. Best practices specific to this area are described below. Third, programming should support the creation of alliances and networks between community agencies and public and private sector organizations. Fourth, programs should encourage involvement of people living with HIV/AIDS –as members of government decision-making bodies, community mobilization efforts, or support groups. Fifth, programs should promote community capacity building. Sixth, prevention programs require “safe and supportive environments,” in which health care and social services are available and policy promotes open discussion of sexual issues, including those of marginalized groups. Seventh, successful prevention programming should employ a multisectoral approach. Finally, programming should involve researchers and be thoroughly evaluated. (Malcolm and Dowsett, 1998, p. 58-64).

Mobilizing communities around prevention programs can be difficult. UNAIDS recommends the following: the community should “own” the program; the program should create strong links between the community and outside resources; the program should replenish participants’ skills, energy, and resources regularly in order to secure long term support; and the program should support good leadership and work towards optimal representation, including that of marginalized groups. Best practices for community mobilization are discussed further in Community mobilization. (UNAIDS: Community Mobilization and AIDS, 1997).

Evaluations of existing programs and recommendations for the future:

The MSPP’s National Strategic Plan for the Prevention and Control of HIV/AIDS highlights a number of flaws in current prevention programming. First, condom availability continues to be limited by supply and stocking problems. Second, few programs employ strategies aimed at increasing women’s negotiating skills. Third, community groups have taken little initiative in promoting condom use. Finally, the prevention component of the national program is heavily reliant upon external aid.

The CHANGE Project’s report on USAID-funded behavior change communication programs suggested that interventions should focus more on “second generation” HIV/AIDS messages that emphasize personal risk and its reduction, the reduction of stigma, and care-seeking behavior, rather than simply “the facts.” (Faulkner and Maynard-Tucker, 2002, p. 4). The authors also argue that if programs are to succeed, they must account for “cultural realities of Haitian behavior patterns and belief systems.”

Based upon the experience of the AIDSCAP program, it was suggested that future prevention efforts should include an expanded focus on STIs other than HIV, take into account women’s constraints in sexual decision making, involve youth in program design and implementation, and adequately address the needs of men. (Final Report for the AIDSCAP Program in Haiti, retrieved June 20, 2003, from www.fhi.org).

Marie St. Cyr-Delpe suggests that prevention programs should account for the differences between urban and rural Haiti. She recommends community mobilization and interpersonal communication-based programs in rural areas, and use of mass media and social marketing in urban areas. (St. Cyr-Delpe, 1995).

4.1.2 Prevention – youth and peer education:

Young people under the age of 19 comprise more than 60% of Haiti's population. (Thomas, 2002, p. 1). Due to a combination of biological, social, cultural, and economic factors, they are also among the groups most vulnerable to HIV/AIDS.

A behavioral study conducted in 2000 indicated that boys tended to become sexually active earlier than girls (13 years for boys versus 15.2 years for girls). (CERA/FHI, 2000, p. 6). The same study found that girls were significantly less likely to know where to obtain a condom than boys, or to report having used condoms with their regular partners. (FHI/CERA, 2000, p. 7). Similarly, girls were less likely to be able to name a symptom of STI or a method of HIV prevention than were boys. (CERA/FHI, 2000, p. 11).

A study conducted in northern Haiti in 1998 found that self-efficacy to communicate about HIV/AIDS, refuse unsafe situations, or use a condom were strong predictors of preventive sexual behavior among teenagers. Young people with lower perceptions of traditional gender norms were likely to have fewer lifetime partners than those with higher perceptions. The authors suggest that HIV-prevention programs should focus upon communication efficacy, address gender roles, and target young people early, before sexual habits are formed. (Holschneider, 2003).

Three organizations that are particularly well known for their work with Haitian youth are FOSREF, VDH, and PSI. Although they emphasize different points of entry and types of interventions, all three have successfully used peer educators. Although these programs have not yet been formally evaluated, both their staff and their peer educators feel that they have had positive effects in their areas of intervention. (Thomas, 2002).

Fondation pour la Santé Réproductive et l'Éducation Familiale (FOSREF)

FOSREF offers clinical services for young people as well as health education and outreach. Most of FOSREF's youth services are run out of the program's youth centers, although some have been integrated into VDH youth houses. Peer educators work in youth centers, in schools, and in communities. FOSREF's programs include condom distribution, family life education courses, special-interest clubs, an information bus staffed by peer educators, theater groups, libraries in youth centers, and collaboration with the Telephone Bleu hotline run by POZ. (Thomas, 2002). An average of 120,000 young Haitians participate in FOSREF's IEC activities every year. (Haiti Field Diary, retrieved June 20, 2003, from www.unicefusa.org). FOSREF also works with CSWs through Project Lakay, which provides a variety of services, including counseling. The bulk of FOSREF's work is in Port-au-Prince, but it maintains offices in five other cities and aimed to have a presence in Haiti's nine territorial departments by the end of 2003. (Haiti Field Diary, retrieved June 20, 2003, from www.unicefusa.org).

Volontariat pour le Développement d'Haïti (VDH)

VDH, which is active in the Northeast and Northwest provinces, works with youth in three areas: health, social and economic development, and the strengthening of youth groups. VDH's activities are run by peer educators out of the program's 13 youth houses or community spaces. Other program activities include a national contest on reproductive and sexual health for high school students, trainings for clinicians on communicating with young people, special-interest clubs, study spaces, hostel spaces for young people at odds with their families, parents' meetings, a weekly radio show, and youth discount cards. (Thomas, 2002) In 2000, VDH, the Haitian Ministry of Health (MSPP), UNAIDS, UNICEF, and a number of other organizations organized a traveling HIV/AIDS awareness and prevention campaign that featured parades, movies, youth meetings, testimonials from people living with AIDS, and concerts by popular Haitian musicians. The campaign relied heavily upon VDH peer educators, who organized events, facilitated discussions, and distributed condoms. (Simeon, 2000).

World Relief

Another organization working with youth in Haiti is World Relief, which has been active in the country for more than a decade, working primarily through evangelical churches. The organization is active in a number of departments, with the bulk of its activities concentrated in the South, the West, and the Artibonite, where it works in conjunction with the Hôpital Albert Schweitzer (HAS). Although World Relief works in a variety of sectors, in recent years it has demonstrated an increasingly strong commitment to the fight against HIV/AIDS. World Relief's activities include: training of pastors in HIV/AIDS counseling, including care and support of PLWHA; awareness-raising on HIV/AIDS among evangelical church members; promotion of abstinence among youth people; training of members of evangelical churches in home care and support of PLWHA.

Caritas Nationale d'Haiti

Caritas was created in 1975 at the Conference of Haitian Bishops with the aim of promoting social justice, development, and solidarity in communities throughout the country. To this end, the organization works to develop solutions to social problems, create diocese- and parish- level Caritas branches, and support community-based development efforts. Caritas will be collaborating with HCP to educate youth in the dioceses of Cayes, Port-au-Prince, and Gonaïves about STIs and HIV/AIDS. This project is peer educator-driven and stresses the benefits of abstinence, faithfulness, and personal responsibility.

Youth and peer education best practices:

According to one UNAIDS publication, the most effective HIV/AIDS programs targeting young people: “respond to the diversity of young people and their needs; encourage youth participation in design and implementation; work in a climate of openness that recognizes realities that young people face; focus on young men’s sexual health needs as well as those of young women; focus on the positive aspects of sexual health as well as unwanted pregnancy and STIs; promote greater awareness of sexual and reproductive health rights; and offer improved access to education and health services.” (Adolescent Sexuality, retrieved July 20, 2003, from www.unaids.org).

A second UNAIDS document reviewing peer education programs notes that few documented programs use rigorous research designs or outcome measures (such as HIV incidence). “Instead, many programs collect only proxies of outcome measures, such as HIV-related knowledge, self-efficacy, and/or attitudes and beliefs, through the use of uncontrolled pre- and post-test or post-test only research designs.” (Kerrigan, 1999).

A report released by the Horizons Project offers further suggestions for successful peer education programming. First, it is important to understand that peer education is not always the best choice for prevention programs. Some types of information can be more effectively conveyed via “expert” educators. Second, peer education should be linked to other types of programming, such as clinical services, community health, or development. Third, programs should work with stakeholders and young people to establish clear criteria for educator selection. Fourth, peer educators should be compensated in some way. Fifth, educator training needs to address not only HIV/AIDS, but also participatory techniques for engaging the audience. Training should be competency-based and ongoing, and educators should be supervised both in the field and in the office. Peer educators should take part in the development of program training curriculums. Sixth, program messages should be reinforced through a variety of peer educator-led activities. Seventh, program activities should address gender inequities that affect sexuality and HIV transmission. Finally, programs should generate enough financial resources and support to ensure their sustainability. Peer education programs are often misunderstood to be inexpensive because they rely on volunteers; in fact, high quality training and materials can be quite expensive, so assuring adequate funding mechanisms is crucial. (Kerrigan, 1996).

Evaluation of existing programs and recommendations for the future:

A 2002 assessment of USAID-funded programs in Haiti noted that there existed a “crucial resource allocation decision: whether to continue to concentrate efforts on (and to strengthen and deepen expertise in)

its current area of strategic advantage, the youth market, or to diversify the investment by enlarging programming for other segments of the high risk group, such as commercial sex workers and men away from home. The priorities of other donors...should be taken into account in determining the answer to this question.” (Faulkner and Maynard-Tucker, 2002, p.9).

UNPFA, which supports several Haitian organizations that work with youth, has noted that monitoring and evaluation are “critical shortcomings” of many of these organizations. (Putnam et al., 2001, p. 13).

Based upon their experience, FOSREF, VDH, and PSI have made a number of recommendations for future peer education programs targeting young people. While many of these suggestions reflect the best practices described above, others point to programmatic weaknesses specific to the Haitian milieu. It is recommended that: peer educators should “practice what they preach”; peer educators should receive adequate stocks of condoms for distribution in their communities; programs should try to include similar numbers of boys and girls as members and peer educators; programs should account for the fact that peer educators of different ages will have different needs and abilities; and programs should seek to include young people not enrolled in school in their activities. (Thomas, 2002).

Table I: Organizations Working in HIV Prevention in Haiti						
Organization: Project	Primary activities – Past and Present	Department – No. of sites	Collaborators	Program duration	Funding source	Comments
AED (Academy for Educational Development): SMARTWork	<p>Training of business managers and union members in HIV/AIDS prevention</p> <p>Development of HIV/AIDS prevention programs for employees</p>	West, PAP	ADIH, USAID, POZ, PSI, HS2004, MAST	1999-2003	US Department of Labor	
<p>CARE: YDI (Bassin Bleu Youth Initiative)</p> <p>Care and Support for PLWHA</p>	<p>Multisectoral youth program focusing on education, health, economic development, and agriculture.</p> <p>Outreach and training activities addressing the needs of PLWHA, as well as technical information on HIV/AIDS</p> <p>Home visits to PLWHA</p>	<p>Northwest</p> <p>Grande Anse, Nippes, Artibonite, Northwest</p>	VDH, PSI, MSPP	2001-2003	CARE USA, Kellogg Foundation	Uses peer educators to coordinate activities.
Caritas	Peer education	Gonaïves, Artibonite				
CHASS (Centre Haitien de Service Social)	<p>Peer education</p> <p>Condom social marketing targeting urban youth</p>				USAID – FHI/AIDSCAP	In the early 1990's, CHASS ran a program in PAP in which young health educators distributed condoms through beauty salons.
CPF0 (Centre de Promotion des Femmes Ouvrieres)	<p>Educational activities targeting female factory workers</p> <p>Round tables</p> <p>Information sessions</p>	West, PAP			USAID – FHI/AIDSCAP	

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CRS (Catholic Relief Services)	Community education during village festivals	South	MSPP – Sud, GIPA-PECAS, GRASADIS	June-September 2003	Private funders – CRS	
	Training of youth and staff for a drop-in center	South	ASON	2002-2006	Private funders – CRS	
	Training of credit program participants in HIV/AIDS and stigma (with CARE)	Southeast	MHDR	2002-2006	Private funders – CRS	
	Training on stigma and discrimination with community leaders and student committees	Southwest	UNASCAD-ASON, FEB	2002-2006	Private funders – CRS	
	Training for children and staff at orphanages	Southeast West		2002-2004	USAID	
	Anti discrimination campaign	Nationwide	UNASCAD and other partners	2002-2004	USAID	
FHI (Family Health International):AIDSCAP, IMPACT	AIDSCAP: Technical and material support for organizations conducting interventions to reduce sexual transmission of STIs and HIV	Nationwide	GLAS, CPCO, VDH, CHASS, GHESKIO, CDS	AIDSCAP 1992-96	USAID	
	IMPACT: Technical and material support for local organizations working with young people, commercial sex workers, men who have sex with men, the military, orphans and vulnerable children, and the media	West, Grande Anse, North, Center	FOSREF, VDH, Maison Arc-en-Ciel, POZ	IMPACT 1997-2007	USAID	
	Support for national anti-stigma campaign	Nationwide	MSPP	2002-2003	USAID	
	Second-round behavioral surveillance surveys (BSS)	Nationwide	MSPP, UNICEF, UNFPA, CERA, PSI, IHE, WHO	2002-2003	USAID and partners	

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FOSREF (Fondation pour la Santé Reproductive et l'Education Familiale)	<p>Clinical services for young people, including STI diagnosis and treatment</p> <p>Health education and outreach for young people, including family life education courses and activities in communities, secondary schools and universities</p> <p>Project Lakay: services, counseling, and support to CSWs</p> <p>Telephone hotline</p> <p>Condom distribution</p>	Most work in PAP, with additional offices in five other cities.	VDH, POZ		UNFPA, FHI/IMPACT, the Gates Foundation	USAID
GLAS (Groupe de Lutte Anti-SIDA)	<p>Workplace-based education on HIV transmission and prevention</p> <p>Workplace discussion groups covering gender roles, relationships, and communication</p>	PAP and some provinces	AIDSCAP, USAID	1990-1996	USAID – FHI/AIDSCAP	During the 1990's GLAS did noteworthy work in client empowerment and self-efficacy. It used the therapeutic technique transactional analysis (TA) as a tool to stimulate discussion and reflection in its bi-weekly workplace support groups.
HAS (Hospital Albert Schweitzer)	Training in which local leaders were invited to hear the personal stories of people living with HIV/AIDS	Artibonite				Trainees conducted discussions and other HIV prevention activities in their own communities after attending the workshop. The focus of both the original training and many trainee-led activities was upon personal risk reduction and destigmatization of PLWHA

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HHD (Health and Human Development)	Training for educators in personal risk reduction, advocacy (for school-based prevention efforts), and implementation of skills-based HIV prevention in the classroom.		Education International			
Konesans Fanmi	Community education and mobilization School-based and distance education for young people on sexuality and HIV/AIDS Training in BCC, community mobilization, and gender equity for health staff	West, South, Southeast, Artibonite	VDH, POZ, FOSREF, UNICEF, HS-2004, MSPP	2003-2004	MSH, Policy Project, UNICEF, Global Fund	KF is an umbrella organization that encompasses a variety of women's groups and community organizations KF has had considerable success securing financial support from the Haitian commercial sector
MSPP (Ministère de la Sante Publique et de la Population) and MENJS (Ministère de l'Education Nationale, de la Jeunesse, et des Sports)	Condom distribution and management of stock Development of Family Life curriculum Decentralized activities in the 11 health departments Traveling youth "caravan"	Nationwide	Promess		UNFPA	
UCC (Unité Centrale de Coordination)	Development of BCC strategies and messages for STI/HIV/AIDS Development of norms for counseling and VCT	Nationwide				Norms and strategies are currently in development

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Organization: Project	Primary activities – Past and Present	Department – No. of sites	Collaborators	Program duration	Funding source	Comments
PESADEV (Perspectives pour la Santé et le Développement)	Development of educational materials Mass communication activities Outreach targeting the media and young people	West, Northwest			AAA(Agro Action Allemande), FHI	
Plan Haiti	Community education and outreach, with an emphasis on village festivals Production of educational materials Youth peer education Support for national anti-stigma campaign	West, Northeast, Southeast	MSPP, CDS, DSSE MSPP	2003-2008 2003-2008	Plan	
POZ (Promoteurs Objectif ZeroSIDA)	Counseling center (PAP) Telephone Bleu counseling and information hotline Production of national HIV/AIDS newsletter	National	FHI, UNFPA, FOSREF, CRS	1999-present		

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Organization: Project	Primary activities – Past and Present	Department – No. of sites	Collaborators	Program duration	Funding source	Comments	
PSI (Population Services International)	Condom social marketing	Nationwide	MSPP, AOPS, ADRA, CITIMED, FOSREF, SADA, OBCG, SANTE PLUS, Save the Children, World Vision, the Haitian Health Foundation, Konesans Fanmi, Peace Corps, HELP	1989-present	MSH, Global Fund, Japanese Government, Private foundations, UNICEF, USAID – FHI/AIDSCAP	Collaboration with partner NGOs has enabled PSI to achieve broad distribution coverage.	
	Youth peer education through Club Cool program	Nationwide		2003-2004			Global Fund
	Publication of youth magazine <i>Jounal Jenn Yo</i>	Nationwide					
	Carnival season community education, including collaboration with local artists and musicians						
	Creation of a network of PMTCT service providers and media promotion of PMTCT services	West	UNICEF and a network of local clinicians and health service sites	2003-2004	UNICEF, Global Fund, USAID, AIDSMARK		
	Education for at-risk groups, including CSWs and their clients	West, North	FOSREF, MSPP	2003-2004	Global Fund		
	Qualitative and quantitative study of CSWs and promotion of condom use among CSWs	West		2003	Global Fund		
SCF/UK (Save the Children UK)	Community development						
	Coordination of HIV prevention activities among smaller NGOs in its work area						

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Organization: Project	Primary activities – Past and Present	Department – No. of sites	Collaborators	Program duration	Funding source	Comments
VDH (Volontariat pour le Développement d’Haïti)	<p>Youth peer education pertaining to health and social and economic development</p> <p>Social marketing targeting youth</p> <p>Trainings for clinicians on working with youth</p>	Northeast, Northwest	FOSREF		USAID – FHI/AIDSCAP, IMPACT UNPFA	In past years, VDH has worked with other groups to organize a “Caravan of Artists and Youth against AIDS.”
World Relief	<p>Training of religious and community leaders in STI and HIV/AIDS</p> <p>Training of pastors in HIV/AIDS counseling</p> <p>Peer education</p> <p>Literary and musical competitions surrounding stigma and abstinence</p> <p>Mobilization of member churches</p> <p>Production of educational materials relating to religion, sexuality, and HIV/AIDS</p>	South, West, Artibonite	FHI	1999-present	World Relief, Global Fund, U.S. Churches	
World Vision	<p>Education of women, service providers, men, and youth</p> <p>Mobilization of health personnel against stigma</p> <p>Training of staff and community groups in BCC, community mobilization, and gender equity.</p>					

4.2.1 Services and treatment – VCT and multi-service:

HIV/AIDS services and treatment are limited in Haiti. Of the 660 healthcare sites in the country, less than half provide any kind of HIV services or treatment. GHESKIO, HAS, and Zanmi Lasanté are the major providers of HIV/AIDS care in the country. (IHE, 2002, p. 14). There does not appear to be any information on quality of care for HIV/AIDS services and treatment in Haiti.

Current information about VCT services in Haiti is scarce, a fact that may be due to the rapid expansion of services in recent years. It appears that new information on VCT will become available in late 2003 and early 2004. Clearly, however, this is an area in which further research must be done.

As recently as 2002, only 24 sites in Haiti provided VCT services. That number is expected to increase to 70 by August 2004. This change may be attributed in part to the fact that much of the \$67 million that Haiti is currently receiving from the Global Fund to Fight AIDS, Tuberculosis, and Malaria is earmarked for the creation of 25 new testing and counseling centers. (New Kaisernetwork.org Feature Examines AIDS in Haiti, retrieved June 20, 2003, from www.kaisernetwork.org). The vast majority of currently operational sites receive support or supervision from MSH, PSI, FHI, or GHESKIO. VCT sites are disproportionately concentrated in the Port-au-Prince area, where 20 sites are located (compared to 3-7 per department outside of the capital).

Qualitative research conducted by CARE in 2000 indicated that attitudes towards VCT were generally positive. Despite this fact, study participants were far more likely to support testing for others than for themselves. In keeping with this, some participants suggested that VCT services should target specific groups, such as partners of PLWHA or young people, rather than the population as a whole. (CARE, 2000, 35).

Ministère de la Santé Publique et de la Population (MSPP)

Through government health centers, the MSPP provides a number of HIV/AIDS-related services, including VCT, PMTCT, and syndromic management of STIs. The MSPP is also responsible for formulating and revising norms for HIV/AIDS-related services and treatment.

Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO)

GHESKIO has long been on the forefront of VCT service provision in Haiti. As recently as 1996, it was the only provider of free VCT in the country. In addition to VCT, GHESKIO provides a wide variety of HIV/AIDS and RH-related services, including IEC, condom distribution, and treatment for TB, STIs, and other illnesses. "It has also treated a number of private patients who could afford access to US-priced drugs, offered post-exposure prophylaxis to health professionals and rape victims when possible, and provided AZT to pregnant women." (Adesky, 2001, p. 4). GHESKIO, which receives funding from both the private and public sectors, provides its services to patients at no cost. About 100,000 patients are received every year. The organization also conducts research and trains health professionals. (GHESKIO Projects, retrieved June 20, 2003, from www.haitimedical.com/gheskio/projects.html).

Hôpital Albert Schweitzer (HAS)

Hôpital Albert Schweitzer (HAS) is a private institution in Haiti's Artibonite valley that provides high quality health care to thousands of people in its catchment area. HAS provides a wide variety of services, including VCT, PMTCT, and primary health care. HAS also sponsors community development efforts and innovative HIV and TB prevention outreach programs. One such program used the personal stories of people living with AIDS to combat stigma and create a sense of personal vulnerability to HIV/AIDS. Church leaders, schoolteachers, and voodoo practitioners attended a training at which people living with AIDS recounted their experiences. The trainees then returned to their own communities, where many of them, filled with a new sense of personal risk, began to conduct discussions and other HIV-prevention activities. (Fitzgerald and Simon, 2001).

Management Sciences for Health (MSH)

For several years, MSH and its subcontractors (including CCP) have been “the largest conduit of USAID funding for reproductive health activities in Haiti through the HS-2004 project.” (Putnam et al., 2001, p. 7). Through this project, USAID provides financial and technical support to a network of 34 organizations and institutions. The project’s current phase focuses upon establishing performance standards, monitoring and evaluation, mobilizing technical resources, and improving access to services and quality of care. Historically, HIV prevention and treatment have not been a large component of the reproductive health programming offered by HS-2004 partner organizations. In recent years, however, MSH has made efforts to evaluate organizational capacity to support this kind of program and to integrate services when appropriate. (Putnam et al., 2001).

The Centre de Développement Sanitaire (CDS)

The Centre de Développement Sanitaire (CDS), which has worked with MSH through the HS-2004 project, provides reproductive health and HIV-related services including VCT, STI treatment, and TB care. The organization runs its own service sites as well as managing government hospitals in certain areas. Although it has been commended for its efforts, CDS lacks outreach capacity and has not always been able to provide the full range of services (such as high quality counseling) that should, in theory, complement those it does offer. (Putnam et al., 2001).

VCT best practices:

UNAIDS recommends that VCT services meet a number of criteria. First, VCT programs function best in a supportive policy environment, in which the government is committed to making VCT available, as well as to protecting the rights of people living with HIV/AIDS. Ideally, governments and other organizations working in HIV/AIDS should ensure that high quality VCT services are available, accessible, and affordable. Quality is defined by, among other things, confidentiality, the use of informed consent, reasonable service location and hours of operation, and individually tailored pre-and-post test counseling services. Counseling should be integrated into other services, including STI care and antenatal and family planning services. VCT services should be tailored to meet the needs of specific groups, including pregnant women, couples, children, commercial sex workers, and men who have sex with men. Counselors should be adequately trained and supported in order to avoid burnout. Counseling services should be monitored to assure quality of care. VCT should take place in conjunction with stigma-reducing activities, including those that involve people living with HIV/AIDS. VCT can and should serve as an entry point for medical care, such as TB testing and treatment and PMTCT services. VCT program counselors should be knowledgeable about all services available to people living with HIV/AIDS, including traditional healing, spiritual support, and legal and social services. To this end, referral systems should be developed to coordinate the services offered by NGOs, clinics, community organizations and other groups. Promotion of VCT services should be an integral part of HIV education and IEC materials. In order to promote and expand VCT services, it is also important that programs document their successes and work to improve service and cost-effectiveness. (UNAIDS: Voluntary Testing and Counseling, 2000).

Evaluation of existing programs and recommendations for the future:

According to the MSPP, weaknesses of existing VCT programs include mandatory testing at some healthcare sites, lack of confidentiality on the part of healthcare providers, and stigmatization of HIV-positive individuals by providers. (IHE, 2002, p.15).

A retrospective study of GHESKIO patient records indicated that integrating primary care and VCT services, as GHESKIO does, is a useful strategy. “VCT attracts a population at risk for multiple communicable diseases and thereby serves as an excellent entry point for primary care services. Reciprocally, provision of on-site primary care services attracts populations at high risk for HIV and may thereby improve the efficacy of VCT.”(Peck et al., 2003, p.474).

In a study conducted between 1990 and 1992, Desormeaux et al. demonstrated that VCT services could be successfully linked to TB screening and control programs. By providing community education about TB and publicizing TB testing services, the investigators were able to attract large numbers of people to the testing site, where they were offered HIV VCT in addition to TB testing. Using this method, the investigators were able to screen 10% of the adult population of the study area for HIV. The study did not indicate, however, whether this kind of large-scale screening effort was cost effective in terms of HIV prevention. (Desormeaux et al., 1996).

The Synergy Project's final report recommended increased collaboration between the public and private sectors, and specifically the creation of referral centers "for provision of high-quality VCT and STI and HIV services in public and private sector health facilities in selected departments." (Putnam et al., 2001, p. 22). It was suggested VCT services should include high-quality pre-and-post test counseling, high-quality clinical and laboratory procedures, a network of providers covering the prevention-care continuum, and a mechanism to appropriately build demand for VCT and mobilize community support for people living with HIV/AIDS. Other recommendations pertaining to VCT include stronger linkages between HIV/AIDS and TB services and increased focus upon certain target groups, including young people, young men with disposable income, and commercial sex workers. (Putnam et al., 2001).

4.2.2 Services and treatment – antiretroviral therapy:

Zanmi Lasanté

The medical center sponsored by Zanmi Lasanté in Cange provides care for thousands of people, offering low-cost or free services that include primary care, malaria and TB treatments, STI diagnosis and treatment, zidovudine therapy for pregnant women, and post-exposure HIV prophylaxis, among other things. In 1998, Zanmi Lasanté launched the HIV Equity Initiative, under which it provides HAART drugs to AIDS patients who are no longer responding to syndromic treatment of their opportunistic infections. The initiative, like Zanmi Lasanté's DOTS-plus TB program, uses a buddy system to ensure that patients adhere to their therapy and receive the necessary support during their illnesses. This strategy has a number of advantages. First, it allows for increased service delivery without requiring extra clinical staff. Second, it is hoped that using DOT from the outset may minimize the development of drug-resistance, as it has in the case of TB. As of 2001, 65 Zanmi Lasanté patients were on triple therapy regimens, and many more were on a waiting list. Farmer and others working on the initiative note that one of the project's major challenges is ensuring that patients have enough food with which to take their medications. Providing food to patients and using buddies to support drug adherence has mitigated this problem to a certain degree. (Adesky, 2001; Farmer et al., 2001). Zanmi Lasanté is also active in community mobilization efforts around Cange. In August 2001, the organization sponsored a forum on health and human rights that was attended by more than 1000 local residents, including a number of those participating in the center's HIV Equity Initiative. This event served to both address stigma in the community and to advocate for greater access to HAART drugs in Haiti. (Adesky, 2001).

The Global Fund to Fight AIDS, Tuberculosis, and Malaria

A portion of the \$67 million that Haiti will receive from the Global Fund to Fight AIDS, Tuberculosis, and Malaria during the next five years will be used to make antiretroviral drugs more widely available. More than 1000 people are scheduled to receive these drugs by the end of 2003. UNDP and the SOGEBANK foundation are the major recipients of Global Fund support in Haiti. (Haiti, retrieved August 10, 2003, from www.globalfundatm.org).

The Bill Clinton Foundation on HIV/AIDS and PAHO

The Bill Clinton Foundation on HIV/AIDS and PAHO are assisting in negotiations to obtain reduced-cost antiretroviral drugs from pharmaceutical companies for use in the Caribbean. Edward Greene, the assistant secretary general of human and social development for the Caribbean Community, has said that it is likely that Haiti will be fast-tracked to benefit from the lower prices due to its extreme poverty. The lower prices

were expected to take effect in spring or summer 2003. (Haiti, Small Caribbean Islands to Get Cheaper HIV/AIDS Drugs, retrieved June 20, 2003, from www.thebody.com).

Antiretroviral therapy best practices:

The use of antiretroviral therapy in developing countries has, until this point, been limited. For this reason, there are not well developed best practices in this area. The major challenges to antiretroviral therapy provision are access, correct use, adherence, and the development of drug resistance. Antiretroviral therapy should, therefore, include: triple drug therapy, correct and supervised use of medications, strict individual protocols, and reliable psychosocial and material support. Other questions in this area that merit further consideration are the cost-effectiveness of antiretroviral care and the optimal distribution of drugs. (Antiretroviral therapy, retrieved July 20, 2003, from www.unaids.org).

Evaluation of existing programs and recommendations for the future:

The authors of the MSPP's National Strategic Plan cite a number of weaknesses in current programming in care for people living with HIV/AIDS. First, there is a lack of trained clinical personnel and social workers. Second, there is not a standardized protocol for the care of people living with HIV/AIDS. Third, stigmatization of HIV positive individuals remains a problem among health care providers, due in part to a lack of adequate training and sensitization. Finally, according to the National Strategic Plan, the public healthcare system has a limited capacity to absorb the funds necessary for improving services in this area. (IHE, 2002, p. 14).

4.2.3 Services and treatment – PMTCT:

Reducing MTCT in Haiti is dependant upon decreasing HIV incidence among women, reducing fertility among seropositive women, and providing care and preventative treatment for seropositive women who are pregnant or nursing. (IHE, 2003, p. 4).

In their 1999 study of the natural history of HIV-1 in Haitian infants, Jean et al. suggested that, in the absence of zidovudine or other chemotherapy, the rate of transmission of HIV from mother to child might be as high as 37%. (Jean et al., 1999, p.63).

Serostatus may have little effect upon the reproductive desires or behavior of Haitian women. It has been suggested that fear of death in a country where there is no available treatment for AIDS may actually encourage women to become pregnant in order to reassure themselves that they are still healthy and capable of bearing children, which is a major aspect of female identity in Haitian culture. (IHE, 2003, p. 9).

Breastfeeding is a primary factor in MTCT in Haiti. Nearly all Haitian newborns are breastfed. The mean length of breastfeeding in Haiti is 21.4 months, which far exceeds the recommended period for seropositive mothers. Furthermore, most Haitian women practice mixed feeding, which is specifically not advised for seropositive women. (IHE, 2003, p. 10).

A 1995 qualitative study conducted in Port-au-Prince and Les Cayes suggested that respondents had limited knowledge and understanding of mother-to-child transmission of HIV. (Ulin et al., 1995). These findings are confirmed by those of the EMMUS III, in which approximately 20% of respondents were not aware of vertical transmission. (Cayemittes et al., 2001, p. 209). Female respondents were slightly better informed about this mode of transmission than males.

Focus groups conducted in 1998 near Port-au-Prince indicated that many women did not have a thorough understanding of MTCT. The role of breastfeeding in transmission was a particular source of confusion. Many older respondents, for example, believed that any infant born to an HIV-positive mother would be infected. Women who had personal experience with HIV and whose breastfed infants were healthy often argued that breastfeeding was not a mode of transmission. (Coreil et al., 1998, p. 51).

As of 2000, Haiti was participating in an international study of zidovudine to prevent MTCT. The results of this study have not yet been published. It should also be noted that, regardless of the study's findings, interventions using antiretroviral therapy to prevent MTCT are not likely to be widely available for another 2-7 years. (FHI/IMPACT, 2000).

MSPP, GHESKIO, Zanmi Lasanté, and the Centre Hospitalier Sainte Catherine Labouré (CHOSCAL)

In 1999, UNFPA, the MSPP, GHESKIO, Zanmi Lasanté, and the Centre Hospitalier Sainte Catherine Labouré (CHOSCAL) collaborated to develop a pilot project targeting MTCT through the use of antiretroviral therapy and formula feeding. The project produced encouraging results, most notably a reduction of MTCT of 80-90% in the study populations. (IHE, 2003, p. 14). The three hospitals involved in the pilot project have continued to offer PMTCT services, and a number of other institutions (including HAS, Hôpital Port de Paix, Hôpital Claire Heureuse de Marchand Dessalines, Hôpital Mirebalais, and Hôpital Diquini) have since added such services.

UNICEF and President Bush's International Mother and Child HIV Prevention Initiative

Both UNICEF and President Bush's International Mother and Child HIV Prevention Initiative focus on PMTCT in Haiti. The two programs seek to promote, among other services, counseling for people living with AIDS and their families, expanded VCT services, access to anti-retroviral drugs, and breastfeeding education and counseling for HIV-positive mothers. (Mother and Child HIV Prevention Initiative, retrieved June 20, 2003, from www.aidsinfo.nih.gov; Slavin, 2002).

PMTCT best practices:

UNAIDS emphasizes that primary prevention of HIV in women of childbearing age remains the most effective PMTCT strategy. "Any national strategy to prevent mother-to-child transmission should therefore be part of broader strategies to prevent the transmission of HIV and STDs, to care for HIV-positive women and their families, and to promote maternal and child health." (UNAIDS: Mother-to-Child Transmission of HIV, 1998, p. 7). Other considerations in the development of effective PMTCT programs are political will, affordability of interventions, and strength of existing human resources and infrastructures. UNAIDS elaborates upon six primary criteria for successful PMTCT programming. First, all women should have knowledge of HIV and access to the necessary information to make appropriate choices about their sexual and reproductive health. This may require, among other things, strengthening linkages between VCT services and family planning programs. Second, HIV counseling should be available to pregnant women, those considering pregnancy, and their partners. Pilot programs have indicated that this is best achieved by integrating PMTCT services with other routine health care, such as family planning and maternal and child health services. VCT is the cornerstone of PMTCT, and assuring high quality VCT services is essential to effective PMTCT. (Psycho-social and Socio-anthropological Issues Affecting Uptake of Prevention of Mother-to-Child Transmission Services, retrieved July 20, 2003, from www.unaids.org). Third, all pregnant women should have access to antenatal, delivery, and postpartum care by a skilled attendant. Fourth, children should be followed up to at least 18 months. Fifth, medical and other support services should be accessible to HIV-infected mothers and their families. An important aspect of this care is counseling regarding infant feeding options and the assurance of safe, affordable alternatives to traditional breastfeeding. Sixth, human rights, including those to reproductive decision-making and confidentiality, should be respected. . (Mother-to-Child Transmission of HIV, 1998). As in other areas of HIV/AIDS programming, there is a need for increased monitoring and documentation of PMTCT programs, so that new programs may be developed and existing programs expanded and improved. (Psycho-social and Socio-anthropological Issues Affecting Uptake of Prevention of Mother-to-Child Transmission Services, retrieved July 20, 2003, from www.unaids.org).

Evaluation of existing programs and recommendations for the future

The pilot project by the MSPP and other institutions encountered a number of obstacles. These problems included: a lack of coordination between sites and agencies; a lack of standardized protocols; and a lack of adherence to patient selection criteria. (IHE, 2002, p. 13).

GHESKIO's PMTCT services, which include VCT, group counseling, formula provision, shortcourse ART, and microcredit for families affected by HIV/AIDS, have twice been evaluated (in 2002 and 2003) by the research firm Centre de Recherche pour le Développement (CRD). These evaluations indicated that, in general, GHESKIO's program had been successful, surpassing most of its stated objectives and reducing MTCT by more than 75%. (Clérismé, 2002, 11; Clérismé, 2003, 17). Areas in which objectives were not met were: use of AZT by new mothers (2002 and 2003), condom distribution (2002), and birthing at hospitals by seropositive women (2003). (Clérismé, 2002, 11; Clérismé, 2003, 16). Both evaluations highlighted to impact of stigma upon program success, noting that fear of discrimination seemed to decrease use of services, including support groups, post-natal AZT provision, and counseling. (Clérismé, 2002, 16; Clérismé, 2003, 22). Similarly, both evaluations noted the need for more services targeting men or the larger family unit. (Clérismé, 2002, 19; Clérismé, 2003, 22). Factors that may have contributed to the program's success were that all services were provided the same day and were free. (Clérismé, 2002, 17; Clérismé, 2003, 21).

A qualitative study conducted in 2002 for PSI indicated that fear of testing positive, lack of health education for women, lack of counseling training for providers, and limited availability of VCT at sites frequented by pregnant women were all possible barriers to PMTCT programming in Haiti. The same study recommended increased BCC; use of home visits to ensure maximum program coverage; broad availability of testing services; extensive training and support for clinical personnel; strengthened referral networks; and development of standardized infant feeding protocol for HIV positive mothers. (Boulos, 2002, p. 6).

Table II: Organizations Working in HIV/AIDS Services and Treatment in Haiti						
Organization: Project	Primary activities	Department – No. of sites	Collaborators	Program duration	Funding source	Comments – Past highlights
Bill Clinton Foundation on HIV/AIDS	Assisting in negotiations for reduced-cost antiretroviral drugs from pharmaceutical companies	N/A	PAHO		Various -Fundraising	
CARE	Pre- and post-test counseling for VCT Distribution of coordinators' kits	Grande Anse, Northwest Nippes, Artibonite	FOSREF, MSPP, PSI, CRS	Until 2006	Global Fund, UNICEF, Japan	
CDS (Centre de Developpement Sanitaire)	Provides a variety of HIV/AIDS-related services, including VCT, STI management, and TB treatment.	Northeast, West	MSPP, Plan Haiti		MSH, USAID, Plan Haiti	
CHOSCAL (Centre Hospitalier Ste. Catherine Labouré)	PMTCT	PAP	MSPP, GHESKIO, Zanmi Lasanté			
FHI	Promotion of VCT services Counseling training – youth clinics					
FOSREF	Management of information corners STI/FP/RH counseling	Nationwide	MSPP	2003-2006	Global Fund, Gates Foundation	
GHESKIO (Groupe Haitien d'Etude du Sarcome de Kaposi et des Infections Opportunistes)	Clinician training Research on STIs and HIV/AIDS Provides a wide variety of HIV/AIDS and RH-related clinical services, including VCT and PMTCT	PAP	MSPP	1982-present	USAID, Cornell University Medical College, UNICEF, UNFPA, CAID, FAC, PAHO, MSPP, Institut Alfred Fournier	
Global Fund to Fight AIDS, Tuberculosis, and Malaria	Expanding access to ART through partner organizations Creation of new VCT centers	N/A	UNDP, Fondation SOGEBANK, 17 NGOs	2003-2006		
HAS (Hôpital Albert Schweitzer)		Artibonite	MSPP		Global Fund	

Table II: Organizations Working in HIV/AIDS Services and Treatment in Haiti						
Organization: Project	Primary activities	Department – No. of sites	Collaborators	Program duration	Funding source	Comments – Past highlights
MSH (Management Science for Health): HS2004 (Health Systems 2004)	Phase I: 1995-2000 Establishment of an NGO network to streamline RH services and inform and educate the public Phase II: 2000-2005 Increasing institutional capacity to create and respond to client needs through the establishment of performance standards, program monitoring and evaluation, mobilizing technical resources, and improve access to services and quality of care.		Network of 34 local NGOs	1995-present	USAID	
MSPP	VCT PMTCT Syndromic management of STIs Revision of norms for syndromic management of STIs	Nationwide	GHESKIO, FHI, AOPS, HS2004	On-going	Global Fund, National Treasury	
PAHO (Pan-American Health Organization)	Assisting in negotiations for reduced-cost antiretroviral drugs from pharmaceutical companies	N/A	Bill Clinton Foundation on HIV/AIDS, MSPP, BID	On-going	BID	
Plan Haiti	Internal staff training Counseling training with Maison Arc en Ciel	West, Northeast, Southeast	MAEC, CDS	On-going	Plan International	
POZ	Pre- and post-test counseling for VCT	West	MSPP			
PSI: AIDSMARK	Study of PMTCT services and knowledge Promotion of PMTCT services in the media PMTCT education activities					
UNICEF	Currently working with 21 NGO NGOs to prevent MTCT					

Table II: Organizations Working in HIV/AIDS Services and Treatment in Haiti

Organization: Project	Primary activities	Department – No. of sites	Collaborators	Program duration	Funding source	Comments – Past highlights
CRS	Provides services in VCT/PMTCT	North (Pilate)	Hôpital Espérance		UNICEF	
Zanmi Lasanté	Provides a variety of HIV/AIDS-related services, including STI management, TB treatment, PMTCT and post-exposure HIV prophylaxis Provides ART to a limited number of patients using a DOT strategy	Center	GHESKIO			

4.3 Advocacy and planning :

Formal advocacy efforts seem to be relatively rare in Haiti. Those that do exist, however, target a wide range of audiences (including the media, community leaders, business leaders, and international organizations), and advocate for improvements to many different aspects of Haiti's response to HIV/AIDS.

Futures Group/Policy Project

The Futures Group's Policy Project has received funding from USAID to assist in the projection and presentation of data on population growth and HIV/AIDS in Haiti. The project has also assisted the MSPP in the analysis of recent sentinel surveillance data and preparation of updated HIV/AIDS projections for Haiti's National AIDS Plan (2002-2006). (HIV/AIDS in Haiti and USAID Involvement, retrieved May 7, 2003, from www.usaid.org).

Academy for Educational Development (AED)/SMARTWork

AED's SMARTWork project seeks to establish effective HIV/AIDS programs and policies for the workplace. Recently, SMARTWork has trained managers and union leaders in HIV/AIDS prevention strategies. SMARTWork also seeks to address the issue of stigma in the workplace by helping businesses to develop anti-stigma policies. In collaboration with the Association des Industries d'Haiti (ADIH), SMARTWork has developed a document entitled "Politique relative au VIH/SIDA sur le lieu de travail," which outlines ADIH's policy on HIV/AIDS in the workplace. SMARTWork partners with a wide variety of local and international organizations, including PSI, HS2004, and POZ. SMARTWork is active primarily in the department of the West. The project builds, to a certain extent, upon the work undertaken by the Groupe de Lutte Anti-SIDA (GLAS) during the early 1990's, which is described in Table I: Organizations Working in HIV/AIDS Prevention in Haiti.

Centre pour la Communication sur le SIDA (CECOSIDA)

The Centre pour la Communication sur le SIDA (CECOSIDA) is a network of Haitian journalists that was formed in 1999 with the aim of producing and disseminating information about HIV/STI prevention and other health-related topics. The network also seeks to create opportunities for people living with HIV/AIDS to publicly discuss their experience with the disease. CECOSIDA has worked with POZ, FHI, and REHVIH (an association of NGOs working in HIV/AIDS) to develop interactive media approaches to HIV prevention. CECOSIDA is supported by POZ and the Panos Institute. (Octave, 2000; Putnam et al., 2001).

Advocacy best practices:

There is little information available regarding best practices for advocacy programs in the area of HIV/AIDS. This is due, in part, to the fact that there are few developing countries in which there is evidence that public policy has impacted the spread of HIV/AIDS on a national level. Thailand is an example of such a country. A review of the Thai experience suggests strategic lessons that may be applied in other developing countries. First, epidemiological surveillance and behavioral surveys carried out in the country served to generate public awareness, political commitment, and action. Second, effective pilot projects demonstrated their effectiveness and influenced national policy. Third, the involvement of NGOs in the effort helped to sustain policies despite changes in political administration. Similarly, the use of a multisectoral approach draw new participants into the dialogue surrounding HIV/AIDS policy, set national priorities, and provided direction and political mandate to programs at every level. Finally, it is important to note that public policy momentum on HIV/AIDS has slowed in Thailand since the late 1990's, when there were significant reductions in HIV incidence. It is recommended, therefore, that advocacy programs sustain and adapt their efforts as the state of the HIV/AIDS epidemic in their country changes. (Ainsworth et al., 2003).

Evaluation of existing programs and recommendations for the future:

This literature review did not find any evaluation of existing advocacy programs in Haiti or recommendations for the future in this area.

Table III: Organizations Working in Advocacy and Planning in Haiti						
Organization: Project	Primary activities	Department – No. of sites	Collaborators	Program duration	Funding source	Comments – Past highlights
AED (Academy for Educational Development): SMARTWork	Training of business managers and union leaders Assistance to businesses to develop policies against stigmatization	West	ADIH, POZ, PSI, UNDP, HS2004, MASTT	1999-2003	US Department of Labor	
CARE	Advocacy among leaders	Grande Anse., Northwest, Artibonite, Nippes	MSPP, VDH, local organizations		Global Fund, UNICEF	
CECOSIDA (Centre pour la communication sur le SIDA)	Produce and disseminate information relating to HIV and STI prevention, as well as other health topics Create opportunities for PLWHA to speak publicly about their experiences		POZ, FHI, REHVIH		POZ, Panos Institute	
CRS (Catholic Relief Services)	Advocacy among community leaders Training of community leaders on human rights and PLWA rights	South North	Local organizations Hôpital Espérance		UNICEF	
FHI	Support to MSPP for development of norms and standards pertaining to VCT and PMTCT	Nationwide	MSPP, POZ, AOPS, FOSREF, HS2004, VDH		USAID	Norms and standards will be revised. Norms for VCT have already been validated.
FOSREF	Advocacy targeting parents and youth	8 departments				Program will be expanded to 9 departments in 12/2003
Futures Group: Policy Project	Projection and presentation of data on the implications of population growth and HIV/AIDS Analysis of behavioral sentinel surveillance (BSS) data (with MSPP)		MSPP			
MSPP (Ministère de la Sante Publique et de la Population)/	Advocacy for Haitian/Dominican partnership Advocacy for prevention of HIV and care for PLWHA Epidemiological	Northeast, Southeast, Center, West	GHEKIO			

Table III: Organizations Working in Advocacy and Planning in Haiti						
Organization: Project	Primary activities	Department – No. of sites	Collaborators	Program duration	Funding source	Comments – Past highlights
	surveillance					
Plan Haiti	Elaboration of a reference plan for community-based care of PLWHA	Nationwide	MSPP			
POZ	Mobilization against stigma in the workplace Coordination of World AIDS Day activities		Various religious organizations and social groups			
Robert F. Kennedy Foundation	Financial assistance to local NGOs involved in advocacy activities		CRS, GRASADIS, MAEC			
Scouts d'Haïti	Advocacy targeting parents, school directors, teachers, and youth	Nationwide	MSPP, Red Cross, Health centers	Not yet determined	Scouts	
VDH	Advocacy targeting parents and leaders	Nationwide				
World Relief						

4.4 Community mobilization:

Documented efforts to mobilize communities around care and support of people living with HIV/AIDS in Haiti are relatively uncommon, and there is little coordination between groups working in this area. Although in recent years the welfare of people living with HIV/AIDS has been highlighted as a priority, the number of programs in this area is still small. One reproductive health specialist working in Haiti in the early 1990's noted that "a problem in mobilizing people in Haiti around AIDS might be a prevailing sense that AIDS is just one of many diseases from which one can die." (AIDS and Family Planning, 1992).

It has been suggested that, because anti-stigma programming is new to both Haiti and much of the rest of the world, "Haiti has the opportunity to begin its programming based on the best available practice and to serve as a leader in introducing new interventions." (Faulkner and Maynard-Tucker, 2002, p. 10).

CARE

The organization that has apparently been most successful in mobilizing communities in support of people living with HIV/AIDS is CARE. "With USAID funding, CARE is implementing a care and support program for people living with HIV/AIDS, using an integrated family and community approach." (Haiti: USAID Support, retrieved June 20, 2003, from www.usaid.gov). Program activities include: establishing support groups for PLWHA; training community leaders, educating families of PLWHA, performing community-level situational analyses; and training families and community members to provide psycho-social support for PLWHA. As of 2001, the project is currently active in Grande Anse and the Northwest. (Putnam et al., 2001). In addition to its work in community mobilization, CARE is involved in a variety of prevention activities. These include the multisectoral Bassin Bleu Youth Development Initiative (YDI), which is funded by CARE and the Kellogg Foundation. The project works in the sectors of health, agriculture, education, and income generation. Although the project addresses the sectors separately, it coordinates its strategy through a group of peer educators who are trained in all four sectors. (Tipton, retrieved June 20, 2003, from www.fhi.org).

Catholic Relief Services (CRS)

Another organization active in outreach and support to PLWHA is CRS. CRS has been involved in HIV/AIDS programming in Haiti since the late 1990's, when it partnered with Haitian organizations to form an HIV/AIDS information center. Although it continues to pursue education and prevention activities, CRS now focuses primarily upon outreach and support to people directly affected by AIDS. CRS' major partners include POZ, ASON, the Mouvement Haïtien pour le Développement Rural (MHDR), the Union des Amis Socio-Culturels d'Action en Développement (UNASCAD), and the Grande Implication des Personnes Affectées and Infectées par le VIH/SIDA (GIPA). Through these partners, CRS educates communities about HIV/AIDS and the needs of PLWHA and provides micro-credit to families affected by HIV/AIDS, among other things. CRS is also working with other partner organizations on a variety of smaller education projects, most of which focus upon training peer educators and community members in HIV/AIDS and behavior change. With the support of USAID, CRS provides food aid to PLWHA. Although most of its activities are concentrated in the Southern Peninsula, CRS also collaborates with Diocesan Caritas offices in the departments of the North and the Center. (CRS/Haiti Annual Public Summary, 2002).

Association de la Solidarité Nationale (ASON)

ASON was Haiti's first AIDS community advocacy group. The group focuses on HIV/AIDS education and prevention and destigmatization of the disease. Members organize speaking events and performances, at which they often offer testimonials about their personal experiences with HIV/AIDS. ASON has been particularly active in organizing IEC programs catering to young people. (Haitian Program May Serve as Model for Drug Therapy in Developing World, retrieved June 20, 2003, from www.kaisernetwork.org).

Community mobilization best practices:

The best practices for community mobilization are in many ways similar to those for other areas of HIV/AIDS programming. As with prevention, involving people living with HIV/AIDS is essential. Some

organizations working in community mobilization have noted that, in order to focus their programs, local organizations may require support to better understand the vulnerability of certain population subgroups. It is also important to promote a continuum of care and support, in which NGOs and community groups complement the work being done in other sectors. The International HIV/AIDS Alliance recommends that community mobilization efforts seek to address socio-economic marginalization of people affected by HIV/AIDS as well as other needs. Programs should access appropriate expertise for their community initiatives. If, for example, an organization wishes to develop income-generating activities for people living with HIV/AIDS and their families, it should plan these activities in conjunction with an organization or group that has experience in microcredit. As in other areas of HIV/AIDS programming, monitoring and evaluation is a priority, both to assure program quality and to provide groundwork for program expansion or advocacy. It is recommended that NGOs focus on financial sustainability; one way to do so is by providing modest funding for a program over a period of several years, rather than offering a larger sum at one time. (International HIV/AIDS Alliance, 2000; Greig, 1998).

In a review of interventions addressing stigma, the Horizons Project found few well-documented programs. The review indicated that a variety of strategies (including information, counseling, coping skills acquisition, and contact) could be effective in reducing stigma. Due to a lack of studies reporting negative results, the review did not indicate what, if anything, did not work. In most interventions, although using one anti-stigma intervention strategy was effective in changing attitudes or behaviors, using different modes of the same strategy (e.g. different approaches to providing information) did not make a difference. Many interventions conducted in developing countries used a community-based approach, reflecting an understanding that stigma must be addressed on both collective and individual levels. The review found that few interventions had been rigorously evaluated or assessed in terms of sustained attitude and behavior change. (Brown et al., 2001).

Evaluations of existing programs and recommendations for the future:

This literature review did not find any evaluations of existing community mobilization efforts in Haiti or recommendations for the future in this area.

Table IV: Organizations Working in Community Mobilization in Haiti						
Organization: Project	Primary activities	Department – No. of sites	Collaborators	Program duration	Funding source	Comments – Past highlights
AOPS (Association des Oeuvres Privées de Santé)	Inventory of existing community organizations Increasing the capacity of member organizations in community mobilization around community-based care of PLWHA	Nationwide	HS2004, FHI	2003-2004	USAID	
ASON (Association de Solidarité Nationale)	Organizes a variety of community mobilization activities – often with testimonies by PLWHA					
CARE: Care and Support Project for People Living with HIV/AIDS	Community-based prevention Establishment of support groups STI/HIV/AIDS training for community leaders Support for people infected and affected Education of families of PLWHA Training in psychosocial support Community-level situation analysis	Eight localities in Grande Anse	MSPP, MAST, VDH, FOSREF, local parish organizations and youth groups	2000-present	CARE USA, USAID, FHI, UNICEF, Japan	
CDS	Education of families of PLWHA	North, Northeast, West			HS2004, Plan Haiti	

Table IV: Organizations Working in Community Mobilization in Haiti						
Organization: Project	Primary activities	Department – No. of sites	Collaborators	Program duration	Funding source	Comments – Past highlights
CRS	<p>Situation analysis</p> <p>STI/HIV/AIDS training for community leaders</p> <p>Support groups for people infected and affected</p> <p>Community education and outreach on the needs of PLWHA</p> <p>Provision of microcredit to families affected by HIV/AIDS</p>	South, Southeast, West				
FEBS (Fondation Esther Boucicault Stanislas)	<p>Support groups for PLWHA</p> <p>Mobilization of community groups in support of PLWHA</p> <p>Documentary video</p>	Artibonite	POZ, PALIH		Global Fund	
FHI	<p>Support for orphans and vulnerable children</p> <p>Awareness-raising for Christian religious leaders</p>		<p>MAEC</p> <p>POZ</p>	<p>2002-present</p> <p>2003-present</p>	<p>USAID</p> <p>USAID</p>	
HS2004	<p>Mobilization of community groups</p> <p>Trainings of community leaders</p> <p>Support for PLWHA</p>	Grande Anse, Centre, West, South, Northeast, Artibonite		2000-2004	USAID	
Konesans Fanmi	Social and community mobilization to prevent HIV transmission and stigmatization of PLWHA	West, South, Southeast, Artibonite	VDH, POZ, FOSREF, UNICEF, MSPP, HS2004	2003-2004	HS2004, Global Fund, UNICEF, Policy Project	
MAEC (Maison Arc en Ciel)	<p>Education for families of PLWHA</p> <p>Support for orphans</p> <p>Training workshops for PLWHA</p>	West, PAP		2001-present	<p>Plan Haiti</p> <p>FHI, UNICEF</p>	

Table IV: Organizations Working in Community Mobilization in Haiti						
Organization: Project	Primary activities	Department – No. of sites	Collaborators	Program duration	Funding source	Comments – Past highlights
Plan Haiti	Situation analysis Support for orphans Education for families of PLWHA Training workshops for PLWHA	Northeast, Southeast, West	CDS, MSPP	2003 2001-2008 2001-2008		
POZ	Mobilization of religious sector Psychological training/support for people infected and affected by HIV/AIDS Support groups for people infected and affected	Northwest, Northeast, Southeast, North, West	FHI, MSPP		Global Fund, HS2004, USAID	In April 1999, POZ, Plan Haiti and the Panos Institute organized a forum on solidarity for people living with HIV/AIDS. POZ was recently awarded a Pact/USAID grant to address stigma and support PLWHA. Funds will be used to create and strengthen self-help groups and to increase the capacity of these groups to advocate for HIV prevention and care.
PSI	Mass media anti-stigma campaign Psycho-social for pregnant HIV+ women Research on stigma and discrimination PLWHA documentary	Nationwide West West	MSPP, UNICEF, FOSREF, other NGOs	2003-2004 2003-2004 2003	USAID, Global Fund, UNICEF UNICEF, Global Fund Global Fund	
World Vision	Situation analysis Mobilization of women, leaders, and providers against stigmatization Mobilization of community groups	Center, West, South, North			Private funders, fundraising	
Zanmi Lasanté		Center			Global Fund	2001 forum on health and human rights in Cange

5. **Recommendations:**

Information pertaining to Haiti's HIV/AIDS epidemic is limited. Both biological and behavioral surveillance systems could be improved. There is a particular dearth of current socio-cultural information pertaining to HIV/AIDS, which should be addressed as soon as possible. Information relating to HIV/AIDS programming is similarly lacking. Although the work of USAID and its primary collaborating agencies is relatively well documented, that of smaller organizations is not. Documenting the work of these smaller organizations is crucial for purposes of evaluation and expansion. Improved documentation could also serve to minimize the duplication of efforts that seems to be common in Haiti by improving communication and collaboration between different groups. This problem could be solved through the creation of a resource base containing all major documents produced by organizations working in HIV/AIDS in Haiti. Such a collection would require ongoing updates and management, a task that could perhaps be handled by a member of the *Groupe Technique*. Finally, it is clear that evaluation is a major weakness of much of the HIV/AIDS programming currently in place in Haiti. If efforts are to be expanded or improved in the future, they must be rigorously evaluated now.

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