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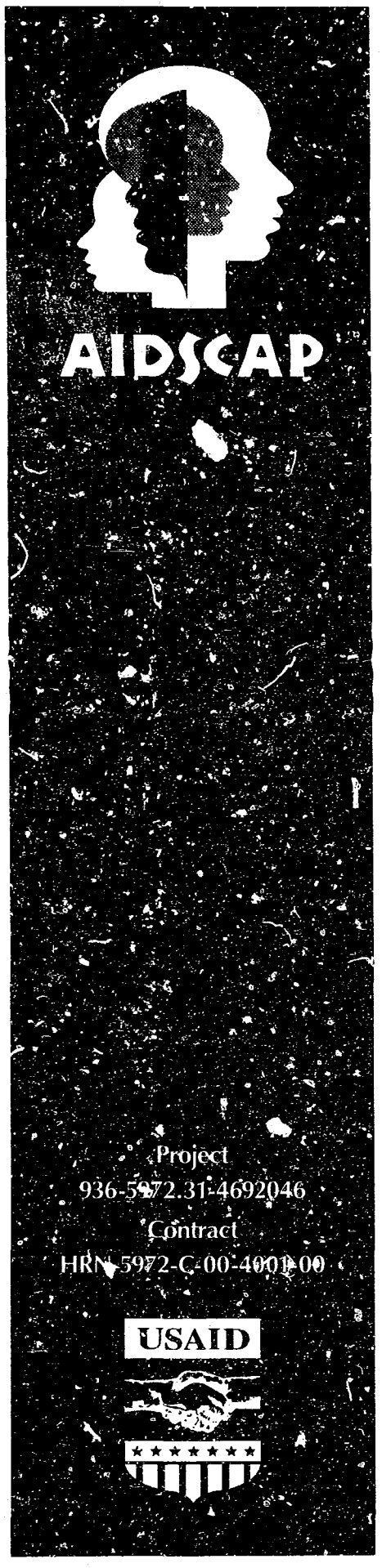

the technical strategy

reduction of sexually transmitted diseases

behavior change communication

condom programming

policy development

behavioral research

evaluation

AIDS Control and Prevention Project

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AIDS control and prevention (AIDSCAP) project

Family Health International

in collaboration

with

The Center for AIDS Prevention Studies, University of California

John Snow, Incorporated

Ogilvy Adams & Rinehart

Population Services International

The Program for Appropriate Technology in Health

Prospect Associates

The Institute of Tropical Medicine, Antwerp

The University of North Carolina at Chapel Hill

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By the year 2000 an estimated 30 to 40 million people will have become infected with HIV worldwide, compared to the 19.5 million currently infected. Seventy-five percent of all infections occur in developing countries, where HIV transmission occurs principally through sexual intercourse. The pandemic challenges the best efforts of the biological, behavioral, and social sciences. With effective vaccines perhaps decades away, prevention is the only viable strategy for slowing the progressive spread of HIV infection.

Since 1987 the World Health Organization's Global Programme on AIDS (WHO/GPA) has developed national HIV/AIDS control programs in 113 countries worldwide. The United States Agency for International Development (USAID) has provided financial contributions and technical expertise to WHO/GPA and has launched over 900 HIV/AIDS interventions in 75 developing countries since 1986.

The AIDS Technical Support Project (ATSP) was created in 1987 to implement the USAID strategy for AIDS prevention. Technical assistance was provided through AIDSCOM, AIDSTECH, the Centers for Disease Control and Prevention (CDC), and the National Council for International Health (NCIH), as well as other U.S.-based private voluntary organizations (PVOs) and nongovernmental organizations (NGOs). In April 1991, USAID redesigned the ATSP, based on lessons learned from four years of project implementation in the developing world. In August 1991, USAID entered into a new five-year agreement with Family Health International (FHI) to administer the AIDS Control and Prevention (AIDSCAP) Project, which is part of the current ATSP and is authorized through August 1996.

I. the AIDSCAP framework

The goal of the AIDSCAP Project is to reduce the rate of sexually transmitted HIV infection in selected developing countries.

AIDSCAP hopes to achieve a measurable impact on the incidence of HIV infection by strengthening the capacity of developing countries to undertake programs that will reduce sexually transmitted diseases (STDs), increase condom use, and reduce the number of sex partners among the sexually active population. These prevention initiatives consist of interventions and subprojects targeting populations at high risk of acquiring HIV. Successful interventions are expanded for regional and national application. Critical policy issues are addressed and, as findings from behavioral research become available, they are applied to the interventions. In addition to interventions in "priority" countries, AIDSCAP also makes short-term technical assistance available to other countries, designated as "associate" countries.

II. guiding principles of the project

AIDSCAP develops interventions in close collaboration with USAID missions to ensure consistency with bilateral programs.

AIDSCAP collaborates with government agencies, NGOs, university institutions, the private sector, and community groups to mobilize resources and secure community participation in AIDS prevention programs.

AIDSCAP uses three primary strategies: behavior change communication, condom programming, and reduction of STDs. Three support strategies enhance the effectiveness of the three primary components: behavioral research, policy development, and evaluation. In addition, AIDSCAP builds the in-country technical capacity to undertake HIV/AIDS prevention programs. The scope of capacity building is discussed extensively under the various strategy components in this document.

III. the purpose of this document

This strategy document was developed for the AIDSCAP Project. It is meant to define AIDSCAP's approach to HIV/AIDS prevention and provide guidelines for developing specific interventions to reduce the rate of sexually transmitted HIV infection in priority countries. This document is also used to define the nature and extent of technical assistance given to associate countries.

AIDSCAP staff and project subcontractors use this strategy document during technical visits to develop comprehensive, integrated country strategies for AIDS prevention and to design plans for implementation. The details of implementation are not set out in this document; implementation plans must be based on each country's needs and available resources.

It is not feasible to prescribe a set of strategic priorities that would apply universally. AIDSCAP does not attempt to undertake every intervention in this document in each country. All the components are presented with prioritization in mind, even though a strategic focus section is not always included. The strategies in this document do not function independently of each other but are mutually reinforcing. Priorities for each strategy component are based on the specific needs and resources available to each country and are developed from this document with the help of USAID Missions.

This document does not function as a substitute for the countries' medium term plans (MTPs) but supports and enhances national efforts. AIDSCAP integrates its strategic plans with national efforts in a way that is consistent with the national AIDS control program of each country. Finally, the AIDSCAP strategy is periodically reviewed to keep pace with project development and the experiences acquired through the project's ongoing evaluation process.

IV. the AIDSCAP technical strategy

The six components of the AIDSCAP technical strategy are:

- Reduction of STDs
- Behavior change communication
- Condom programming
- Policy development
- Behavioral research
- Evaluation.

Technical working groups (TWGs) composed of AIDSCAP and USAID staff and expert consultants developed the first five components; the evaluation component was developed by the AIDSCAP evaluation unit.

A number of assumptions and lessons learned from previous HIV/AIDS control efforts were considered in developing the six components of the AIDSCAP strategy. The prevailing assumptions are discussed below.

A. reduction of STDs

STD prevention and control will continue to play an important role in the prevention and control of HIV infection, even after effective AIDS treatments and vaccines become available. STDs, particularly genital ulcer diseases, are believed to facilitate the transmission of HIV. Since diagnosis and treatment interrupts the chain of STD transmission and reduces the chances of HIV infection during sexual contact, AIDSCAP makes diagnosis and treatment of STDs a fundamental component of the project.

A variety of concurrent interventions are needed to promote the behavior change associated with controlling the spread of STDs, including: counseling for risk reduction (including partner reduction); promoting acceptability and correct use of condoms; encouraging compliance with medical prescriptions; notifying and treating patient contacts; training in symptom recognition; risk assessment; and changing normative behavior as well as changing the behavior of health providers. These interventions have often been ignored in the delivery of STD prevention and control services; however, this project ensures that behavioral interventions become an integral part of all aspects of STD services. Research activities are undertaken and findings are integrated into the project to improve the design, implementation, and evaluation of STD prevention and control services.

B. behavior change communication

Communication programs, in combination with other activities, can lead to changes in behavior at the individual and community level. Programs that attempt to increase knowledge alone are not sufficient to bring about sustained behavior change. A participatory educational process that includes technology transfer to build local skills is critical to the development of sustainable communication programs. Sustainability also depends on sufficient funds, political will, existing infrastructures, highly skilled counterparts, and a high level of community participation, acceptability, and ownership.

C. condom programming

Condoms are one of the most effective defenses currently available in the fight against HIV infection. Condom use provides barriers to the transmission of HIV and other microbes that cause diseases facilitating the sexual transmission of HIV. To ensure that condoms are used regularly and effectively, they must be readily available. A reliable supply and an efficient distribution network are essential components of an effective condom program. It is imperative that condom use be vigorously promoted because condoms are unpopular in many developing countries and often are not used correctly.

D. policy development

AIDS prevention programs do not exist in a vacuum. They are shaped by political, economic, and social factors and by the policies of resource holders and political leaders. Key individuals in government, business, unions, community settings, private voluntary or-

ganizations, international donor agencies, and religious institutions may have a profound impact on the course of the epidemic and the success of prevention efforts. Private and public sector leaders, particularly those making policy, must be informed about AIDS prevention programs and motivated to support and develop desired policies and practices.

E. behavioral research

International efforts to bring about behavior change in order to reduce HIV transmission have not been as successful as expected. Our understanding of human sexual behavior is limited; however, it appears that behaviors can be changed. Social and behavioral science provide the tools for understanding sexual behavior change processes and therefore can be used to improve current interventions. Behavioral research clearly is important for condom programming, reduction of STDs, behavior change communication, and even policy development.

F. evaluation

The impact of interventions conducted under AIDSTECH and AIDSCOM is still being assessed. Programs developed under AIDSCAP incorporate new insights as they become available. The project focuses on expanding viable process, outcome, and impact measurement systems from the individual project or local level to regional and national levels. AIDSCAP evaluations combine complementary qualitative and quantitative methodologies in order to collect and analyze reliable and valid data throughout the life of the project.

reduction of sexually transmitted diseases

I. introduction

This section defines STD program area priorities and serves as a guide for the development of regional and country strategies. Within the context of the AIDSCAP technical strategy, it offers a menu of potential program activities to be considered in designing and evaluating the reduction of STDs (refer to Appendix I on page 18).

II. goal

The goal of this strategy component is to reduce the rate of STDs by addressing three broad program areas:

- biomedical and behavioral interventions for the diagnosis, treatment, and prevention of STD/HIV;
- institutional strengthening for capacity building and sustainability;
- STD-related research.

III. strategic focus

AIDSCAP focuses on strengthening STD case management services at the point of first encounter between the patient and the service provider and prioritizes STD interventions for:

- groups whose behavior puts them at high risk (core groups);
- urban/high density areas with high STD prevalence, and symptomatic individuals in urban/high density areas.

Emphasis is placed on the management of syndromes of genital ulcer disease (GUD) and discharges, and those specific STDs most strongly associated with HIV transmission for which diagnosis and treatment are most feasible. Because the prevalence of syphilis in antenatal women is an evaluation outcome of the project and because congenital syphilis is still a major problem in many parts of the developing world, AIDSCAP works in concert with other donors to strengthen antenatal syphilis screening in urban and high-density populations.

AIDSCAP does not attempt to establish comprehensive STD services for the entire population but concentrates resources on those whose behavior puts them at highest risk of STD and HIV

infection. Interruption of STD and HIV transmission in this group will have a larger impact on the overall STD and HIV prevalence in the general population than providing services in the general population alone. Urban high-density areas are prioritized because of their higher rates of STD infection and potential or existing HIV infection.

The morbidity associated with lower genital tract infections in women is well recognized. AIDSCAP addresses this problem by: educating both men and women to recognize STD symptoms and seek treatment; improving points of first encounter services for symptomatic women in maternal and child health (MCH) or family planning (FP) clinics; treating symptomatic male patients; creating a partner notification system to treat partners of symptomatic male clients; and working with groups evaluating newer diagnostic methods for STD in women. With the exception of syphilis serology in antenatal women and possibly commercial sex workers (depending on laboratory facilities), screening of asymptomatic populations is beyond the scope of this project.

IV. guiding principles

The project concentrates and coordinates resources to strengthen STD prevention and control by collaborating with and acquiring support from other donors, particularly in the procurement of STD drugs, supplies, and diagnostics.

Ensuring the sustainability of services represents a major commitment of the AIDSCAP project. However, sustainability does not imply operating independently of external resources. For instance, ongoing external support may be required in some countries to support the purchase of diagnostics and drugs. To help ensure a framework for sustainability there is a need for:

- political commitment to STD prevention and control as a national priority reflected in the mobilization and allocation of resources;
- integration or close coordination of STD with AIDS control programs in all sectors;
- integration into existing primary health care initiatives and infrastructure where appropriate, and utilization of first points of entry;
- public and private sector partnership with collaboration and coordination between governmental, NGOs, and community-based organizations (CBOs);
- individual and community recognition of and demand for STD services, including involvement in planning for the delivery of those services.

Although the AIDSCAP project explores opportunities for self-financing and cost-sharing or cost-recovery, it does not do so to the extent that access to services is impaired.

Research must support the objectives of the AIDSCAP project and therefore improve the design, implementation, and evaluation of interventions. Research is conducted in such a way as to strengthen the research capability and independence of developing countries. Local investigators play a critical role in the design and implementation of research projects.

Where current approaches to STD prevention and control have not been effective, AIDSCAP explores and evaluates new approaches to funding, planning, and implementation.

V. program areas

The objectives and activities of the three program areas listed under II of this section are outlined in more detail below. Not all areas or activities are equally relevant in all countries, and priorities vary by country.

A. biomedical and behavioral interventions for the diagnosis, treatment, and prevention of STD/HIV

The objective of biomedical and behavioral interventions is to improve access to quality STD services that provide and promote appropriate diagnosis and treatment, as well as providing for the "four Cs": counseling/education, condom promotion, compliance with antibiotic treatments, and contact tracing/partner notification for the treatment of sex partners.

The AIDSCAP Project will achieve this objective through the utilization of three outputs:

1. improved STD management at points of first encounter

Care for STD patients is provided through many different services and individuals, both medically qualified and otherwise. Whatever the source of care, the point of first encounter of the STD patient with the health system (formal or informal) is the most important. The first encounter may be the patient's only contact and may in-

fluence future health-seeking behavior and costs. Therefore, the first encounter patient should receive efficient diagnosis and treatment, a variety of messages to promote risk reduction, and condoms with instructions on their proper use. Partner notification should also be initiated during the first encounter. Elevating the standards and quality of STD services should lead to a shift in health-seeking behavior, away from untrained street vendors toward the more formal sector of trained providers, where there is better supervision.

The highest priority is given to STD services in urban or high density areas where STDs are prevalent and HIV infection is also an existing or potential problem. This includes public and private sector clinics and pharmacies (including through NGOs/PVOs), special clinics that ensure STD service access to core groups of so-called high-frequency transmitters, as well as maternal and child health (MCH) and family planning (FP) clinics. In some instances it is necessary to create new points of first encounter to reach individuals at highest risk for transmitting STD.

To improve points of first encounter, the activities listed in Appendix I should be considered at a country and specific population level.

2. strengthened STD center(s) for clinical, laboratory, and educational services

AIDSCAP establishes or strengthens national "STD Centers of Excellence" to serve as the technical/scientific and policy-making focus for STD control within each country. The director of each center is an STD expert, who has expertise in and a commitment to public health. These centers:

- provide professional and technical training and continuing education to master trainers, mid-level practitioners, nurses, health educators, and medical students continuing their education (refer to section V.B.2 of this section: Institutionalized training);
- act as a reference laboratory and conducts epidemiologic surveillance;
- conduct operations research necessary for program implementation and evaluation;
- guide supervision and program evaluation;
- provide clinical and health education services;
- act as a referral center.

A national center serves an adequate patient volume to support surveillance, teaching and research functions. Therefore, a center not only manages referred cases, but also provides limited care to STD patients from the community. To facilitate the training function, the national centers are closely affiliated with a medical training center and with the national AIDS program.

To strengthen each nation's STD centers for clinical, laboratory, and educational services, the activities listed in Appendix II should be considered at a country or institutional level.

3. enhanced STD screening

STD screening helps to interrupt the transmission of STDs and to prevent the development of sequelae in asymptomatic individuals. Syphilis sentinel surveillance data from antenatal and FP clinics are useful indicators in program evaluation.

The establishment of prenatal syphilis screening in urban/high density areas should be strongly considered in order to enhance STD screening in concert with other donors.

B. institutional strengthening for capacity building and sustainability

The objective of institutional strengthening is to establish the in-country capacity for implementation of effective and sustainable services to prevent and control the spread of STD/HIV.

AIDSCAP will achieve this objective through utilization of two outputs:

1. enhanced management and coordination

Sustainability of STD services is highly dependent on a systems approach to service delivery which, if well managed, assures maximum awareness and use of services. Weak management capacity, whether it be at the central level or at the service delivery level, may be the most critical barrier to the sustainability of STD programs and services. In order to enhance management, the activities listed in Appendix III should be considered at a country level.

2. institutionalized training

Training is a prerequisite to quality service delivery because it ensures a mechanism for setting standards and continually upgrading all aspects of implementation and evaluation. It is also a mechanism of human resource capacity building. As such, AIDSCAP recognizes training as a priority at the highest levels. Training is also discussed above in section V.A.2.: "Strengthened STD Center(s) for Clinical Laboratory and Educational Services." Training focuses on the preparation of master trainers who either conduct courses for practice-level personnel or use their training curricula to prepare other trainers who teach practice-level courses. Training is competency-based with emphasis on skill development. An attempt is made for training to be conducted at the actual work site or in a setting that simulates the actual work setting, with a balance between classroom and on-the-job training. The country personnel are responsible for developing curricula and adapting training materials with assistance from AIDSCAP. To improve the institutional training capacity, the activities listed in Appendix IV should be considered at a country or regional level.

C. STD-related research

The objective of STD-related research is to improve the design, implementation, and evaluation of STD intervention programs. Research areas include biomedical, behavioral, and epidemiological research. Research activities should be prioritized at the country level according to:

- the potential contribution the results might have on program design, implementation, and impact;
- feasibility (not requiring extensive technical assistance);
- cost.

In order for research to be conducted in such a way as to strengthen the research capability and independence of host countries, research endeavors should be built on existing data and coordinated with other global programs. Research activities have been divided into two groups:

1. group one: research activities that may be relevant to program design and implementation

Group One research is likely to be relevant to most comprehensive STD/AIDS programs and appropriate in many countries. This research is designed to enhance the implementation of an STD control program and is usually country or region specific. Local investigators play a critical role in designing and conducting this research. Priority research topics are listed in Appendix V.

2. group two: research activities that are conducted in selected countries only

Group Two research activities are generally more costly and the insights gained benefit all programs; consequently, this research is carried out in selected countries only. Group Three research is conducted by AIDSCAP personnel, subcontractors, and/or a new contractor in collaboration with country-based researchers. Research topics are listed in Appendix V.

appendix I.

outputs to strengthen points of first encounter

1. Establishing special STD clinics where indicated for core groups (for whom rapid reduction approaches such as presumptive/mass treatment may be appropriate).

2. Training a cadre of mid-level providers in both the public and private sectors for:

   - syndromic diagnosis of GUD and discharges using standard treatment guidelines;

   - the appropriate use of a referral system.

3. Establishing mechanisms to promote the "four Cs" as a routine part of care.

4. Establishing procedures to motivate and maintain counseling/education activities by providers.

5. Helping to ensure, through dialogue with government and international donor agencies, that drug purchase, supply, and distribution are adequate so that appropriate drugs are available and affordable at the points of first encounter.

6. Linking clinics and other points of first encounter to a condom social marketing program (or other source if necessary) for the regular supply of condoms (see Condom Programming section of this document).

7. Using media and other marketing techniques for reaching the general population, and using techniques targeted to individuals at highest risk for transmitting STDs in order to:

   - advertise STD services;

   - increase symptom recognition and motivate individuals to seek treatment;

   - promote the use of condoms and the reduction of the number of sex partners.

8. Identifying promoters and barriers to seeking STD treatment, and developing and implementing strategies, logistics and procedures in each setting to overcome these barriers (Section V.C. of this section).

9. Establishing minimum laboratory diagnostic support appropriate to the level of care recommended by WHO in document WHO/VDT/85.437 (see Appendix II).

10. Establishing a practical system for contact tracing/partner notification (Appendix III or WHO Technical Report Series No. 810).

11. Ensuring a source(s) for regular supply of culturally appropriate patient education materials such as brochures, posters and videos (see Behavior Change Communication Strategy section of this document).

12. Ensuring that a co-payment schedule is not a barrier to treatment (see V.C. of this section).

13. Attempting to cultivate the support and cooperation of traditional healers where appropriate and feasible. (Traditional healers can be trained to become effective STD/HIV health educators and condom distributors and to refer patients up the system.)

14. Establishing links with peer workers and community-based organizations (CBOs) to assist in identifying and gaining access to groups of high-risk individuals.

appendix II:

outputs to strengthen STD center(s) for clinical, laboratory, and educational services

1. Training selected clinical, laboratory, and health education staff in clinical, laboratory, counseling/education for risk reduction, condom use skills, and research methods as appropriate to ensure training at other levels.

2. Upgrading the laboratory as needed to the level of a reference laboratory, adapting WHO STD laboratory recommendations and guidelines (WHO/VDT/89.443: Bench-level Methods in Laboratory Diagnosis of STD). In addition to the minimum capability of performing Gram stains, wet mounts, and RPR serology, the reference laboratory should have the capability to perform the following when indicated:

   - Gonorrhea culture and sensitivity;
   - dark field microscopy;
   - Syphilis confirmatory testing;
   - HIV screening and confirmatory testing.

As resources allow, the capability of the reference laboratory can be expanded to perform:

   - chlamydia antigen testing;
   - *H. ducreyi* culture;
   - newer diagnostics such as herpes simplex virus antigen testing.

3. Developing a standard laboratory procedures and quality control manual.

4. Facilitating collaboration between centers and the STD Diagnostics Network in developing, evaluating, and implementing improved diagnostic strategies and in-bulk purchasing of diagnostic reagents.

5. Assisting in the development of standard STD patient management guidelines and a mechanism for periodic review and modification. The guidelines and mechanism will be based on WHO's STD management guidelines (WHO Technical Report No. 810) and adapted to local surveillance data.

6. Providing technical assistance in the selection or development and production of appropriate teaching materials including manuals, wall charts/flip charts, videos, and other provider and patient education materials.

7. Supporting and guiding research activities in the areas emphasized under V.C. of this section.

appendix III:

outputs for enhanced management and coordination

1. Ensuring that a national plan for STD prevention and control that is responsive to community needs is developed and establishes realistic priorities such as the implementation of standardized STD treatment guidelines and access to appropriate drugs.

2. Identifying mechanisms of collaboration and coordination between the public and private sectors and networking with CBOs and representatives of target groups.

3. Strengthening existing management systems by:

   - ensuring adequate staffing and training at all service delivery levels and programmatic areas;
   - clearly defining responsibilities and reporting mechanisms;
   - decentralizing decision making, planning, and resources.

4. Improving a logistics system for the procurement, storage, and distribution of supplies such as drugs, diagnostics, condoms, and educational materials.

5. Establishing an information management system that is simple and provides useful information to monitor and improve services, and helps to ensure continued political commitment and resource allocation.

6. Establishing an effective system of supervision and quality control within each service area.

7. Seeking alternative mechanisms for financing activities with cost-effective practices emphasized.

appendix IV:

outputs for institutionalized training

1. Ensuring that a STD training plan is developed that establishes training priorities for each level of service delivery, and is integrated into existing training activities.

2. Strengthening centers for STD training and continuing education with the following fundamental elements:

   - the planning and scheduling of training for STD service staff from all sectors;
   - the identification and facilitation of training workshops for master trainers;
   - the design and use of competency-based curricula based on training needs assessments;
   - an inventory of training materials;
   - political and financial support for repeat skill-based training;
   - on-site evaluation of skills acquisition and regular follow-up needs assessments;
   - regular curricula re-design or modification based on needs assessments.

4. Creating a clearinghouse for training materials at AIDSCAP central and regional offices that can be shared worldwide and can network with training centers in each country.

5. Conducting or facilitating training workshops for trainers in program and logistics management, clinical, behavioral, laboratory, and research-related skills.

6. Encouraging the introduction of STD prevention, diagnosis, and treatment into the curricula of institutions that train health care professionals.

7. Sponsoring STD service staff to international, regional, and local STD training programs as appropriate.

appendix V:

research activities

A. group two: research activities that may be relevant to program design and implementation

1. Describe the roles played by various existing health care delivery systems (including MCH/FP, pharmacies, STD clinics, primary health care, and the informal sector, such as traditional healers) and other sectors in the provision of STD services to high-risk groups and others.

2. Establishing the most efficient and effective approach for STD service delivery by determining:

The impact of each of the following approaches in reducing the incidence of STD in high-risk groups:

- social marketing of STD services;
- presumptive or periodic treatment of larger selected populations (mass treatment programs);
- screening and treatment;
- provision of clinic-based services;
- behavioral strategies.

The impact of targeting STD interventions based on the prevalence of STDs in the general population.

The roles for different health care delivery systems, including MCH/FP, pharmacies, STD clinics, primary health care, the "informal sector" (e.g., traditional healers), and other sectors on the provision of STD services.

How AIDSCAP can improve the provision of STD services in the private sector.

The role and impact of social marketing of STD drug regimens on STD control.

3. Develop and evaluate diagnostic, screening, and patient management strategies for STDs. This research includes the examination of safety, cost-effectiveness, and acceptability of such strategies—particularly for women. This research also includes the adaptation and validation of STD patient management algorithms based on the etiology of the common STD syndromes and the antibiotic susceptibility patterns of the pathogens.

4. Investigate ways of motivating providers to promote client risk reduction in their clients and motivational strategies that are likely to have the highest impact on reducing recurrent STD and in promoting low-risk behavior.

5. Investigate health-seeking behaviors related to STD including symptom recognition and ways in which entire clinics can be mobilized to provide risk reduction messages and teach condom use skills.

6. Develop and test community-level approaches such as media and interpersonal communication to promote symptom recognition, treatment-seeking behavior and compliance with treatment.

7. Investigate barriers to optimal use of contact tracing and strategies optimizing contact tracing in specific settings.

B. group three: research activities to be conducted in selected countries only

1. Define, select, and/or adapt a small number of key STD/HIV control program indicators, and develop methods for reliably and inexpensively measuring these indicators. This work was begun by AIDSTECH, AIDSCOM, and CDC and continued by GPA. The results are used in the AIDSCAP Project.

2. Evaluate the effects of STD interventions on the transmission of HIV. (This requires utilization of resources of such magnitude that several organizations have to work in collaboration.)

3. Develop simple, inexpensive, and field-appropriate STD diagnostic laboratory tests and evaluate their performance characteristics and cost-effectiveness. (This work is undertaken in collaboration with the STD Diagnostic Network.)

4. Evaluate the impact of HIV infection on the presentation, natural history, diagnosis, and response to therapy of specific STDs.

5. Investigate which behavior changes are most effective in reducing the transmission of each target STD.

behavior change communication

I. introduction

This section describes the basis for the development of effective behavior change communication (BCC) programs. It provides direction for the design of interventions tailored to and appropriate for specific country and audience needs. Detailed steps for the implementation of BBC programming must, of course, be determined at the country level.

II. goal

The goal of the BCC component of the AIDSCAP strategy is to make effective use of behavioral and communication theory and research to develop communication activities that influence individual behaviors and the social context in which they occur. The objective is to reduce the number of high-risk exposures for HIV/STD infection by:

- increasing condom demand and use;
- increasing STD-related treatment-seeking and preventive behaviors;
- decreasing numbers of sexual partners; and
- increasing norms and policies that support HIV prevention activities.

III. strategic focus

In order to achieve AIDSCAP's behavior change communication goal, BCC interventions are based on a theoretical approach that takes into account the complex connections between individual acts and the social settings in which those acts occur. This approach requires a focus that allows for:

- development of interventions and messages acknowledging both the individuals and that individual's sexual partner(s); and
- targeting of social structures that provide the context that influences the individual's knowledge, attitudes, and behaviors.

Therefore, in order to maintain a sharp focus, BCC planners need to investigate the individual and the community environment when formulating a strategy for BCC.

A. Community investigation

The community investigation (situation analysis) includes analysis of:

- THE DEMOGRAPHIC ENVIRONMENT—examining the population in terms of size, density, location, age gender, race, occupation, education, income, family composition, and other statistics.

- THE ECONOMIC ENVIRONMENT—investigating factors that affect people's purchasing power and spending patterns to gain a better understanding of how, for example, commercial sex, condoms, and health care are purchased. An understanding of the macroeconomics of a country helps explain the role that the infrastructure, the media and the market will play in distributing health care messages and facilitating programs.

- THE POLITICIAL ENVIRONMENT—reviewing the laws, government agencies, and pressure groups that influence and limit various organizations and activities. The political environment can affect condom advertising, public health, access to health care, the economic power of women, the sex trade, sex education, the operation of STD clinics, and the drug trade.

- THE CULTURAL ENVIRONMENT—considering the institutions and other forces that shape society's basic values, perceptions, preferences, and behaviors. Religion, language, educational institutions, literature, popular music, the press, and theater all play a role in determining the status of women and in influencing sexual behavior, attitudes towards AIDS and family values.

- THE EPIDEMIOLOGICAL ENVIRONMENT—understanding the incidence and prevalence of STDs, including HIV, among various target audiences.

- THE ORGANIZATIONAL/DEVELOPMENT ENVIRONMENT—assessing the programs, projects and interventions that are already in place in order to encourage complementary and/or shared efforts and avoid duplication.

B. Individual investigation

The individual investigation (audience research) explores such issues as:

- How do members of the target audience currently understand and practice HIV preventive behaviors?

- What do they see as the benefits of practicing safer sexual behaviors?

- What information will help them change their sexual behaviors or continue safe sex?

- When and where do they get information—especially about sexual/family topics?
- How do they communicate with others—where do they meet? When? Who is in their immediate social network?
- What is their perception of the risk of becoming infected with HIV and STDs?
- Who are their sources of information about sex and family topics and which are credible and respected ones?
- What are their perceptions of peer and social norms governing sexual behaviors and HIV prevention?
- When and where would be the best times to talk with them about HIV prevention, distribute condoms, make STD treatment services available, etc.?
- Where do they fall on the behavioral change continuum?

Both the target audience and communities are involved in the development of the BCC program design. This is crucial to ensure that their values, concerns, and needs are reflected in the program.

The strategic focus also calls for the use of multiple communication channels. Information about reach, cost, feasibility, appropriateness to the message, and effectiveness in changing behaviors determine which communication channels (i.e., interpersonal communication, institutional networks, mass media, and small media) are chosen.

IV. guiding principles

AIDSCAP BCC follows seven principles that guide program planning and the development of implementation methods.

1. Targeting

Interventions should focus on well-characterized, specific target audiences. For example, as a national strategy, commercial sex workers (CSWs) might describe a target audience. But when this target audience is to be the focus of local interventions, it must be further segmented and delineated through additional audience research, which may reveal discrete groups of CSWs who vary in their media habits, lifestyles, attitudes toward sex, or other variables. Interventions need to take these differences into account and employ relevant, meaningful, and effective approaches and/or messages for each segment of the target audience.

2. Skill Development

At-risk individuals must be provided with skills and devices/tools to prevent HIV. It is not enough to just communicate HIV risk reduction. BCC programs must ensure that skills are taught and support services are available so that individuals can act on the messages they see and hear. Project activities might include:

- condom use demonstrations at brothels;
- condom distribution to truckers;
- partner negotiation workshops at STD clinics;
- treatment compliance aids for STD patients.

3. Support

A supportive environment needs to be created for HIV prevention activities. Individual behaviors occur within a social and cultural context that needs to be addressed in any BCC activity. A supportive environment is also more likely to foster program sustainability. Examples of project aims that illustrate how such an environment can be modified are:

- attitudinal changes among key policy makers and opinion leaders;
- policy implementation that facilitates program development and service delivery;
- sex education curricula that cover HIV prevention in the schools .

4. Maintenance

BCC programs should include mechanisms that encourage the maintenance of HIV preventive behaviors over time. Examples of appropriate project activities include:

- periodic follow up and recertification of peer educators;
- HIV prevention messages being repeated in the school curriculum at all grade levels;
- campaigns that include messages focused on maintenance;
- specific policy changes;
- annual meetings for organizations working in HIV prevention.

5. Collaboration

Opportunities to work collaboratively and in different sectors of the community/country should be key factors in BCC design. One goal of the situation analysis should be to uncover situations where, with relatively few AIDSCP resources, BCC activities and programs can maximize reach to, and impact on, primary target audiences. If other international donors are working with a specific target audience, the AIDSCAP BCC effort might focus on expanding this project to other areas of the country. Another approach might be to collaborate with the private sector to deliver HIV prevention materials and skills to high-risk behavior groups such as migrant workers.

6. Monitoring and evaluation

BCC monitoring and evaluation indicators must be used to assess program implementation integrity and effectiveness. Although indicators will vary, it is crucial that they are in place and are relevant to the specific intervention. Rigorous experimental designs are not needed for these program evaluations; however, rigorous collection of appropriate data to ensure accuracy and completeness is necessary to draw valid conclusions from the evaluation effort. In addition to process indicators (such as number of training/education sessions held or materials produced/distributed) indicators of effectiveness must be developed. Examples are:

- an increase in grassroots participation in BCC campaign activities;
- more discussion of HIV/AIDS policy issues in legislative bodies;
- greater media openness about sexual issues;
- self-reported changes in ability to discuss safer sex options with partner(s);
- more business policies developed that protect HIV-positive workers from discrimination.

7. Sustainability

HIV prevention programs should be sustainable. AIDSCAP BCC projects support and build the capacity of individuals and organizations to provide HIV prevention programs and services. Project strategies include:

- direct funding of organizations already engaged in HIV prevention activities;
- skill-building workshops for health care providers and communicators;

- funding of existing programs to expand their focus to HIV prevention;
- securing financial support for HIV prevention activities from the private sector.

In practice, following these seven principles involves:

- working at the individual level to increase self-risk perception, increase and improve prevention skills, provide role models, and encourage low-risk behavior;
- working at the community level to change group values, leading to a diffusion of innovation that can support low-risk activities and create a context for leaders and natural social networks to facilitate behavior change;
- building local capacity to design, implement, evaluate, and sustain effective behavior change programming;
- collaborating with ministries of health or other government agencies, NGOs and PVOs, international donors, and the commercial sector as part of a national or regional approach. In addition, work that augments, supports or broadens existing activities (such as family planning and maternal child health) is appropriate to complement and support BCC programming.

V. BCC programming challenges

The AIDSCAP BCC strategy is comprehensive and ambitious; it represents the ideal to which AIDSCAP programs are striving. Achieving this ideal requires the understanding, collaboration, and cooperation of many partners. AIDSCAP continues to be a catalyst in this process.

In addition to the components and principles outlined here, additional factors that influence programs include the following:

- It is still difficult to speak openly about sexual education in many countries, even those most affected by the epidemic. This barrier prevents the creation of programs that speak directly to youth about sexuality, despite the fact that most project planners and national AIDS control programs recognize that preventing HIV infection

among youth should be a priority. In addition, reaching all youth, including those who are not in school, is challenging but essential to effective programming.

- Women are at risk of HIV infection. Because of their biological vulnerability, their often low educational and social/economic status, and the risk behavior of their regular sexual partners, women's risk is unlikely to be reduced without changing men's attitudes and also improving women's status. BCC programs that benefit women must also target men.

- Expanding traditional health education approaches to the more inclusive AIDSCAP behavior change approach is challenging, as is the incorporation of sufficient operations research into BCC programming to inform decision-making processes.

- AIDSCAP is sometimes urged to address the entire general population as opposed to selected target audiences. However, experience has shown that working at the epicenter of the epidemic (with high-risk behaviors) is more cost-effective. It is also evident that there is a need for continuing diffusion of information about HIV/AIDS to the general population. AIDSCAP programs address both of these issues.

- In order to achieve sustainable interventions, there is a need to continue and strengthen communication and behavior change capacity building within NGOs.

- Identifying and training community leaders is crucial to maximize both the diffusion process and behavior change across a community and to promote social change in systems, as well as among individuals.

- Many countries lack the indigenous resources in public relations needed to target community, political, and religious leaders. The support of these leaders is often a prerequisite to successful communication programs and should be built into programming.

condom programming

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I. introduction

This section sets out the parameters for condom programming in the AIDSCAP project and provides guidance in the design and review of AIDSCAP regional and country condom programs.

II. goal

The goal of the condom programming strategy component is to increase the use of condoms for the prevention of STDs.

III. guiding principles

The condom programming component is not meant to be a comprehensive programming document and is limited to the program areas mandated in AIDSCAP. Also, resource limitations and programming constraints within individual countries have restricted the scope of AIDSCAP's condom programming.

AIDSCAP works with other appropriate USAID-funded projects in coordinating technical assistance efforts for condom programming. Collaboration with other multilateral and bilateral donors interested in condom programming also has been sought.

Wherever possible, AIDSCAP builds on existing programs and leverages whatever institutional, financial, and programmatic resources are available to enhance condom accessibility, acceptability, and use. Inadequacies in existing public sector logistics systems are not sufficient reason for delay in initiating condom programs, and private sector participation is being explored.

IV. strategic focus

The condom programming strategy component has three main areas:

- condom procurement, distribution, and logistics management;

- condom promotion;
- strengthening in-country capacity to undertake condom programs.

These components are interrelated, and in a number of cases all three are being implemented simultaneously. However, in attempting to prioritize these components, condom procurement, distribution, and logistics are the first to be undertaken because of the urgent need to get condoms to the users as quickly as possible, and because there is already a baseline demand. Nevertheless, major condom promotion campaigns are being launched in many program areas.

A. condom procurement, distribution, and logistics management

The objective of this strategy component is to ensure an adequate and efficient supply of condoms to target groups and the general population. Important outputs are discussed below in order of their priority:

1. sustainable source of condoms

It is recognized that host countries are likely to require continuous donor support for the procurement of their condom requirements. The condom supply options that national programs face include the following:

- direct procurement by the donor(s);
- direct procurement by the host-country government;
- indirect procurement by the host-country government through an intermediate procuring agent;
- reliance solely on commercial importers to meet demands stimulated by the program, with or without subsidy;
- a combination of the above.

Involvement of other donors in condom procurement is actively being sought. In those instances where there is no alternative to the use of USAID funding for reliable condom supply, mission funds are transferred through operating year budgets (OYB), to G/PHN/POP/CLM for inclusion in routine condom procurement. G/PHN/HN/HIV-AIDS has funds to provide initial and emergency stocks.

The essential steps necessary to define a viable source of condoms include:

- Conducting an assessment of the current supply situation, including historical trends, level of stock, and dispensing in the public and private sectors. This assessment determines the most appropriate supply option and the level of technical assistance required to establish new supply channels. An estimate of the quantity of condoms currently available and their sources is made, as well as the brands of condoms currently in supply. Other donors' interest in condom procurement is identified, and the program's access to convertible currency and any existing logistics and quality assurance systems is determined.

- Establishing an appropriate locus or forum for the coordination of condom supply activities, including forecasting planning, mechanisms for cost-recovery, logistics systems strengthening, and establishment of specifications for procurement. Plans distinguish between private and public sector distribution.

2. effective and appropriate distribution channels

The types of distribution channels that are used exclusively or in combination to reach target condom users include:

- Public Sector Outlets: Clinic Distribution

  These outlets most often distribute condoms free of charge and provide access to the poorest populations. Clinic-based outlets are often small in number, may not achieve significant coverage, and are typically deficient in information, education, and communication (IEC) capabilities.

- Public Sector Outlets: Community-based Distribution

  Community-based distribution (CBD) helps provide access to larger segments of the general population. However, retraining of large numbers of CBD agents is generally required because of their prior strong family planning orientation. Public sector logistics systems are often weak and require technical input.

- Distribution Through Social Marketing

  Social marketing offers the unique opportunity to achieve widespread distribution through private sector networks. For AIDS prevention,

condoms are sold at subsidized prices to commercial outlets or CBD agents who in turn sell the subsidized condoms to the consumer, thus making them affordable to the lowest income earners in the population. Revenue generated from sales contributes significantly to program subsidization, and to some degree cost recovery. Popular advertising techniques are used to promote products in order to create a perceived need in the target population and thus demand for the product. As demand becomes firmly established in the population, subsidy in some instances can gradually be decreased, allowing for improved cost recovery with time.

3. improved logistics management

An appropriate project design incorporating an effective and well-managed logistics system enhances the efficient and timely delivery of stocks and lowers wastage through condom deterioration due to the effects of time, storage conditions, and climate. The latter is of concern because the manufacture of condoms is a demanding process, and latex is a highly variable material requiring careful management during processing in order to yield a consistent and reliable product. Activities to achieve improved logistic management include:

- providing technical assistance and training in requirements forecasting on a national scale and aggregating this information at central level for both the short and longer terms in order to avoid distribution delay, understocking, and overstocking;

- making arrangements for acceptance testing of condoms for use in AIDSCAP projects procured outside the USAID system;

- ensuring the proper storage and timely transportation of condoms in-country. Efforts are made to avoid long-term storage, particularly under harsh climatic conditions. Technical assistance is given as needed in monitoring condom quality and providing training to ensure that procured goods are and remain of the highest quality, regardless of their source;

- implementing the necessary management tools and information system for forecasting, stock management, and inventory control.

B. condom promotion

The objective of condom promotion is to increase the acceptability of, demand for, and effective use of condoms. AIDSCAP meets this objective through the following outputs:

1. established formative research

Formative research is undertaken to give information about social norms, perceptions of condoms, and the barriers to facilitators of condom use. This is essential to the development and improvement of condom promotion materials and in defining distribution targets.

2. defined target groups

Epidemiologic data helps determine where AIDSCAP resources may be most effectively applied in order to prevent the greatest number of HIV infections. Target groups are identified by high-risk behavior and defined by country-specific, demographic, or culture-specific characteristics.

3. appropriate condom messages

Clear and focused messages are designed to avoid confusion while conveying the basic message: appropriate condom use helps prevent HIV transmission. Condom promotion in general should be characterized by positive images. Brand promotion messages through social marketing should not include direct or implied derogatory messages about other condoms, as this could create distrust about condoms in general.

4. use of all effective communication channels

Ongoing monitoring takes place, and timely action is taken to discourage policies that put constraints on effective promotion or on the use of effective channels to promote condom use (see the AIDSCAP policy development section).

5. established monitoring system

Mechanisms for tracking the level of demand for condoms and the effectiveness of promotion campaigns, and for monitoring and giving feedback to program managers and implementors are established.

C. strengthening in-country capacity

The objective of strengthening in-country capacity is to provide, through technology transfer, the skills and knowledge required to plan and manage effective programs for increasing condom availability and use. AIDSCAP achieves this objective through a variety of outputs discussed below.

1. established importance of condom programming

AIDSCAP encourages policy makers, health administrators, and indigenous NGOs to see the potential effectiveness and feasibility of condom programs and to set condom programming as a high priority in their AIDS control programs. This can be achieved through a number of activities, including policy dialogue and modeling.

2. enhanced management capability

Weak management is a constraint not only to effective project implementation, but also to the sustainability of service delivery activities. The following are activities addressing this issue:

- creating a forum for dialogue and coordination between the government, donor agencies, NGOs, and the private sector in the management of the condom program;
- strengthening existing management systems by training appropriate level staff, clearly defining responsibilities and reporting mechanisms and decentralizing decision making where necessary;
- establishing an information management system that is conceptually and operationally simple and provides information used to monitor and improve services.

3. enhanced technical training

The transfer of technical expertise to local implementing bodies is important and expedites efforts for dealing with the AIDS epidemic. Training workshops are conducted in the following specialized areas as specific needs for such skills are identified:

- marketing management to include brand marketing, market research, sales management, and advertising;
- financial management to include cost accounting, overhead, and indirect cost allocation as well as inventory control;
- IEC design and management to include techniques of formative research, control and direction of the creative process, production, media planning, and evaluation;
- logistics management to include requirements forecasting, logistics management and information system operation and use, warehouse management, transportation systems control, and quality assurance requirements;
- creating a clearinghouse for condom training materials and logistics management systems at AIDSCAP's central and regional offices.

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I. introduction

The role of policy development is to establish a framework for conducting policy assessments, identifying and educating policy makers, and creating policy support and development programs that will facilitate the implementation of AIDSCAP's three primary strategy components and other HIV control efforts. This section is not a comprehensive text on policy and is written as a guide for the AIDSCAP project.

II. goal

The goal of the AIDSCAP policy development component is to provide policy makers with the information and motivation necessary to support and develop efficient policies and mobilize resources needed to reduce the spread and impact of HIV infection.

III. strategic focus

AIDSCAP accomplishes the policy development goal by: assessing existing HIV-related policies; assessing the policy setting environment; educating and involving policy makers in prevention activities; and creating collaborative processes to establish policy priorities and implement needed policy support and development programs.

The AIDSCAP primary strategy components of behavior change communication, condom programming, and the reduction of STDs form the logical focal point for policy interventions. Perceived policy obstacles to these three primary goals are the starting point in policy assessment and program design. Operating within a focus on the three AIDSCAP primary components and the proper policy setting environment, the policy programs also offer USAID missions the opportunity to assess and address other policy needs related to HIV prevention, care and treatment.

IV. guiding principles

The following general guidelines are considered in the design and implementation of AIDSCAP policy activities.

- The AIDSCAP program is charged with maintaining a supportive environment for policy setting. The term policy is defined broadly to encompass formal and informal rules, regulations, plans, and practices in the public and private sector.
- Policy support and development involves collaboration at all levels with host country counterparts, USAID missions and other donors.
- The term policy makers is broadly defined to include leaders and resource holders in all sectors and from all levels, ranging from international donors to local community elders.
- USAID, AIDSCAP country staff, AIDSCAP headquarters staff, subcontractors, and in-country program participants have a major role in identifying policy initiatives critical to the success of the AIDSCAP project.
- Policy development and support activities are likely to affect and rely on the participation of individuals and institutions not directly involved in the AIDSCAP effort. These individuals and institutions are, to the greatest extent feasible, made part of the priority-setting process.
- Priority setting is revisited regularly to make adjustments for social, economic, and political change and new directions in the AIDSCAP prevention activities.
- The AIDSCAP policy program supports the development and implementation of policies that are humane and conform to WHO and UN guidelines for the protection of human rights and human subjects of research.

V. program areas

The following program areas offer a framework for carrying out the policy strategy component. Not all program areas or activities are relevant in all countries.

A. assessing the in-country policy-setting environment

Conducting a policy assessment is the first step in maintaining an environment conducive to policy setting. Each assessment includes identifying key policy makers in all sectors; developing an understanding of where HIV prevention fits into a larger public agenda; assessing the relevance of ongoing social, economic, and political change; and listing ongoing and prior policy efforts and the measurement of current policy maker knowledge, attitudes, and level of involvement in HIV prevention. The assessment pays particularly close attention to in-country counterparts and those individuals and institutions that play a major role in influencing policy makers. The assessment is conducted using qualitative and quantitative data collected through interviews, attitude surveys, policy check lists, and literature reviews.

B. identification of desired policies for effective condom distribution, STD prevention, and the promotion of healthier lifestyles

AIDSCAP works with USAID missions and counterparts in all priority countries to identify existing and needed policies supportive of key AIDSCAP initiatives.

Desired policies for the reduction of STDs include but are not limited to an in-country commitment to national STD control, accessibility to STD drugs and diagnostics, assurance of quality measures, and the assurance of non-stigmatization and patient confidentiality.

Desired policies for condom promotion and distribution include assurance of universal access to the product, absence of burdensome tariffs and taxation, absence of marketing restrictions, and the availability of multiple institutional settings for condom promotion.

Desired policies for communications include access to appropriate public and private media, absence of censorship, lack of burdensome media costs, and access to all audiences.

Desired policies for behavioral research include access to data, expedient approvals and access to study participants, promoting research, protection of privacy, peer review, and the freedom of research design, data collection, analysis, and publication.

Desired policies and priorities are identified by local missions, AIDSCAP staff, collaborating institutions, and in-country counterparts. Policy needs change as the epidemic prevention program evolves.

C. identification of social and economic policies relevant to the spread of HIV infection

While the primary focus of this policy program is to support the AIDSCAP prevention objectives, assistance is available to address a broad range of social and economic factors that contribute to or thwart the spread of HIV infection. These factors include: discrimination towards those who are HIV-infected, established gender roles, employment patterns that separate spouses for long periods, impasses over desired strategies for changing sexual behaviors, and the availability of care for people with AIDS. These broader issues are identified by working with the missions and counterparts, conducting interviews, using data collection and analysis of past prevention, disease and epidemic control experience.

D. policy maker education

AIDSCAP takes an active role in ensuring that policy makers have relevant information on HIV infection and prevention activities, have the best available analysis of likely outcomes and costs of various policy choices, and when appropriate, become personally vested in prevention and infection control efforts.

Activities include briefings, seminars, observation, travel, and publications to present epidemiological and economic impact models in order to highlight successful interventions, present current research, and illustrate the benefits of policy maker support and involvement. In-country and other appropriate universities, media, businesses, trade associations, trade unions, donor organizations, and NGOs are among the institutions involved in information, analysis, and involvement activities. International guidelines and meetings are useful in rapid dissemination of information and ideas across multiple countries. AIDSCAP works closely with appropriate international organizations including WHO/GPA, UNICEF, the World Bank, CDC, and UNDP.

E. AIDSCAP policy interventions

AIDSCAP supports policy interventions that facilitate the project's ongoing prevention efforts. In-country efforts include dialogue with policy makers and specific requests for policy reform.

The AIDSCAP policy unit provides assistance on strategy development, staff support, materials, modeling and socioeconomic impact presentations, and the development of case histories in order to assist USAID, AIDSCAP in-country staff, and AIDSCAP subcontractors in discussing policy issues and making direct appeals for needed policy reform.

F. collaborative efforts with donor agencies, NGOs, businesses, religious institutions, unions, and community groups

While the AIDSCAP program is in a position to share its assessments and policy needs directly with policy makers, in many instances it is more advantageous to create collaborative policy development efforts. AIDSCAP supports in-country coalitions that support health care access, national AIDS prevention task forces, regional training and exchanges of policy makers and policy influencers.

The AIDSCAP policy unit provides necessary support to implement and monitor these interventions. Every effort is made in program design and implementation to involve a broad cross-section of the local population with sensitivity to culture, the need for collaboration among in-country groups, and the desire to sustain activities.

VI. evaluation

AIDSCAP conducts a formative evaluation, comparing initial and subsequent assessments of policy developments and examining process and outcome measures. Objective outcomes include measurement of changes in policy maker knowledge, attitudes, and actions and the imple-

mentation of desired policies. Subjective outcomes include increased internal and international collaboration, ability to address priorities, and the efficient use of available resources. Process evaluation includes the measurement of the number of policy makers reached, meetings held, media articles placed, and publications distributed.

VII. research

AIDSCAP initiates research to evaluate the efficacy and efficiency of different policy intervention approaches. Research focuses on comparative approaches to policy making for HIV/AIDS prevention; socioeconomic impact analysis; opinion leader attitudes; and AIDS costs to businesses.

behavioral research

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I. introduction

An innovative feature of the AIDSCAP project is the recognition of the role of the social and behavioral sciences in understanding and modifying behaviors. All human behavior, including sexual practices, is potentially modifiable, and communication can encourage changes in sexual behavior to reduce disease and infection transmission. Central to the AIDSCAP project is the recognition of the twin needs for significant research about human behavior to understand natural processes of adaption and change, and research to enhance AIDSCAP interventions.

II. goal

The goal of the behavioral research unit is to contribute to the scientific understanding of high-risk behaviors through the application of social and behavioral science, and to provide methods for modification of sexual behavior to be incorporated into AIDSCAP prevention activities.

Behavioral research conducted under the AIDSCAP project is designed to meet three objectives:

- contribute to the basic knowledge and contexts of behaviors associated with the transmission of HIV, the determinants of these behaviors, and methods for modifying them;
- test and analyze the acceptability and sustainability of new behavior change interventions on sexual behavior and condom use;
- support the development of the capacity of developing country social scientists and institutions in priority countries to conduct AIDS behavioral research.

III. guiding principles

A. advancing the scientific understanding of AIDS-relevant behavioral, social, and cultural issues

The research conducted under this project is designed to advance the broader scientific understanding of sexuality and associated risk behaviors, their contexts, and methods of modifying those behaviors for AIDS prevention. Multidisciplinary designs, integrating qualitative and quantitative methods in innovative ways, lie at the core of this research. Studies designed to promote the generalization of findings across research sites or countries also are promoted, as well as studies that explore intra-cultural variation. Because human behavior appears to be changing rapidly in response to the AIDS epidemic, and because many studies require measuring changing beliefs and linking changes to behaviors and serological status, it is important to conduct longitudinal and prospective studies. The behavioral research unit developed longitudinal study sites in Thailand and Brazil in the first year of project life. Additional new interventions are tested for effectiveness, using designs that provide generalizable results, including controlled intervention trials.

Much early behavior-related AIDS research was descriptive and evaluative, and as such provided an appropriate first response to the epidemic. However, the AIDSCAP project goes beyond descriptive goals, and explores the context and antecedents of behavior. There is a need for exploring such topics as:

- family planning and HIV;
- impact of community interventions;
- care and support;
- environmental determinants of HIV risk taking;
- women in stable relationships;
- youth and HIV.

The list of potentially useful research topics is much greater than AIDSCAP's resources to conduct research. The project selects from among the potential topics in order to develop

practical and applied research. The research is designed to advance the understanding of high-risk behaviors and methods for changing those behaviors. It also is designed to meet the highest scientific standards and is based on sound principles of research, including: peer review and oversight, the use of well-known designs and research methods, and publication in peer-reviewed journals, together with other forms of dissemination.

B. identifying the research agenda

The AIDSCAP behavioral research agenda is developed in close collaboration with the project's technical working group and leading behavioral research centers in the U.S. and developing countries. The development process also includes a review of the WHO/GPA behavioral research agenda.

C. capacity building in developing countries

Capacity building efforts need to focus as many resources as possible on developing country institutions. In the past, programs have found that institutional support often has floundered because equipment or funds were diffused over too many projects, or because program efforts were co-opted by administrators. A key principle for institutional support within the AIDSCAP project is that all capacity building is tied to concrete research project activities.

A second principle stipulates the need to involve developing country social and behavioral scientists. The social and behavioral research needs for prevention programs, as well as the needs of the scientific and donor community, can only be met if the growing cadre of developing country scientists is actively involved. A great disparity exists between available resources in the social sciences in North America and Europe and social science resources in the rest of the world. One dilemma facing developing country scientists is the absence, for the most part, of an institutional base. Scientists in developing countries are often confronted by research careers in disciplines where salaries are extremely low, research funding minuscule, libraries and computer access inadequate, and senior mentors absent. Although the AIDSCAP project cannot remedy all of these deficits, it recognizes that to truly encourage the active participation of developing country scientists, institutional as well as individual scholar support is required.

Possible support activities include:

- research sabbaticals so that researchers can commit full-time to research projects;
- focus on a small number of institutions and sites so that the limited resources of the project can make an institutional difference;
- identifying mentors for junior developing country scientists;
- encouraging a long-term relationship between developing country researchers and developed country consultants;
- providing enhanced microcomputer hardware and data analysis, data management, funds management, and communication software.

D. responding to program needs

Behavioral research is often identified with long-term esoteric academic activities that have little immediate relevance for projects. Research that is driven by a pre-defined agenda and panel of experts is especially vulnerable to this criticism. The AIDSCAP behavioral research agenda responds quickly to country- and mission-defined needs. Most often this includes research to identify and improve interventions, to help decide the appropriate mix of interventions, or to solve special problems identified during implementation or through evaluation. This component of the research program facilitates research by simplifying and accelerating the development and review process and by expediting the disbursement of funds.

E. proactive research development

The AIDSCAP behavioral research program adopts a hands-on, proactive approach in identifying researchers and research topics, in anticipating and providing support, and in encouraging careful analysis and dissemination of results.

F. ethics

All research supported by the program aspires to the highest ethical standards, including concern for the health and well-being of participants. Privacy, truly informed consent,

and the right of refusal to participate are safeguarded in the projects. Research subjects are protected against the least possible harm. All research meets U.S. federal guidelines set forth by the National Institutes of Health for the protection of human subjects and receives ethical clearance from appropriate developing country and developed country institutions. Strict adherence to the informed consent of all participants in a research project is necessary to build consensus to proceed.

IV. program areas

Three mechanisms are used to further these objectives: thematic grants, commissioned research, and program-related research.

A. the thematic grants program

The thematic grants program provides opportunities for theory-based research and capacity building. Each thematic grant has been awarded through a competitive process and should continue for two to three years. They have been awarded in two phases—first in Asia and second in Africa. Each of the grants has been awarded to developing country and developed country collaborators. Because the institutional and national considerations in each country differ, no single policy for the obligation and disbursement of funds can be made. On the whole, however, the grants program attempts to maximize the funds spent in the developing country. Each grant focuses on a theoretical, thematic, or disciplinary approach to AIDS prevention and an effort is made to coordinate research across projects and to share designs and instruments.

B. commissioned research

Studies developed through commissioned research arise out of discussion and consultation between AIDSCAP staff and scientists, policy makers, and program implementors from other institutions. These studies are intended to address major gaps in knowledge related to the prevention of HIV/AIDS. Funding for these studies is not competitively awarded; instead, these studies are initiated or solicited by the Behavioral Research Unit. Nevertheless, proposals that we receive through this mechanism are reviewed by the technical working group and the program committee before funding is awarded.

C. program-related research

Program-related research pursues issues of regional or global interest that are raised in the application of AIDSCAP's strategies for the prevention of HIV/AIDS in priority countries. This research aims to contribute to the design, implementation and evaluation of specific interventions. It focuses not so much on impact ("does the intervention work?") but rather on process ("how does it work?" and "under what conditions does it work best?"), and seeks to identify and resolve significant and recurrent constraints to the impact of AIDSCAP's activities at country level. Program-related research is closely tied to ongoing activities at a country and regional level.

V. dissemination

In order to ensure recognition of the projects, grantees frequently are assisted by AIDSCAP and the staff of the University of California, San Francisco, Center for AIDS Prevention Studies (UCSF/CAPS) in the dissemination of results to policy makers and program managers. All projects include briefings for researchers, policy makers, and officials of host-country governments and USAID. The design of the commissioned and program-related research guarantees that policy and decision makers are involved in the identification of research topics and researchers, and involved in utilizing the findings. The dissemination of research results is also encouraged through the participation of principal investigators for major grants in panels at scientific meetings, in pre-conference workshops, and in regional meetings. Finally, each proposal received includes a detailed plan for dissemination of research results. This includes a list of expected research products and the journals to which they might be submitted or the conferences at which they might be presented.

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I. introduction

AIDSCAP's overall goal requires the implementation of effective interventions most likely to alter those behaviors known to facilitate transmission of the HIV. Limited resources have to be divided among the various strategy components: reduction of STDs, condom programming, behavior change communication, policy development, and behavioral research.

II. goal

The goal of the evaluation component is to comprehensively assess and document the effectiveness of AIDSCAP activities over the life of the project. In order to accomplish this goal, the unit implements a systematic approach to evaluation of AIDSCAP, including (but not limited to) priority country programs and their subprojects, as well as associate country activities.

This systematic approach takes the form of: an approved overall evaluation plan at AIDSCAP, country program, and subproject levels by month six of the project (March 1992), with individual country and subproject evaluation plans developed prior to final approval of each country plan or subproject subagreement.

III. outputs/ specific objectives

A. evaluation plans for all levels of the AIDSCAP Project

AIDSCAP measures the performance of all components of the technical strategy and the work plans developed by each unit by incorporating quantitative and qualitative indicators of accomplishment. Each strategy component is also linked to specific indicators.

Country-level evaluation plans define quantified objectives and detailed methodological guidelines for measuring the prevention indicators (PIs), in addition to program specific indicators. This plan includes defining methods for conducting the necessary formative research to establish baseline data as well as methods for collecting process, outcome, and impact evaluation data prior to approval of the final draft of the country's implementation document.

Each subproject within each country program contains an evaluation plan developed with the implementing organization to: incorporate PI constructs and/or the broader set of project-specific indicators; establish a schedule for collection and reporting of baseline and process data; and determine specific outcome indicators and data collection points and methods. These subproject evaluation plans are incorporated into subagreements prior to sign-off.

B. routine and special analyses

Plans for supplementary or special analyses or studies are developed within one year of implementation of an individual country program. Larger regional and program-wide study plans are developed by the end of year two. For example, AIDSCAP initiated, with Abt Associates, Inc., a three-country assessment of the impact of AIDS on economic, social, and political development. In-depth regional or country-specific studies also fall in this category.

IV. country program evaluation

A. overview

While each individual subproject within each country program is monitored and evaluated, the summary outcome and impact of all of the components is monitored and evaluated by the AIDSCAP evaluation unit at the regional and headquarters level. The evaluation plan for country programs uses as an evaluation core measures similar to those developed by the WHO/GPA and USAID AIDS PI process. The PIs are being refined by WHO/GPA/USAID as country-level HIV/AIDS prevention indicators of program impact. The purpose of developing this set of indicators is to provide a standardized protocol for monitoring and evaluating HIV/AIDS prevention and control programs that allows cross-national comparisons. The basic constructs within the PIs that are measured within AIDSCAP include:

- HIV and syphilis seroprevalence shifts assessed over the medium term (five years);
- survey-based (as well as qualitatively measured) reported behavior change (e.g., partner-type specific condom use, number and types of partners) assessed over the short (two years) and medium terms;

- survey-based knowledge of HIV prevention in the general population assessed over the short and medium terms;
- survey-based self-report of history of STDs in males assessed over the medium term;
- a facility-based assessment of STD case management (biomedical and condom/communication aspects) at the onset of activities in the STD program, and re-evaluated in the final year;
- condom distribution and sales figures aggregated from participating organizations and institutions on an ongoing basis, with an additional assessment of condom outlets in the initial (and final) years of program activity.

These PIs are not intended to provide national AIDS control programs or AIDSCAP with all the information necessary to monitor the implementation of prevention programs, nor to measure the impact of all prevention and control activities. NACP strategic plans include other monitoring and evaluation protocols, and AIDSCAP country program strategic plans also include additional indicators depending on the specific components (subprojects) of country programs.

B. implementation of AIDSCAP PIs

1. HIV and syphilis seroprevalence rates

Within AIDSCAP, HIV and syphilis seroprevalence rate indicators are monitored in 15- to 24-year-old women presenting for antenatal care in specific sites (both within the regions of project activity and in regions not included in project activity) throughout the life of the project. The project does not collect independent serologic results, but rather makes use of ongoing sentinel surveillance data collection by ministries of health or national AIDS control programs. If needed and requested, the project provides short-term technical assistance to strengthen this activity.

In areas of low seroprevalence an alternate population may be chosen for surveillance (i.e., patients presenting at tuberculosis treatment clinics). Whichever population is selected, the reported seroprevalence rates are coupled with attempts to define how representative these samples are to the larger adult population (e.g., asking on survey instruments about antenatal attendance for the most recent birth in the household). It is anticipated that both HIV and syphilis seroprevalence rates should remain level or decrease slightly in areas of project activity after five years, and continue upward slightly, or perhaps stabilize in non-project areas.

2. reported behavior change

Target population surveys are conducted among independent samples of men and women in both project and non-project areas at baseline (and as needed during the life of the subproject) to assess reported behavior change. If possible, key indicators are incorporated into ongoing or planned surveys by other agencies in priority countries. The AIDSCAP-supported surveys provide the bulk of indicators, including, but not limited to measures of:

- condom use, stratified by gender and age of respondent and type of partner, reported as use of a condom during the most recent act of sexual intercourse;
- partner reduction, where number of partners are a time-bound measure, stratified by gender, age, and type of partner;
- knowledge of prevention, measured in an unprompted fashion;
- self-reported STD history, where a time-bound measure of male history of STD will be assessed by a validated series of questions, as they become available.

3. STD case management assessment

STD control and prevention programs incorporate measures of appropriate levels of diagnosis and treatment, in accordance with national standards. Adequacy of case management includes condom distribution and advice on partner notification, among other management guidelines. Case management assessment is conducted as part of the general needs assessment undertaken at the onset of STD clinic-based prevention activities. A follow-up evaluation will be conducted in the last year of the project in the context of routine facility supervision. The three PIs captured with this methodology are:

- proportion of clients (male and female) presenting with a specific syndrome (GUD or discharge) who are assessed and treated according to national guidelines;
- proportion of clients presenting for treatment of any syndrome who receive condoms and instructions in their use;
- proportion of clients presenting for treatment of any syndrome who receive counseling to promote partner notification and treatment.

4. condom distribution and availability

The number of condoms distributed by participating organizations and institutions is tracked on a monthly basis, and aggregated on a quarterly or semiannual basis by type of outlet to monitor progress in this area. Existing data on the availability of condoms in a priority country is used in tracking total numbers of condoms coming into each country. Shifts in physical accessibility (number of outlets) are assessed through the monitoring of routine statistics collected during the implementation of condom social marketing programs.

5. additional country-level indicators

Each priority country selects additional country-specific indicators to be measured at baseline and assessed again at the end of the intervention (outcome indicators), and to be used during monitoring of project activities (process indicators). Additional indicators might include:

- reported delays in onset of sexual activity among youth (<20 years);
- sources of HIV/AIDS information in the past three months, and the most useful of these sources;
- percentage of population that specifically mentions condom use as a method to protect themselves from HIV infection;
- percentage of population surveyed who believe that a majority of their friends and peers use condoms (or other risk-reduction behaviors);
- awareness of and perceived accessibility of condoms, STD services, etc.;
- personal acquaintance with HIV carriers or persons with AIDS (PWAs), particularly in low prevalence countries;
- perceived risk of HIV/AIDS in the population and reasons for expressed level of risk;
- changes in policies assessed to be ineffective or impediments to AIDS prevention and control initiatives;
- number of facilities or organizations "upgraded," including number of staff/educators/clinicians trained;
- amount of time (days/weeks) of technical assistance (by technical area) that is provided to a country program;

- number of contacts/meetings with NACP, MOH, other donors, and policy makers;
- number of appropriate newspaper/magazine articles published about AIDS.

C. qualitative research

Many aspects of HIV prevention are difficult to measure or fully comprehend in a quantitative manner. Thus, qualitative data-collection activities are conducted to complement quantitative assessments, both at baseline and throughout the life of the project. The content of these qualitative efforts is designed to complement the quantitative measures at both the country program and subproject level.

For example, more subtle aspects of the quality of STD services (such as the extent to which services are accessible, confidential and private, the waiting times minimal, and the staff well trained) are best evaluated through participant observation. Researchers equipped with check lists can be sent to STD clinics to record their observations. After a few days of observation, well-trained observers can produce an accurate assessment.

D. internal reviews

During the life of the country project, and at the discretion of the resident advisor and the evaluation staff, AIDSCAP may support a team to visit and assess the current level of implementation, as well as the detailed plans for following years. These visits should not be viewed as official external evaluations, but rather as internal procedures to critically assess the progress of the project to date.

E. implementation and technical support

Regional and country offices, as well as many implementing agencies, each have a copy of the document, "Tools for Program Evaluation: A Guide for Evaluating AIDSTECH and AIDSCAP Interventions," as developed by the evaluation units of the two projects. This document is the primary evaluation resource for subproject, country, and regional levels, in addition to AIDSCAP's evaluation strategy. Additional, complementary modules are in ongoing development.

As with all research, the exact wording of many of the constructs to be measured within the AIDSCAP Project requires careful development within priority countries using qualitative, formative research techniques such as focus group discussions and key informant

interviewing. Translations and back-translations into indigenous languages, as well as interviewer training, are critical to accurate measurement.

V. subproject evaluation

Each subproject within the country program portfolio is designed in cooperation with locally designated NGOs, PVOs, USAID missions, and AIDSCAP staff. Each subproject proposal contains an evaluation plan incorporating PIs or additional country program indicators relevant to the particular subproject, along with process and outcome indicators specific to the subproject, developed with input and oversight by the designated evaluation unit staff member (most often the regional evaluation officer).

Subproject evaluations often provide interim estimates of progress toward objectives for the country program as a whole, in addition to their primary purpose of assessing the success of a particular subproject. Subproject evaluations should be as participatory in nature as possible, to facilitate the utilization of evaluation results at the local level, and to strengthen implementing agencies' capacity and inclination relative to evaluation.

Data from subprojects, country offices, and regional offices is collected in a standardized format to maximize comparability, with regional offices responsible for data entry and validation of information from their region. All staff have "read" access, but only a finite number are able to modify the information contained in the system. Standardized reports are generated to go both up and down the system to stimulate utilization of collected information. Ad hoc reporting is also possible in selected instances.

Many of the indicators listed above are applicable at the subproject level, but some additional process indicators for a subproject designed to enhance the prevention component of a national STD program might include:

- the number of STD patients counseled about STD and HIV prevention;
- the number of patients receiving condoms and number of condoms distributed;
- the number of persons contacted through outreach activities.

Examples of outcome indicators for the same project might include the:

- the proportion of patients intending implementation of risk-reduction behaviors (e.g., condoms, reduced numbers of partners);

- the proportion of clients who are repeat attenders at STD clinics;
- the proportion of counselors who exhibit satisfactory skill levels at assessment and supervisory visits.

An example of impact assessment for a counseling and testing intervention might consist of the following:

- A special study of 75 recruited men and 75 recruited women who have gone through counseling and testing, matched by gender, age, and marital status with an equal number of community members not participating;
- The subjects will be assessed for HIV-risk behaviors at baseline and again at six months and one year, including: partner testing and HIV status; reported condom use; reported number of partners; contraceptive use; and other outcome variables, such as pregnancy;
- Recruited subjects will also be reassessed for HIV at the end of one year, and community control subjects will be offered counseling and testing at the end of the study.