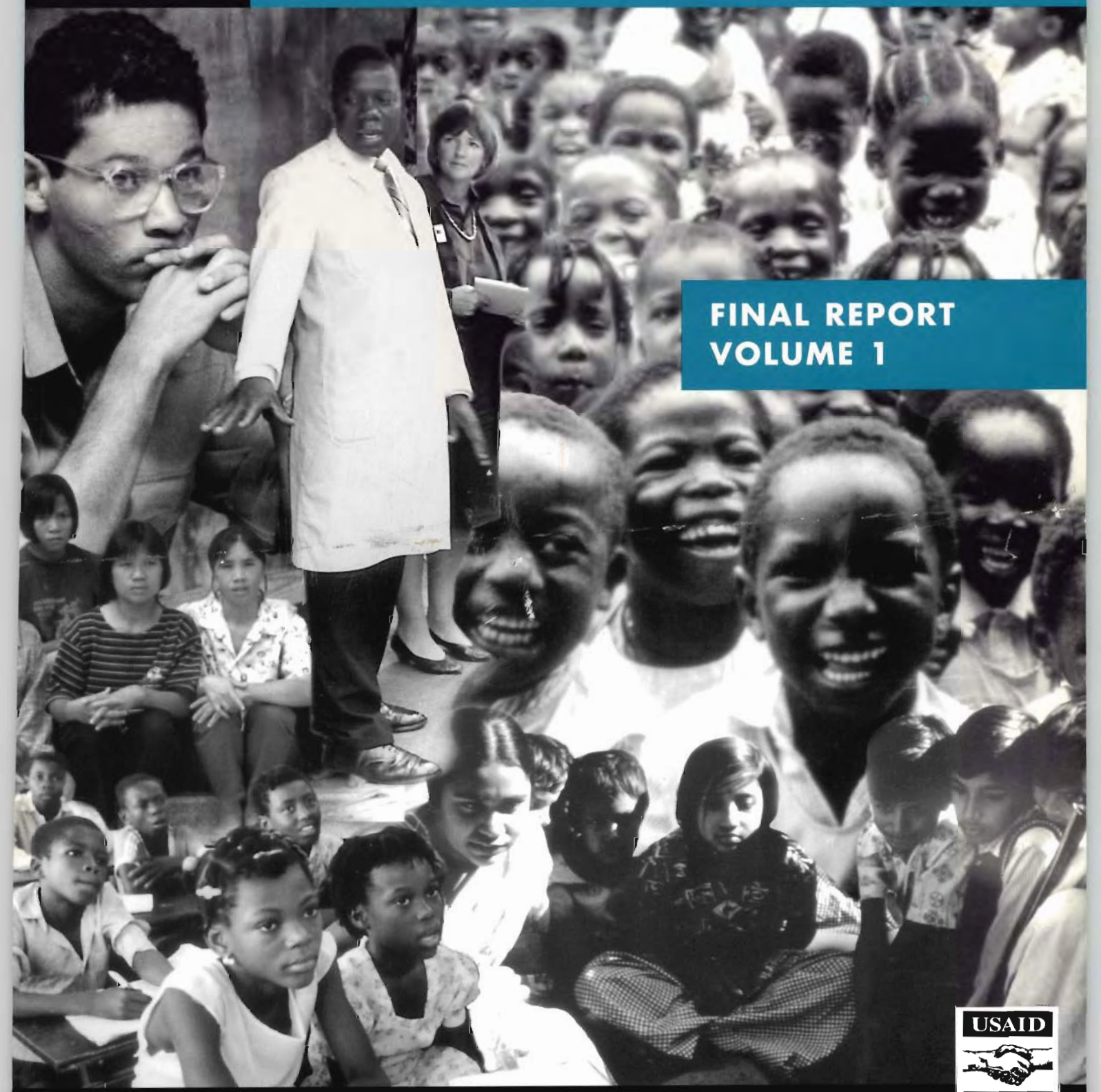
AIDSCAP

FAMILY HEALTH INTERNATIONAL

AIDS CONTROL AND PREVENTION PROJECT

AUGUST 27, 1991 - DECEMBER 31, 1997



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Final Report

Family Health International

AIDS Control and Prevention Project

August 21, 1991–December 31, 1997

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ACRONYMS

AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
AIDSCOM	AIDS Public Health Communication (former USAID project)
AIDSTECH	AIDS Technical Support (former USAID project)
ANE	Asia Near East Bureau
APAC	USAID AIDS Prevention and Control Project
ATSP	AIDS Technical Support Project
AWI	AIDSCAP Women's Initiative
BAP	Bhoruka AIDS Prevention Project
BCC	behavior change communication
BSS	behavioral surveillance surveys
C&T	counseling and testing
CAPS	Center for AIDS Prevention Studies
CDC	Centers for Disease Control and Prevention
CSM	condom social marketing

CSW	commercial sex worker
FHI	Family Health International
FSIT	focus site intervention team
GHESKIO	Haitian Study Group for Kaposi's Sarcoma and Opportunistic Infections
GPA	Global Programme on AIDS
GUD	genital ulcer disease
HAPP	HIV/AIDS Prevention Project
HCP	health care providers
HIV	human immunodeficiency virus
HQ	headquarters
IA	implementing agency
JAS	Jamaica AIDS Support
JSI	John Snow, Inc.
KANCO	Kenya AIDS NGO Consortium
LAC	Latin America and the Caribbean
LLD	long-distance driver
MAP	Medical Assistance Program (MAP International)
MAP	Monitoring the AIDS Pandemic Network
MCH	maternal and child health
MOH	Ministry of Health
MPSC	(people with) multiple partner sexual contacts
MWM	men who have sex with men

NACP	National AIDS Control Program
NAP	National AIDS Program
NGO	nongovernmental organization
PHE	peer health educator
PI	prevention indicator
PSI	Population Services International
PVO	private voluntary organization
ROs	regional offices
STI	sexually transmitted infections
SYGA	Save Your Generation Association
TIR	targeted intervention research
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organization

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Introduction

Background

AIDS—a word unknown and unspoken 20 years ago—has become one of the most commonplace terms at the end of the twentieth century. Once an obscure, unexplainable, and deadly disease infecting a small group of poor and stigmatized individuals, AIDS now reaches across every corner of the world and touches people's lives everywhere. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), since the beginning of the epidemic more than 38.7 million adults and 2.7 million children had acquired HIV and 11.8 million people had died from AIDS. During the past decade, HIV/AIDS has expanded from an emerging disease to an epidemic among individuals associated with clearly defined risks to a pandemic that affects even rural women who do not receive blood or have any sexual partners other than their spouses. According to UNAIDS, 60 percent of new infections globally occur among women aged 15 to 24, with twice as many young women infected as men in this age group.

Since the mid-1980s, USAID has provided global leadership to the international efforts to prevent further transmission of HIV and, more recently, to mitigate the impact of AIDS on individuals and communities. In 1986, USAID support to the World Health Organization (WHO) helped launch its Global Programme on AIDS (GPA). A few months later, USAID developed its agencywide policy for addressing HIV/AIDS through a concerted prevention strategy that in May 1987 resulted in the authorization of the AIDS Technical Support Project (ATSP). The ATSP incorporated USAID's initial public health communication project for HIV/AIDS prevention (AIDSCOM) started in 1986, launched a broad support project (AIDSTECH), provided funding to a number of U.S. private voluntary organizations (PVOs) and to the

Centers for Disease Control and Prevention (CDC), created a mechanism for USAID Mission and Bureau participation, and included continued financial commitment to the GPA.

An evaluation of the ATSP and its two major components (AIDSCOM and AIDSTECH) in 1980 noted the impressive beginnings of the two efforts as well as a number of inherent problems. Among the problems were the expansive nature of the response (addressing all modes of transmission), the expansive number of USAID Missions seeking support from ATSP (nearly 60 countries), and the confusion and competition created by two program efforts with several overlapping areas of responsibility. On the basis of the findings and recommendations of the evaluation, USAID expanded the 5-year life of the ATSP and designed a new project to eventually replace AIDSCOM and AIDSTECH that would aim to work in fewer countries and address a narrower scope of intervention.

Project Description

The AIDS Control and Prevention Project, a cooperative agreement between USAID and Family Health International (FHI), was launched in September 1991, with a budget of $168 million. In response to the recommendation to limit its focus, AIDSCAP/FHI was designed to prevent the spread of HIV through sexual transmission using three key strategies—increased condom use, improved management and prevention of sexually transmitted infections (STIs), and the adoption of safer sexual practices, including partner reduction. This approach was chosen based on computer modeling that demonstrated the synergistic benefits of these strategies in achieving prevention results. These strategies were reinforced by commitments to policy support to create a positive environment for prevention, behavioral research as a means of improving the quality of interventions, and evaluation to measure the progress of individual efforts. As the project evolved, AIDSCAP/FHI broadened its areas of expertise to include special attention to the unique issues surrounding women and HIV, the connection between prevention and care, and the impact of the epidemic on women and children and its mitigation. This project became the flagship effort of the ATSP.

As originally designed, the goal of the AIDSCAP Project was to reduce the rate of sexually transmitted HIV infection in the developing world. The purpose—to strengthen the capacity of developing countries to increase condom use, decrease STIs, and decrease the number of partners—was to be achieved through three major outputs: (1) improved multidimensional programs designed, implemented, and evaluated; (2) findings from behavior research applied to interventions; and (3) critical policy issues resolved. This design was refined over the course of the project to reflect changing circumstances and the global evolution of the response to the epidemic. The refined objectives—restated in the new USAID language of results—are presented in Table 1. The revisions acknowledged that given the dynamics of the epidemic, measuring a reduced rate of sexually transmitted HIV in 5 years would be nearly impossible. In addition, the revisions acknowledged the need to address HIV/AIDS more comprehensively and recognized strengthened local capacity as the critical interim step to improving programs and eventually achieving reductions in sexually transmitted HIV.

Table 1. Objectives of the AIDSCAP Project

Original	Revised
Supergoal:	**Supergoal:**
None	Reduced rate of sexually transmitted HIV infection in developing countries
Goal:	**Goal:**
To reduce the rate of sexually transmitted HIV infection in the developing world	Improved HIV risk reduction strategies in selected populations and countries in the developing world
Purpose:	**Purpose:**
To strengthen capacity of developing countries to increase condom use, decrease STIs, and decrease number of partners	Strengthened capacity of developing countries to design, implement and evaluate technically comprehensive HIV programs
Outputs:	**Outputs/results:**
1. Improved, multidimensional programs designed, implemented, and evaluated	1. Improved, multidimensional programs designed, implemented, and evaluated
2. Findings from behavioral research applied to interventions	2. Lessons learned from project implementation disseminated
3. Critical policy issues resolved	3. Findings from research applied to interventions
	4. Critical policy issues identified and addressed

The AIDSCAP Project was designed to facilitate comprehensive programming in as many as 15 countries and to support smaller scale efforts to a wider audience of associate countries. To ensure state-of-the-art technical cooperation, FHI teamed up with nine subcontractors: Population Services International for condom social marketing; John Snow, Inc. for condom logistics management; the Center for AIDS Prevention Studies at the University of California at San Francisco for behavioral research; the Program for Appropriate Technology in Health, Ogilvy Adams & Reinhart, and Prospect Associates for communication support; and the Institute for Tropical Medicine, University of Washington in Seattle, and the University of North Carolina at Chapel Hill for STI technical assistance.

The project completion date was extended 1 year from September 21, 1996 to December 31, 1997. This was done to compensate for nearly 1 year of implementation time lost when AIDSCAP was changed from a cooperative agreement to a contract (2 1/2 years into the project) and to allow a smoother transition from AIDSCAP/FHI to the new USAID programming that would succeed the ATSP.

Accomplishments and Results

"If AIDSCAP/FHI had to be compared to other initiatives undertaken globally in the field of STI/HIV/AIDS prevention, and if, in order to do so, one had to take into consideration the technical quality of the program's content, the variety of geographic, social, and cultural settings within which prevention interventions are adapted and implemented, the capacity of the program to reach particularly vulnerable communities and at-risk populations, and the ability of the program to share its experience with others, then AIDSCAP/FHI would rank among the very best and most powerful STI/HIV/AIDS prevention programs funded by any official development agency."

Management Review of the AIDSCAP Project, 1995

Table 2. AIDSCAP Global Process Data

	Cumulative
Total People Educated:	**21,886,842**
Total People Trained:	**186,967**
Total Condoms Distributed:	**227,562,111**
Free	**45,402,395**
Sold	**182,159,716**
Total Materials Distributed:	**19,128,768**

Process indicators are used to track measurable data in a subproject. *People educated* includes number of people attending educational sessions or contacted through AIDSCAP interventions. *People trained* includes number of people attending training of trainers sessions. *Condoms distributed* indicates condoms sold through condom social marketing programs and condoms distributed for free. *Materials distributed* includes behavior change, condom promotion, and HIV/STI educational materials such as posters, pamphlets, handbooks, tapes, newsletters, and comic books.

For 6 years, AIDSCAP/FHI successfully contributed on several levels to improving HIV/AIDS risk-reduction strategies in selected populations and countries in the developing world. As the body of this final report articulates, the project

- facilitated the design, implementation, and evaluation of multidimensional programs.
- introduced innovative programming.
- increased the capacity of developing-country partners through technical cooperation, training, and the development of valuable field-targeted tools.
- conducted important intervention-focused research.
- disseminated its lessons learned and best practices widely.
- achieved impact on defined behavioral outcomes.

Designed, Implemented, and Evaluated Multidimensional Programs

Working in partnership with governments, nongovernmental organizations, and communities around the world, AIDSCAP/FHI designed and supported comprehensive, multiyear programs in 18 countries located in Africa, Asia, Latin America, and the Caribbean, as shown in Table 3. These programs generally included efforts in each of the six major strategies.

AIDSCAP/FHI also assisted more than 25 additional countries (see Table 4) in developing and implementing smaller targeted programs and activities, such as strengthening Zambia's national STI service, infusing state-of-the-art HIV prevention expertise into the design and implementation of a comprehensive reproductive health project in West Africa, and training epidemiologists and social scientists in the conduct of socioeconomic impact studies in Central America. In a few countries, including Benin, Burkina Faso, and Guinea, AIDSCAP/FHI provided short-term technical assistance.

In both the major countries and the smaller associate countries, AIDSCAP/FHI funded nearly 800 individual subprojects that were implemented by more than 500 program partners. These partners ranged from large U.S. PVOs implementing HIV/AIDS prevention efforts within larger community development efforts to microsized community groups.

Table 3. AIDSCAP/FHI Major Country Programs

Africa	Asia	Latin America/ Caribbean
Cameroon, Ethiopia, Kenya, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Zimbabwe	India Indonesia Nepal Thailand	Brazil Dominican Republic Haiti Honduras Jamaica

Table 4. AIDSCAP/FHI Associate Country Programs and Activities

Africa	Asia/ Near East	Latin America/ Caribbean
Benin	Bangladesh	Bolivia
Burkina Faso	Cambodia	Colombia
Côte d'Ivoire	Egypt	Costa Rica
Lesotho	Lao PDR	Ecuador
Mali	Mongolia	El Salvador
Mozambique	Morocco	Guatemala
Niger	Papua New Guinea	Mexico
Zambia	Philippines	Nicaragua
	Sri Lanka	Peru

Introduced Innovative Programs and Approaches

The AIDSCAP Project expanded both the range of at-risk groups reached by STI/HIV/AIDS prevention messages and innovative practices to guide the way to more effective interventions. Thus, for example, beyond reaching youth in and out of school and men and women where they work and socialize, AIDSCAP/FHI field partners developed programs to reach at-risk groups with special needs, including border-crossing migrant workers, refugees, orphans, and the deaf.

The project also tested several program innovations with the demonstrated capacity or potential for significantly improving prevention programming. Some innovations were adopted as best practices; others provided ground-breaking information on which to build further advances, as the following examples show:

- AIDSCAP/FHI contributed to the global effort to gain clinician acceptance of a syndromic management approach to STI diagnosis and treatment and developed a system for increasing partner referral for STI treatment. These approaches maximized the results obtained from frequently understaffed, poorly equipped government health clinics and from overused, rapid-turnaround private clinics.

- AIDSCAP/FHI refined strategies for dialogue on sexual behavior between partners and between mothers and daughters that have opened healthy communication.

- AIDSCAP/FHI also demonstrated that materials well crafted with participation from around the world can transcend national borders and cultural nuances to sound a broadly resonant chord. AIDSCAP/FHI's *Emma Says* comic books, originally designed for Senegal and Nigeria, have been widely accepted by audiences in countries as diverse as

Benin, Burkina Faso, Tanzania, Zambia, Zimbabwe, Rwanda, Kenya, Cameroon, Côte d'Ivoire, Madagascar, South Africa, Thailand, Haiti, and Brazil.

- AIDSCAP/FHI developed a program for engaging nongovernmental organizations (NGOs) as condom social marketing partners. In Haiti, the strategy worked so well that NGOs accounted for one-third of condom sales.

- AIDSCAP/FHI defined the importance of, and created successful models for, addressing the unique challenges and opportunities for preventing HIV transmission in cross-border areas of affinity.

Increased the Capacity of Developing-Country Partners

Capacity building was a predominant focus of AIDSCAP. For the past 6 years, the project has conducted or sponsored training opportunities for 186,967 professional and volunteer frontline workers in STI/HIV/AIDS prevention. Capacity has been built to improve technical skills in providing services to thousands of peer educators, health care workers, pharmacists, clinicians, condom logistics managers, materials developers, and researchers. The capacity of hundreds of government agency and NGO managers has also been enhanced in strategic planning, resource development, advocacy, planning, budgeting, evaluation, and program and organizational management. These efforts were designed to help host country partners more effectively implement AIDSCAP/FHI-supported activities. They were also conducted with foresight to the long-term growth and viability of government and civil society.

In addition to technical support and training, AIDSCAP/FHI contributed to capacity building of institutions and individuals who had little or no contact with the project through the development and broad dissemination of learning tools. These tools include the following:

- The targeted intervention research manual that guides program planners in designing and carrying out ethnographic research on community attitudes and practices surrounding STI.

- Behavior change communication (BCC) how-to manuals that provide clear, insightful steps to developing, for example, a communication strategy, a peer education program, a media campaign, and a project-monitoring plan.

- The Private Sector AIDS Policy manual that walks work-site managers through the process for assessing, articulating, and implementing HIV/AIDS prevention programs and policies.

- A gender-training manual that guides the design of policies and programs that explicitly recognize and address gender as it relates to HIV/AIDS.

- Policy tools that make socioeconomic impact assessments more applicable and easier for field personnel use.

- A capacity assessment tool that helps organizations inventory their strengths and limitations and a strategic planning tool that guides long-term goal setting.
- An STI manager's handbook for clinicians and health care workers that provides practical directions and guidance for improving STI management and prevention at program or clinic level.
- Evaluation tools modules that address specific methodologies and practices for measuring project results and program impact.
- The behavioral surveillance surveys (BSS) methodology that monitors trends in sexual behavior among target populations.

In addition to providing training and tools, the AIDSCAP Project strengthened the capacity of developing-country partners through a special program to expand the participation of community-based groups in STI/HIV/AIDS prevention and care. AIDSCAP/FHI's rapid-response fund, managed at the country level, provided seed funding to more than 200 organizations, many of which had never received donor funding previously. A final accomplishment in capacity building was the transformation of a number of AIDSCAP/FHI country offices into independent NGOs, allowing them to continue serving their communities beyond the life of the project.

Although the project has been successful in developing the capacity of governmental and nongovernmental organizations around the world, clearly the need for collaboration, partnership, and financial assistance remains an ongoing, essential priority.

Conducted Intervention-Focused Research

AIDSCAP/FHI's research agenda focused primarily on intervention-linked issues with clear and potentially rapid application to improve programming. Examples of such research include the following:

- A presumptive treatment study conducted with commercial sex workers (CSWs) and the mining community in Welkom, South Africa demonstrated reduced STIs among partners of CSWs who were periodically treated presumptively for common STIs.
- An assessment of emerging patterns of HIV incidence in Uganda and other East African countries provided important information on the impact of population movements within and among countries.
- Targeted intervention research conducted in Senegal, Ethiopia, Malawi, Zambia, Benin, Swaziland, South Africa, and Morocco defined local customs and attitudes about STIs and treatment-seeking behavior. Research results were used in each country to refine STI programming.
- An indepth assessment of 21 peer education programs across Africa, Asia, Latin America, and the Caribbean identified strengths, limitations,

and needs for further training to maximize the effectiveness of this popular intervention strategy.

- A study examining the impact of providing care and support to individuals newly diagnosed with HIV/AIDS on their adoption of safer sexual behaviors.

- The first pilot study conducted in Cameroon, of prepackaged antibiotic therapy for the treatment of urethritis, provided critical data on acceptability among consumers and on the barriers to effective introduction of this approach.

- A multicenter study on the effectiveness of voluntary HIV counseling and testing was jointly sponsored with WHO and the UNAIDS. Preliminary results of this study offered evidence of the effectiveness of such services as a prevention strategy in resource-poor countries. The final results of this study will help guide decisions about establishing and funding HIV counseling and testing services in countries throughout the developing world.

Disseminated Lessons and Best Practices

The AIDSCAP Project used several approaches for sharing information, lessons, and best practices. A primary vehicle was the written word presented in nine languages. Publications included books, peer-reviewed papers, reports, magazine issues, newsletters, book chapters, comic books, brochures, fact sheets, and press releases. Special accomplishments include the following:

- More than 150 peer-reviewed articles were published in medical, scientific, or other professional journals.

- AIDSCAP/FHI's magazine, *AIDScaptions,* was the first to focus on the prevention of STIs and HIV internationally. The magazine has a readership of 350,000 people worldwide.

- Information packages consisting of recent journal articles were sent quarterly in English and semiannually in French to approximately 1,000 individuals and institutions in developing countries.

- A CD-ROM containing more than 300 AIDSCAP/FHI publications, manuals, journal articles, and reports was produced and disseminated.

AIDSCAP/FHI also provided global leadership in advancing dialogue and discussion on the status and trends of the pandemic. Through its role as the Interim Secretariat of the Monitoring the AIDS Pandemic (MAP) Network, AIDSCAP/FHI worked with its partners (Harvard University's François-Xavier Bagnoud Center and UNAIDS) to bring together more than 100 global experts in five symposia to examine epidemiologic trends and monitor the effects of prevention and care programs. Finally, AIDSCAP/FHI sponsored 550 individuals to participate in international conferences.

Achieved Impact on Behavioral Outcomes

A major strength of the AIDSCAP Project was its recognition of the importance of program evaluation as a tool to guide program planning and management. In the area of behavior change interventions—the core of AIDSCAP/FHI's prevention activities—evaluation efforts focused on assessing accurate knowledge about HIV/AIDS risks, reduction of risk behaviors, and adoption of protective behavior as the most appropriate intermediate outcome indicators for interventions designed to reduce sexual transmission of HIV. Almost 400 quantitative and qualitative studies were carried out over 6 years to collect such behavioral outcome data.

The evaluation results, highlighted in the individual country overviews, suggest that the project did make a difference in most intervention settings. It should be noted that the detection of significant behavior changes is becoming increasingly difficult over time, especially after substantial changes have already occurred (a ceiling effect). In these cases, interventions have reinforcing rather than new effects. These effects may look small when they are, in fact, indicative of the prevention of relapses in unsafe behavior.

Overall, knowledge of HIV transmission modes and methods of HIV/AIDS prevention have reached high levels in the targeted populations, but misconceptions about acquiring or preventing HIV infection remain. Encouraging findings have been reported from different regions on the reduction of risk behaviors (such as avoiding commercial sex, having fewer casual partners, or delaying onset of sexual relations) and the adoption of protective behaviors (such as the use of condoms). Especially impressive is the high level of condom use in commercial sex among the groups targeted by programs that implemented peer education and condom social marketing as complementary prevention strategies. In other population groups, however, reported condom use with nonregular partners (WHO prevention indicator 5) was generally reported at lower levels. Selected examples from different countries are shown in Table 5.

Interpretation of these data requires an understanding of the social and cultural context within which the interventions were operating. Comparing outcome data from different countries is further complicated when the studies used different definitions of target audiences, outcome measures, or wording in survey instruments. Not only do these differences make it hard to compare studies, they also make results difficult to generalize. The BSS methodology, an innovative approach developed by AIDSCAP/FHI to monitor behavioral trends in target populations, is designed to eliminate the need for collecting data separately in a multitude of projects that reach the same target groups. When implemented at a national or a regional level, the BSS approach offers greater comparability and ensures a higher degree of standardization not necessarily present when data are collected by a variety of different implementing agencies.

Another interpretation issue involves the measurement of risk behaviors in either absolute or relative terms. Percentage figures of condom use measure the proportion of sexual exposures that are considered safe, which may or may not reflect the absolute number of sex acts that place individuals at risk for exposure to sexual transmission. For example, 25 percent condom use in 10 HIV-associated sexual

Table 5. Reported Condom Use With Nonregular Partners During Last Sexual Intercourse by Target Population

Country	Target Population	Reported Condom Use	
		Baseline	Follow-up
Brazil	CSWs	57% (1993)	97% (Sept. 1996)
Cameroon	CSWs	69% (1994)	69% (1996)
	University Students	63% females (1993) 75% males (1993)	77% females (1996) 70% males (1996)
Dominican Republic	CSWs Hotel Workers	65% (1992) 86% (1993)	98% (April 1996) 95% (April 1996)
Ethiopia	CSWs Out-of-School Youth	75% (1993) 21% females (1993) 49% males (1993)	80% (1996) 48% females (1996) 58% males (1996)
Jamaica	General Population (national survey) (age 15–49 years)	20% females (1994) 73% males (1994)	17% females (1996) 74% males (1996)
Nepal	CSWs	35% intervention area (1994) 48% control area (1994)	61% intervention area (1996) 47% control area (1996)
Nigeria	CSWs Long-Distance Drivers	23% (1989–90) 26% (1995)	84% (1997) 48% (1997)
Tanzania	General Population (DHS)* (age 15–59 years)	20% females (1994) 36% males (1994)	17% females (1996) 35% males (1996)

*Demographic Health Survey

episodes is still safer than 75 percent condom use in 100 HIV-associated sexual episodes. Therefore, it is also important to determine the frequency of condom use in absolute terms in a given risk situation. AIDSCAP/FHI's behavioral surveys began to address this dilemma by collecting additional data on "always or consistent" condom use during sexual episodes with nonregular partners.

For many reasons (e.g., cost and feasibility), nonexperimental observational methods with no control groups were routinely used in AIDSCAP/FHI's behavioral outcome evaluations. With such a design, however, it is often difficult to conclude that the observed differences are attributable to the intervention. Secular trends toward risk reduction will occur, especially when growing numbers of people are developing AIDS-related illnesses. For example, having a friend or relative with HIV/AIDS may influence adolescents to delay the onset of sexual relations or motivate those with nonregular sex partners to use condoms.

In the absence of more rigorous evaluation designs, triangulation procedures were applied to substantiate a link between interventions and observed behavior changes. In Cameroon, for example, process evaluation data on condom sales, the intensity of peer education, or the quality and coverage of media campaigns were combined with an analysis of behavioral outcome data to provide an understanding of the process through which interventions achieve effects. In addition, results from behavioral surveys were analyzed together with findings from qualitative evaluation research (e.g., focus group discussions, key informant interviews, and rapid ethnographic studies) carried out in subsamples of surveyed target populations. This analysis suggests that the observed outcome data are likely results of the aggregate effect of multiple interventions as well as environmental and personal factors.

Did the reported behavior changes lead to reductions in HIV transmission? This important question is usually not answered by individual intervention programs given the financial, logistical, and technical constraints and the methodological difficulties associated with field-based assessments of intervention impacts through large-scale incidence studies. However, AIDSCAP/FHI's newly developed AVERT model may provide answers. The AVERT model computer is used to estimate the impact of intervention outcomes, such as increased use of condoms, improved STI treatments, or changes in sexual behaviors, on the number of primary HIV transmissions averted over a given period. This spreadsheet-type model will also enable program managers to carry out analyses of the cost-effectiveness of different intervention combinations, providing the basis for designing cost-effective prevention measures for specific target populations in defined epidemiological settings.

Finally, it is important to realize that behavior change interventions have to be implemented for sufficient amounts of time and on a large enough scale to have an impact on personal behavior, social norms in communities, and on the epidemic. The example of Thailand shows that a focused intervention strategy implemented at a national scale can result in substantial declines in HIV incidence and prevalence in targeted populations. Two important program elements helped document this success story: STI/HIV/AIDS trends were systematically monitored by sentinel serosurveillance systems, and behavioral surveillance data provided the necessary supplementary information to interpret the observed seroepidemiological trends.

There is growing consensus that country programs need to monitor risk behavior trends together with trends in HIV infection. The AIDSCAP Project is proud to have made an essential contribution to that development.

Regional Program Overviews

AIDSCAP

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Africa

Status and Trends of the Epidemic

While remarkable efforts to contain the spread of HIV have been made worldwide since the onset of the epidemic approximately 15 years ago, the number of people infected with HIV and with full-blown AIDS has continued to increase unabated. From the beginning of the epidemic in the early 1980s until mid-1996, an estimated 29.4 million people worldwide were infected with HIV. The largest number of persons infected with HIV, totaling 19 million, or 68 percent of the global total, live in sub-Saharan Africa. World Health Organization (WHO) projections for sub-Saharan Africa paint a gloomy picture for the future. In 1980, HIV infections for this region were estimated to number 620,000. This number increased to 2.5 million infections by 1985, 10 million by 1990, and is projected to reach 40 million by the year 2000. Between 1992 and 1995 alone, it was estimated that sub-Saharan Africa experienced a 47 percent increase in new infections, representing more than 3.6 million new cases of HIV.

The face of HIV/AIDS has also changed during the 6 years of the AIDSCAP Project. In the early years of the epidemic, persons most often infected with HIV were adult males in their mid- to late-twenties and their partners, who were often commercial sex workers (CSWs). Recent statistical information reveals disturbing changes in this profile. More new infections seem to be occurring in young people aged 15 to 24, and many of them show risk factors that are less evident. Infection rates among women, particularly young girls, are increasing at a faster rate than among their male counterparts. This increase is due, in part, to young girls experiencing sexual activity at an earlier age, marrying older men (who are thus more likely to be infected), or exchanging sex for money. In Kenya, Rwanda, and Tanzania, more than 10 percent

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of the women surveyed in urban areas attending antenatal clinics are found to be HIV-positive, with rates exceeding 30 percent at some surveillance sites. Most of these women are housewives infected by their partners.

There are significant regional variations in levels of HIV infection among countries and between urban and rural areas within countries. Countries such as Malawi, Tanzania, and Rwanda have high prevalence rates ranging between 4 and 30 percent in sexually active urban populations; the rate is as high as 40 percent among groups who engage in sexual risk taking. Rates of HIV infection as high as 80 percent have been recorded among CSWs surveyed in Nairobi and Abidjan. In countries where the epidemic is at an earlier stage, such as Senegal and Nigeria, the estimated seroprevalence ranges from 2 to 12 percent among at-risk groups in urban areas. However, throughout Africa, differences between urban and rural infection rates are narrowing, sometimes rapidly. In 1994 in Kenya, for example, rural adult prevalence had increased to almost 6 percent, which is nearly half of the 12 to 13 percent estimated for urban areas. Furthermore, because far more people in Africa live in rural areas than urban, the burden on already underfunded rural services is great.

The cumulative number of AIDS cases in sub-Saharan Africa had reached 8.4 million by January 1996. Of these cases, 24 percent are children under age 15. During 1995 alone, 1,375 million people developed full-blown AIDS, with 40, 36, and 24 percent of these cases in women, men, and children, respectively. The most recent figures show a cumulative total of more than 7.6 million AIDS deaths in the region, with 1.3 million occurring in 1995 alone.

The progress made in Africa in the past three decades in economic and human development has already been compromised by HIV/AIDS. The disease affects people in their most sexually active period of life, which coincides with their most economically productive years. Recent statistics indicate that significant increases in infant and child mortality and major increases in adult mortality in several countries are mostly the result of HIV/AIDS. Projections for Zambia and Zimbabwe, for example, indicate that HIV/AIDS may increase child mortality rates nearly three-fold by the year 2010. Life expectancy in the countries most affected will fall significantly because of HIV/AIDS, nullifying all the gains in the health status of people in Africa.

HIV/AIDS has created unique demands at all levels of society. Throughout Africa, the number of AIDS orphans has increased. In Kenya, 1996 estimates indicate that there were about 300,000 Kenyan children under age 15 who had lost mothers to AIDS. This number is projected to reach approximately 600,000 by the year 2000 and 1 million by the year 2005. While the extended family in Africa has traditionally looked after orphaned children, the high incidence of HIV/AIDS and the growing number of children left behind have already overwhelmed the traditional care structure in countries such as Kenya and Uganda. In some instances, children as young as 10 to 12 years old have become heads of household. In other families, the entire family structure has fallen apart, leaving orphans homeless and vulnerable to HIV infection. Elderly grandparents, themselves orphaned because of the loss of support from their deceased children, are unable to take care of their grandchildren.

The cost of treating AIDS patients is high, and the treatment is absorbing more and more health care resources. In some cases, half of all hospital beds are occupied by AIDS patients. In addition to the impact on individuals and families, HIV/AIDS affects the productivity and profitability of businesses, with likely economic implications extending well into the future. It has already increased labor costs because of employee absenteeism, labor turnover, health care costs, burial fees, and recruitment costs.

Still, there is reason for hope. Evidence that the rate of new infections is decreasing in some areas comes from studies conducted in Uganda, a country with one of the older epidemics in Africa. The decrease appears to reflect sustained adoption of safer sexual practices, particularly among younger Ugandans. A randomized trial conducted in rural Tanzania concluded that availability of improved sexually transmitted infection (STI) treatment reduced HIV incidence by approximately 40 percent in the population studied. It seems that the decreases in Uganda and Tanzania resulted, at least in part, from behavior modification and improved STI management, meaning that methods to substantially reduce HIV incidence are now within the technical capacity of many countries in sub-Saharan Africa.

Accomplishments and Results

Mobilized Communities in Support of Sustained Behavior Change

On a continent where many national governments are able to budget no more than U.S. $2 per citizen per year for all medical and health-promoting services, AIDSCAP/

Table 6. Africa Regional Process Data 1991–1997

	Cumulative
Total People Educated:	**14,527,377**
Total People Trained:	**97,283**
Total Condoms Distributed:	**86,629,096**
Free	**14,720,555**
Sold	**71,908,541**
Total Materials Distributed:	**7,923,451**

Process indicators are used to track measurable data in a subproject. *People educated* includes number of people attending educational sessions or contacted through AIDSCAP interventions. *People trained* includes number of people attending training of trainers sessions. *Condoms distributed* indicates condoms sold through condom social marketing programs and condoms distributed for free. *Materials distributed* includes behavior change, condom promotion, and HIV/STI educational materials such as posters, pamphlets, handbooks, tapes, newsletters, and comic books.

FHI led the way in identifying and funding voluntary, grassroots efforts to educate, inform, and motivate communities, institutions, and individuals to take responsibility for their own protection from HIV/AIDS infection.

Community Strengthening

To strengthen communities' ability to prevent HIV/AIDS, AIDSCAP/FHI implemented activities like those in Tanzania, where sustainable nongovernmental organization (NGO) networks were established, and in Ethiopia, where focus site intervention teams of NGO, community, business, and governmental leaders coordinated their HIV/AIDS interventions.

In Tanzania, AIDSCAP/FHI stimulated and facilitated the formation of clusters of small, indigenous, community-based organizations in 9 of Tanzania's 20 far-flung administrative regions, covering more than half of Tanzania's population of 27 million. By binding together under an umbrella organization, the individual groups—each with a prior, specialized interest in AIDS-related issues—were able to design integrated, synergistic activities that more effectively delivered HIV/AIDS prevention and care services to their constituencies. The nine clusters have more than 100 NGO members. Each cluster has decentralized into at least two districts within its region, and together all the clusters cover a total of 20 out of 132 districts in Tanzania.

The participation of the clusters in national policy dialogue served to strengthen advocacy for policy changes in HIV/AIDS nationwide. Through regional policy sensitization workshops, senior government officials, including members of parliament and cabinet ministers, community and religious leaders, private sector entrepreneurs, and other key decision makers, were informed of the dangers of the HIV/AIDS epidemic and the need for community responsibility in effecting policy changes. More than 450 policymakers, government ministers, elected government officials, religious and community leaders, private sector business managers, and trade unionists were educated in STI/HIV/AIDS prevention and care needs to ensure their involvement in policymaking.

AIDSCAP interventions such as those described in the Tanzania example and the similar focus site project conducted with the Department of Health in Ethiopia helped reduce duplication of efforts, eliminate competition for support and clients, enhance the stature of participating organizations in their communities, and provide mutual support that reduced the burn-out experienced by many programs that rely on volunteers.

Institutional Capacity Building

To strengthen institutional capacity to develop and mobilize prevention activities, AIDSCAP/FHI funded projects in five countries to foster and strengthen networking and resource-sharing among nascent STI/HIV/AIDS prevention groups, such as the Kenya AIDS NGO Consortium (KANCO).

KANCO established a national resource center for use by members and by other persons and organizations in Kenya with an interest in HIV/AIDS. The center

Save Your Generation

Fassil Nebyeleul was a 21-year-old university student when AIDS claimed one of his best friends. The death shocked Fassil and his mates. They had never imagined that HIV could hit so close to home. But they knew the behavior that had led to their friend's death was no different from their own.

"We decided that we were all HIV-positive and calculated out time of death as 4 or 5 years," Fassil said. "So we said, let us do something before our lives are gone." What they did was organize a group called Save Your Generation Association (SYGA) to warn others about HIV/AIDS. Each of the five founding members invited five friends to the first meeting, where they discussed preventing HIV transmission and urged new members to spread the word.

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

SYGA is one of the seven NGOs that received support from AIDSCAP/FHI over 3 years to bring HIV/AIDS prevention education to out-of-school youth in six urban areas. These projects enlisted the help of young volunteers and community organizations to inform and motivate a segment of the Ethiopian population that is difficult to reach and very much at risk.

By the end of the AIDSCAP program in Ethiopia, SYGA had received grants from several other donors. Fassil remembers when donors shied away from supporting the group because they thought they were too young and inexperienced to manage grants. Now, because of the technical assistance the group received from AIDSCAP and other organizations, he believes SYGA is in a good position to attract additional funding to sustain its programs.

provided prompt access to accurate AIDS-related information and fielded approximately 350 inquiries a month. The consortium also sponsored four regional workshops and one national workshop for representatives from a broad spectrum of community-based groups to identify HIV/AIDS-related issues of concern to their constituents. Three policy papers—"Discrimination of Persons Infected with or Affected by HIV/AIDS," "Removing Stigma and Developing Appropriate IEC Strategies for STI Prevention and Control," and "HIV/AIDS Education for Kenyan Youth"—were prepared and submitted to national policymakers. These papers were used by the Government of Kenya in developing a sessional paper on AIDS, which was approved by Parliament in September 1997. KANCO now has a membership of 360 NGOs and 8 individuals.

Peer Education

To inform individuals about transmission, their personal risks, and strategies for prevention, AIDSCAP/FHI funded 45 peer education interventions in nine countries to promote AIDS information and behavior change. Typical interventions included the following:

- In Calabar, Nigeria, a group of CSWs (275) trained as peer health educators (PHEs), together with two senior PHEs, provided prevention information and advice to peers on condom use and recognizing their own STIs, as well as those of potential clients. STI rates plummeted as a result of the intervention. In addition, some women sold socially marketed condoms to their peers and others, retaining the profits as alternative income to commercial sex work. The network of PHEs has provided one-on-one HIV prevention sessions to 6,330 women and 7,609 men. Furthermore, the PHEs, working in pairs, conducted group educational sessions attended by 3,822 women and 1,054 men; an additional 10 people were educated by outreach workers.

- Employees of the National Railways of Zimbabwe formed peer educator groups throughout the railway network, which employs more than 12,000 persons and has potential access to 45,000 family members. The educators, at scheduled breaks during work hours, provided safer sex instruction, distributed free condoms, motivated peers to stay celibate during long absences from home, and, increasingly, provided home-based care to HIV-infected colleagues and grief and legal counseling to partners and families of deceased colleagues.

- In South Africa, AIDSCAP/FHI funded the national association of traditional healers to train members—the first, and sometimes only, point of health care advice for most South Africans—in providing HIV-transmission knowledge, counseling in prevention measures, recognizing signs and symptoms of possible HIV infection, and determining when to refer suspected HIV/AIDS cases to government health care facilities.

- A pilot project in Soweto, South Africa, assisted secondary school youth in developing information materials and safer sex brochures by using expressions and language appropriate to their peers. The trained peer educators made presentations, with the encouragement of school authorities, in schools throughout the community, and also served as informal information resources for their colleagues after school.

- Military personnel in Africa, as elsewhere, often have a high incidence of STIs, including HIV infection. AIDSCAP/FHI funded local agencies in Cameroon, Rwanda, and Zimbabwe to train military personnel to dispense HIV transmission and prevention information to peers, to promote STI treatment-seeking behavior, and to promote condom use among those unable to remain abstinent or monogamous.

- During of the 3-year AIDSCAP program in Cameroon, 2 military coordinators and 400 military officers were trained as volunteer health educators to teach and encourage appropriate risk-reduction behaviors among members of the units to which they were assigned. These officer-educators conducted 2,300 educational sessions attended by more than 60,000 male and female military personnel. Approximately 16,000 posters and flyers, 250 training manuals, and 100 albums were distributed; two radio spots directed at military personnel were aired during regular radio programs. More than 7,000 condoms were distributed free-of-charge as a promotion. In Rwanda, a similar subproject with the military resulted in the training of 384 PHEs and 84 health care service providers in the syndromic approach to STI management, the development of two posters and one comic book targeting the military, and the establishment of 40 condom distribution points. In addition, 16,600 behavior change communication (BCC) materials and 887,480 free-of-charge condoms were distributed.

- In Ngara, Tanzania, AIDSCAP/FHI funded CARE, Population Services International (PSI), and John Snow International (JSI) to establish a peer education and condom distribution network in the vast Rwandan refugee camps using AIDS community educators. Despite the turbulent camp life, the intervention conclusively demonstrated that if behavior change and STI prevention messages are carefully crafted and delivered by educators with their peers in mind and if condoms are widely available and accessible, a significant number of people will still embrace life-affirming measures to protect themselves and others. During the project, 4,550,000 condoms were distributed, more than 10,000 persons were counseled about STI/HIV, and more than 70,152 persons were reached with prevention messages. More than 1,900 existing health care workers were trained in new STI/HIV prevention skills and more than 1,000 community volunteers, scouts, and peer educators joined project activities. Prompted by CARE, HIV/AIDS strategy meetings with representatives of the United Nations High Commission on Refugees and the various NGOs working in the camps encouraged a common approach to implementing prevention activities across five camps.

Promoted Condom Use and Improved Access

In the absence of a vaccine for HIV or of affordable and accessible treatment in Africa for AIDS, prevention of infection was the major focus of AIDSCAP/FHI interventions in the region. In conjunction with BCC interventions that encouraged delayed start of sexual activity or fidelity and monogamy for those already sexually active, most AIDSCAP/FHI programs also made condoms more available, accessible,

and affordable. As a result of the increasingly visible ravages of HIV/AIDS infections spread, as well as enhanced awareness (promoted, in part, by other AIDSCAP/FHI support interventions), impressive numbers of populations in many countries across the region adopted condom use as a prevention measure.

As the following examples illustrate, AIDSCAP/FHI programs used a wide range of innovative approaches to make condoms more accessible, affordable, and acceptable to target audiences.

- In Ethiopia, Nigeria, Senegal, and Tanzania, AIDSCAP provided technical assistance through JSI by conducting condom logistics needs assessments and recommending to national governmental agencies improvements in the procurement, storage, and distribution of free-of-charge condoms at government clinics and health care facilities.

- Many AIDSCAP/FHI projects in Africa included condom distribution components linked to public supply systems. This kind of promotion and distribution added an alternative, personal dimension (peer educators often delivered the condoms) and a greater credibility (the prevention message was seen as coming from friends) to the condom instruction delivered with clinic-based distribution. As a result, condoms became more popular, and the demand for free-of-charge condoms dramatically increased. In Kenya, for example, free-of-charge condom distribution through public sector channels increased from 6 million units in 1988 to more than 100 million in 1996.

- AIDSCAP/FHI also funded projects to promote the sale of subsidized, affordable condoms distributed through private sector retail networks. By offering attractive profit margins to participating retailers, these social marketing projects were able to establish sales points in a wide range of commercial outlets where condoms had never been available before. Accessibility was also enhanced through these retail networks since many shops were open on days and at hours when (government-run free) distribution locations were closed. Some sales points are also located near or in bars, night clubs, hotels, and rest houses where high-risk sexual activities may take place.

- The PSI social marketing project in the Kingdom of Lesotho offered prevention information, counseling, and condom use negotiating skills and sold condoms to the Lesotho-based wives of men who worked most of the year as migrant labor in South Africa's distant goldfields. The goal was to inform women about HIV/AIDS and to encourage condom use when their absentee partners—who often partner with other women during their prolonged absence—return home on leave.

- Demand for socially marketed condoms was created and strengthened by the implementing agencies through aggressive and innovative

commercial marketing techniques, including prime time radio and TV advertising; production of radio and TV soap operas on HIV/AIDS themes; mobile video shows in rural areas; press and outdoor billboard ads; and dance, drama, puppet show, and rap music competitions addressing HIV/AIDS-related issues.

- In South Africa, the AIDSCAP-funded PSI social marketing project developed prime time public service TV spots that featured the revered Bishop Desmond Tutu plugging condom use "for those unable to remain monogamous."

- Social Marketing of Condoms in Senegal, as part of a social marketing project supported by AIDSCAP, trained 292 pharmacists in condom use demonstration techniques, enhancing their willingness and capacity to advise and counsel their customers on effective condom use to prevent HIV infection.

- In rural Rwanda, a PSI mobile video van toured the countryside, stopping at large regional open air markets to explain and demonstrate condom use, with awareness-raising videos (some filmed by the project in Rwanda and using local languages), question-and-answer sessions with the crowd that were taped and shown live on a 10 x 20 foot screen. Condoms were sold at a nearby stand.

- AIDSCAP-supported condom social marketing projects achieved remarkable increases in sales. In Ethiopia, for example, more than 6 million condoms were sold in the first year of the AIDSCAP program. This meant that 800,000 condoms per month were being sold. By the end of the AIDSCAP program, monthly sales had risen to 2 million. Over 33 months, 43 million condoms were sold through 10,000 sales outlets. AIDSCAP partners distributed more than 830,000 condoms.

- AIDSCAP-funded countries in Africa promoting the sale of low-priced condoms saw annual condom purchases increase from a few million (including all for-profit brands) prior to the introduction of social marketing to 100 million socially marketed brands alone by the end of the project 6 years later. This dramatic increase in sales indicates one of the most successful—and quickest—new product introductions in history.

Improved STI Diagnosis, Treatment, and Prevention

As the connection between infection with other STIs and increased risk of HIV infection became more evident, AIDSCAP/FHI took the lead across Africa in promoting and facilitating the adoption of WHO's simpler, faster, more cost-effective algorithmic methods—using patient interviews and checklists rather than slow and

costly lab tests—to diagnose other STIs.

In South Africa and Tanzania, AIDSCAP/FHI funded local entities to encourage and facilitate the process of changing both public national medical policies and traditional, lab-oriented private medical practitioners to embrace the new diagnostic methods. The syndromic approach was also successfully tested in one medical region of Rwanda. The Government of Rwanda now plans to expand the use of this approach nationwide.

With the adoption of the new diagnostic techniques by national medical bodies and governments, AIDSCAP/FHI then confronted the huge task of training and retraining thousands of field practitioners in accepting and understanding the new diagnostic methods and applying them and related treatment approaches effectively in their daily clinical practices.

In Tanzania, for example, the Institute of Tropical Medicine, an AIDSCAP/FHI subcontractor, provided technical assistance to three local health/medical training institutions, which by the end of the project had trained 657 health care providers (HCPs) representing health care facilities in 7 of the country's 20 regions, in the use of the new diagnostic methods. The quality of posttraining STI case management was assessed by evaluating correct (syndromic) diagnosis and appropriate treatment and the provision of prevention advice, including information about condom use and the importance of partner treatment. The findings indicate that more than 93 percent of

Table 7. Impact of STI Case Management Training in Senegal: Results from Direct Observations of Health Care Providers' Performance

	Before Training			After Training			
	Correct	No	Percent	Correct	No	Percent	P-Value
History	16	35	45.7	24	41	58.5	0.3
Examination	15	35	42.9	26	41	63.4	0.07
Treatment	4	35	11.4	16	41	39.0	0.0006
PI6	4	35	11.4	5	41	12.2	0.6
Condom advice	4	35	11.4	10	41	24.4	0.2
Partner advice	12	35	34.3	30	41	73.2	0.0007
PI7	1	35	2.9	9	41	22.0	0.01
Risk assessment	0	35	0.0	2	41	4.9	0.2

Table 8. Impact of STI Case Management Training in Senegal: Results from Interviews with Health Care Providers

	Before Training			After Training			
	Correct	No	Percent	Correct	No	Percent	P-Value
History	55	65	84.6	180	193	93.3	0.03
Examination	14	65	21.5	148	193	76.7	0.00
Treatment	6	65	9.2	40	193	20.7	0.04
PI6	3	65	4.6	37	193	19.2	0.005
Condom advice	56	65	86.2	186	193	96.4	0.003
Partner advice	63	65	96.9	189	193	97.9	0.5
PI7	54	65	83.1	182	193	94.3	0.005
Risk assessment	0	65	0.0	11	193	5.7	0.04

patients with complaints or signs consistent with common STI syndromes were correctly diagnosed. Correct treatment of STIs assumes that HCPs have access to nationally recommended drugs. Supplies of medications were good in the private sector clinics. Supervisors verified greater than 90 percent availability of recommended drugs for the main STIs, with the exception of candidal vaginitis (70 percent). Seventy percent of the patients received either the first-line recommended drugs for the diagnosed syndrome or approved alternative treatments; 97 percent of patients who returned to the clinics for follow-up reported either cure or improvement.

In Senegal, under implementation agreements with both the public and private sector (including Catholic Church–run clinics), over 1,200 lab personnel, health care providers, and clinic staff were trained by specially recruited medical students in the application of syndromic diagnosis and STI prevention and counseling. An evaluation was carried out to measure baseline levels of the WHO prevention indicators (PIs) related to STI case management (PIs 6&7) and to measure any changes that took place in the short term after training. Ninety-seven percent of health workers in 6 of the 10 regions were trained in the use of STI treatment algorithms (PI6) and prevention education and counseling (PI7). Two methods of obtaining data on PIs 6&7 were used: (1) direct observations of providers interacting with their patients, and (2) interviews with providers. Results obtained from the two methods are summarized in Tables 7 and 8.

As illustrated in Table 7, using the strict WHO criteria during observations, the baseline level of PI6 was 11 percent, and there was little improvement at follow-up (12 percent). However, a significant improvement in HCP performance occurred in two of the three areas that are components of PI6 (examination and treatment). For PI7, the baseline level was 2.9 percent, and the follow-up level was 22 percent. Therefore, there was a significant improvement in HCP performance.

Providers reported better case management practices. The baseline PI6 reported during interviews was 4.6 percent, with an increase to 19.2 percent at follow-up. The already high levels for PI7 at a baseline of 83.1 percent increased significantly to 94.3 percent at follow-up. It should be noted that the time between training and the survey was only 3 months.

Training in STI case management also improved HCP performance in Kenya, where AIDSCAP/FHI funded the Family Planning Private Sector Project run by JSI to train 402 staff from 147 clinics in the new diagnostic methods. After training, more than 90 percent of patients with STI symptoms were correctly diagnosed without recourse to clinical tests.

Africa was also the site of the first pilot project to test marketing of prepackaged STI therapy, an innovative approach to improving access to effective treatment. In Cameroon, the AIDSCAP-funded PSI social marketing project worked with national authorities and the pharmaceutical establishment to package and promote the sale of an STI home treatment kit at clinics and pharmacies. The product included appropriate drugs, awareness information, a referral card to notify partners of potential infection, and a pack of condoms to prevent reinfection. Although sales of the kit were lower than expected for a variety of reasons, those who did buy them reported high levels of satisfaction and compliance with the treatment.

Influenced Policy to Support HIV/AIDS Prevention

Without the support of governments—at both national and local levels—prevention interventions may not be as effective as they might be. Throughout the Africa region, AIDSCAP/FHI funded and provided technical assistance to a broad array of policy initiatives designed to increase the awareness of political, religious, and economic leaders about the dimensions of the problems posed by the HIV/AIDS epidemic and to build support for effective prevention programs, including controversial ones. Some examples follow.

Political Initiatives

- In Senegal, AIDSCAP supported a sensitization seminar for members of the National Assembly. The seminar included the basics of HIV transmission; facts and figures on the reality of HIV/AIDS in Senegal (and projections of future impact); and participatory, thought-provoking activities, such as role-plays on gender and the experiences of people living with HIV/AIDS.

- KANCO, with support from AIDSCAP, provided input to the Government of Kenya in the drafting of major legislation that presented

the government's position on HIV/AIDS. KANCO was also invited by the Joint United Nations Programme on HIV/AIDS (UNAIDS) to sit on the committee advising on the HIV/AIDS components for the national Medium-Term Plan 3 development document and was asked by the National AIDS and STI Control Program to review proposals for World Bank funding through its STI project.

Religious Initiatives

- Also in Senegal, AIDSCAP promoted symposia for both Christian and Islamic leaders to inform them about the HIV/AIDS situation in their country and to allow them to debate and propose roles and responsibilities for religious leaders in combating the epidemic.

- Medical Assistance Program (MAP) International in Kenya mobilized volunteers from Christian churches across the country and trained them as trainers of community-based religious personnel in HIV/AIDS prevention and counseling. MAP also produced an HIV/AIDS module for use in the curriculum of theological schools in the country.

Prevention Services for Rwandan Refugees

In April 1994, hundreds of thousands of Rwandan refugees fled from ethnic violence into northern Tanzania. Emergency camps, created overnight, were overwhelmed with as many as 4,000 new refugees each day. As conditions in the camps grew desperate, relief agencies struggled to take care of basic needs—food, clean water, shelter, sanitation, and first aid.

But even as camp life stabilized, another crisis loomed: the threat of HIV spreading through the refugee population. Before the exodus, Rwanda had estimated urban HIV infection rates as high as 33 percent, based on seroprevalence studies among selected groups of antenatal clinic attendees in Kigali. Overcrowding, days full of idle time, a flourishing commercial sex trade, and severe strains on traditional social structures and family life left camp residents acutely vulnerable to infection.

In August 1994, AIDSCAP/FHI initiated a 1-year HIV education and prevention pilot project in the huge Benaco Camp, which had a population of about 250,000 refugees. AIDSCAP/FHI contracted with CARE, the NGO that has worked in Benaco since the camp's inception, for peer education training and other HIV prevention services, and with PSI for a condom social marketing and distribution program. Another AIDSCAP/FHI subcontractor, JSI, conducted a baseline knowledge, attitudes, and practices survey among camp residents, discovering high levels of HIV/AIDS awareness and understanding of the importance of condom use but a much lower level of safer sex behavior. Such early HIV/AIDS interventions in a refugee setting had never before been attempted on this scale.

Economic Initiatives

- The AIDSCAP office in Kenya mobilized a group of Kenyan governmental agencies, NGOs, and private sector representatives to produce and promote the book *AIDS in Kenya: Socio-Economic Impact and Policy Implications in Kenya* and to distribute it to opinion leaders and policymakers. The book was launched by Kenyan Vice President George Saitoti and received front-page coverage and editorial comment in all the national newspapers, raising awareness about the current and projected impact of HIV/AIDS on Kenyan society and the country's economy.

- In Tanzania, the Africa Medical Research and Education Foundation, with AIDSCAP support, managed an intervention to inform private businesses of the threat HIV/AIDS poses to their investments and to establish peer education programs in the workplace to inform workers about HIV/AIDS, discuss prevention alternatives, and distribute or sell condoms. By the end of the project, businesses were contributing 25 percent of the cost of the programs (with AIDSCAP/FHI funds paying the balance), and they planned to assume all costs within 3 years.

Identified and Addressed Emerging Needs

Throughout the Africa region, as the epidemic expanded and needs at all levels changed, AIDSCAP/FHI was in the forefront of sponsoring new approaches and testing new methods of addressing the epidemic and the needs of those affected by it.

HIV Counseling and Testing

In the Kariobangi slums of Nairobi, Kenya, and in the Tanzanian capital, Dar es Salaam, AIDSCAP/FHI, UNAIDS, and the Center for AIDS Prevention Studies worked with the Kenya Association of Professional Counselors and Muhimbili University in a field study of the effectiveness of HIV counseling and testing compared with health education alone as an inducement to changing personal behavior. Among many positive outcomes, it was found that participants maintained a high level of participation during follow-up visits (retention rates were 87 and 80 percent respectively, in the Kenya and Tanzania study centers). Study participants were overwhelmingly motivated to participate and remain in the study because of the opportunity to know their HIV status as a prelude to changing their sexual practices.

AIDS Orphans

In some of the harder hit areas of eastern Africa, HIV/AIDS has already killed a significant number of adults, leaving large numbers of orphans and elderly parents of the deceased to fend for themselves without adequate skills or resources. AIDSCAP/FHI worked with community-based organizations in Tanzania to help some of these families cope with their loss and earn a livelihood.

In the Moshi area of northern Tanzania, for example, the AIDSCAP/FHI-funded Kilimanjaro community cluster provided skills training to orphaned children and grandparents to enable them to support themselves. Children cultivated their own

vegetable gardens and sold the produce at local markets or apprenticed—through cost sharing between the cluster and local businesses—in occupations such as brick-making, carpentry, and auto repair. Teenage children, and sometimes their aging grandparents, were trained in selling skills, dispensing prevention advice, and selling subsidized, socially marketed condoms to friends and neighbors in the community, along with dispensing the personal and powerful message: "Protect yourself and your family; don't let what happened to me happen to you."

Profits from the condom sales were retained by the individual sellers to meet their personal needs. The cluster also allocated profits from the income-generating projects it sponsored, such as the sale of traditional crafts bearing HIV/AIDS prevention messages, to providing school uniforms and books to scholastically qualified orphans who otherwise might have had to drop out of school for lack of the few dollars required for these supplies.

Care and Management Support for People Living with HIV/AIDS

Although AIDSCAP/FHI's mandate was to build local capacity for HIV/AIDS prevention rather than care, the project was able to conduct short-term pilot projects to test models of care and prevention. One AIDSCAP program, the Tanzania AIDS Project, provided integrated prevention, care, and support services through local NGOs and other community-based organizations.

STI Treatment Innovations

With increasing evidence of the link between untreated STIs and HIV, AIDSCAP/FHI undertook a field trial in South Africa to test the effectiveness of periodic presumptive treatment of persons known to be at high risk of STIs. With this approach, persons in high-risk populations are periodically treated, free-of-charge, with an array of drugs effective against the most common STIs, minus expensive and time-consuming traditional lab exams, on the presumption that they are likely to be infected with one or more of the STIs because of their life-styles.

The trial in South Africa treated the CSW partners of miners working in the goldfields region. Initial follow-ups with both the women and their untreated possible partners showed that STI levels in both groups had declined. If the decline was sustainable, the lower STI levels would lead to declines in HIV infection rates as well. The management of the mine where the trials were conducted was impressed with the results and agreed to continue the program with private funds after the end of the trials.

Gender and HIV/AIDS

As the impact of the HIV epidemic on women became more evident, AIDSCAP/FHI established a worldwide AIDSCAP Women's Initiative (AWI) to ensure that gender issues were considered in field project design and implementation and to fund studies on issues related to the female condom. AWI used untapped channels to reach women and girls, build awareness, and promote capacity building at the grassroots level. Examples of these initiatives include the following:

- Sponsoring a gender and AIDS conference in Mombasa, Kenya, for senior policymakers and program managers from Kenya, Zimbabwe, Tanzania, South Africa, and Ethiopia. AWI funded pilot interventions developed at the conference in each of the five countries and produced a manual based on the workshop.

- Working in Kenya with the Collaborative Center for Gender and Development on a study to identify the factors and rationale determining use and non-use of the female condom. The study concluded that almost all women (93 percent) were satisfied with the condoms and, most were interested in continuing to use it; women's organizations and groups provided useful structures for promoting and sustaining its use.

Strengthened Local Capacity to Respond to HIV/AIDS

Overall, the AIDSCAP/FHI Africa Regional Office worked in 19 of 44 countries in Africa to build the capacity of government national AIDS control programs and indigenous nongovernmental organizations to design, manage, and evaluate STI/HIV/AIDS programs in their communities. This was largely done through training in project design and management, financial management, monitoring and supervision, BCC materials production, peer education, local and community-based theater, and drama and song. This kind of training has left the NGO members with skills to develop STI/HIV/AIDS programs that will respond to the needs of their communities from grassroots to urban societies and has also contributed to their preparedness to respond to any future epidemics.

In some countries, to support the community-based efforts, resource centers were established at regional, district, ward, and village levels and staffed with people who source and maintain all documentation and information on HIV/AIDS and STIs; this material is accessible to everyone. The staff have also been trained as peer educators and counselors and are, therefore, able to assist individuals seeking help with particular sexual issues. Alongside the resource centers, networks were established within certain countries so that experiences were shared, and the best practices were adopted whenever possible.

Reduced Risk Behaviors Among Target Populations

AIDSCAP/FHI prevention interventions focused on populations that are a cross section of those at risk. Men, women, girls, and boys from all walks of life have been addressed: people living with AIDS, CSWs, youth in and out of school, market women, teachers, HCPs, traditional healers, traditional birth attendants, religious leaders (both Christian and Islamic), business and community leaders, uniformed army and air force personnel, and intransit populations at locations where they can be reached between moves.

These prevention interventions helped increase awareness, reduce stigmatization, and encourage appropriate treatment-seeking behavior and safer sex practices. Traditional healers and traditional birth attendants are now observing safer practices in their healing and birth-delivery methods. Although working with army and air

Table 9. Changes in Knowledge Levels of Two or More Methods of HIV/AIDS Prevention

Country	Target Population	Percentage Able to State Two or More HIV/AIDS Prevention Methods			
		Baseline		Follow-up	
Cameroon	CSWs	40%	(1994)	87%	(1996)
	Clients	50%	(1994)	86%	(1996)
	Students: Male	79%	(1993)	95%	(1996)
	Students: Female	84%	(1993)	96%	(1996
	Military	N/A		90%	(1996)
	Youth (Project CARE)	37%	(1993)	70%	(1996)
Ethiopia	MPSCs [1]	62.6%	(1995)	94%	(1996)
	Youth	78%	(1995)	99%	(1996
Nigeria	CSW	88%	(1994)	90%	(1996)
	Youth: Cross River	7%	(1993)	Not Calculated	
	Youth: Jigawa State	9%	(1995)	Not Calculated	
	Youth: Lagos State	61%	(1994)	Not Calculated	
	LDDs Overall [2]	45%	(1995)	92%	(1997)
	Dock Workers	60%	(1995)	85%	(1997)

[1] People with multiple sexual contacts (MPSCs).

[2] Long-distance drivers (LDDs).

force personnel proved difficult, AIDSCAP/FHI succeeded in sensitizing the military leadership in a number of countries to the importance of educating their personnel, along with their families, on the potential consequences of high-risk behavior and the danger of remaining ignorant about HIV/AIDS.

Evaluation surveys found evidence that knowledge of two or more effective methods of preventing HIV transmission had increased significantly in nearly all target populations in AIDSCAP/FHI's major countries in the region. Table 9 shows changes in knowledge of HIV prevention methods among various target groups in selected countries.

These dramatic changes in knowledge levels in nearly all AIDSCAP/FHI programs in the region have also resulted in the decline of incorrect beliefs in means of transmission which include the use of public toilets, shaking hands with persons infected with HIV, and mosquito and other insect bites. In Senegal, for example, the proportion of respondents who cited handshaking, sharing of food with persons infected with HIV, and mosquito and other insect bites as ways of contracting HIV declined from 31 percent, 27 percent, and 44 percent in 1995 to 13–32 percent, 3–13 percent and 18–37 percent, respectively. As these results suggests, however, misconceptions about HIV transmission are still present. Improvements in levels of HIV knowledge have resulted in increases in the proportions of people using condoms with casual sex partners across all projects in the region. These increases are only moderate in the general population of men and women, but condom use is becoming almost universally accepted by CSWs. Table 10 presents results from a few countries in the region.

Most of the AIDSCAP/FHI programs in the region have demonstrated some limited behavior change regarding sexual risk taking. For example, in Cameroon, the percentage of male students reporting more than one sexual partner in the last 3 months dropped from 53 percent in 1993 to 36 percent in 1996; there was no significant change among female students (14 percent in 1993 and 17 percent in 1996). In 1993, 18.6 percent of male university students reported having had sexual relations with an occasional partner during the 30 days preceding the survey; the 1996 figure decreased significantly to 9.4 percent.

Among Cameroon's military population, the percentage of male members reporting more than two sexual partners in the past 3 months dropped significantly from 47 percent in 1993 to 37 percent in 1996.

To improve the treatment of STIs, AIDSCAP/FHI established networks between private and public sector clinicians, pharmacists, traditional healers, and other HCPs in the syndromic management of STIs and cross-referrals of complicated cases. These established networks brought services closer to patients so that they no longer have to wait weeks to have a simple STI properly treated. Availability of condoms—both distributed free-of-charge and socially marketed—has complemented all activities and ensured that simple protection was readily accessible when needed.

The policy environment has been the most difficult to change, but nonetheless, major

Table 10. Reported Condom Use During the Last Sexual Intercourse by Target Population

Country	Target Population	Condom Use: Baseline		Condom Use: Follow-up	
Cameroon	CSWs with Nonregular Clients	52%	(1994)	75%	(1996)
	CSWs with Regular Clients	N/A		63%	(1996)
	Clients with Nonregular Partners	54%	(1992)	97%	(1996)
	Students: Male	75%	(1993)	75%	(1996)
	Military: Consistent Condom Use With CSWs	48%	(1993)	59%	(1996)
	Youth	54%	(1993)	55%	(1996)
Ethiopia	MPSCs[1]	62.6%	(1995)	94%	(1996)
	Youth	78%	(1995)	99%	(1996)
Nigeria	CSWs (Consistent Use)	23%	(1990)	64%	(1996)
	Youth: Cross River	21%	(1993)	80.3%	(1996)
	Youth: Jigawa State	20.4%	(1995)	67%	(1996)
	Youth: Lagos State	18%	(1994)	75%	(1996)
	LDDs: Cross River [2]	32.3%	(1995)	Not Yet Reported	
	LDDs: Jigawa State	23%	(1995)	Not Yet Reported	

[1] People with multiple sexual contacts.
[2] Long-distance drivers.

support for HIV/AIDS interventions has been gained from the national AIDS control programs and ministries of health in the various countries. Special success was recorded in Kenya, where policy interventions culminated in the publication *AIDS in Kenya*, a book that was launched by the vice president of the country with the participation of the U.S. ambassador and eventually led to passage of landmark national HIV/AIDS legislation by Parliament. With the support of the policymakers, it becomes easier to garner the support of the business community, as has been illustrated by the increased interest of business entities in AIDSCAP/FHI's private sector policy package.

Emerging needs in the region are care and support, testing and counseling, and support for AIDS orphans. These new demands on HIV/AIDS programs are the result of high levels of awareness and the general public's acceptance that HIV/AIDS is real. The issue now is how to contain and stop an epidemic that has already killed at least 8 million people in Africa.

Asia

Status and Trends of the Epidemic

Asia is the HIV/AIDS epidemic's last epidemiologic frontier, and the virus' rapid spread throughout areas of the continent has shifted the epicenter from Africa to Asia. Although rates of infection in Asia are estimated to be increasing faster than anywhere in the world, country epidemiologic profiles are dramatically different, and governmental responses are equally varied—from proactive and serious engagement against the epidemic to continued denial and blame on foreigners. Likewise, the past 6 years—from the beginning of the AIDSCAP Project to its conclusion—have witnessed areas of dramatic improvements in HIV control in Asia, as well as continuing challenges.

Thailand: Asia's Leader in HIV/AIDS Control

Evidence that extensive HIV transmission was occurring in Thailand began accumulating in 1988. By 1993, an estimated 500,000 to 750,000 cumulative HIV infections had occurred among a population of 58 million. HIV surveillance indicated that an initial HIV epidemic occurred among injecting drug users; another epidemic of separate origin erupted among female commercial sex workers (CSWs), sexually active heterosexual men, and most recently, the wives and sexual partners of these men. Serosurveys conducted among army recruits at conscription showed an increase from 0.5 percent in 1989 to 3.7 percent in 1994, providing yet more evidence of the epidemic's rapid spread.

In late 1994, however, the overall prevalence of the HIV epidemic among army conscripts decreased to 3.0 percent. An even greater decrease was reported among men from the upper northern part of the country (from 12.4 percent in 1992 to 7.9

percent in 1994), where the prevalence had been highest. Furthermore, new cases of five major sexually transmitted infections (STIs)—syphilis, gonorrhea, nongonoccocal urethritis, *lymphogranuloma venereum*, and chancroid—seen in government hospitals and STI clinics also decreased by 79 percent from 1989 to 1993.

Reductions in sexual risk taking measured by AIDSCAP/FHI's pioneering behavioral surveillance surveys (BSS) in Bangkok helped identify one of the factors responsible for the reductions in HIV and STIs. The five-wave survey, conducted from 1993 to 1996, illustrated that three groups of males (vocational students, STI clinic attendees, and factory workers) reduced their patronage of CSWs by an overall average of 48 percent. This rate mirrors national surveys showing similar declines in commercial sex. Furthermore, in recent survey waves of the Bangkok BSS, the percentage of CSWs reporting condom use during the most recent sexual intercourse was consistently more than 90 percent.

Thailand's 100 Percent Condom Program, which AIDSCAP/FHI helped to design and document (see articles in *AIDS* and the *International Journal of AIDS and STDs*), has been identified as a major contributor to the observed declines in HIV and other STIs. Future challenges in Thailand's HIV/AIDS prevention and control program include maintaining high levels of condom use in commercial sex as relapse to nonuse emerges, and increasing condom use among casual, noncommercial sex partners.

Asia's Continuing Challenges

Apart from Thailand, which experienced the earliest HIV/AIDS epidemic in Asia, there has been substantial variation in the timing and growth of the epidemic in Asia. Cambodia, India, Burma, and Vietnam have documented the most severe epidemics thus far, and Cambodia may surpass Thailand in having Asia's most heavily infected population. HIV surveillance in Cambodia in 1996 indicated that 1.7 percent of urban pregnant women were infected compared with Thailand's 1.8 percent; prevalence rate among CSWs was twice as high as Thailand's. Although condom use in commercial sex has increased significantly during recent years in Cambodia, the current levels are still inadequate to prevent secondary epidemics among wives and casual partners of infected men.

In India, HIV seroprevalence is high in the south and west. For example, surveys of CSWs in Mumbai (Bombay) showed HIV rates rising from 40 percent in 1992 to 51 percent in 1995 and among STI clients from 2 to 3 percent before 1990 to 36 percent in 1994. Studies among CSWs in Calcutta have shown a clear and consistently low prevalence rate of 1.2 percent. In Vellore, Tamil Nadu state, in South India, rates among women attending antenatal clinics have been steady at 0.1 percent, although STI clinic rates grew from 4 percent in 1993 to 15 percent in 1995. The geographic variability and the size of the country have made estimation of the actual number of infections difficult. Evidence suggests that more than 2.5 million individuals were infected with HIV in India by 1997.

The epidemic in Burma is also severe, with an estimated 500,000 people infected with HIV in 1996. HIV prevalence among CSWs increased from 4.3 percent in 1992

to 18 percent in 1995. There is substantial geographic variability in Burma, with infection rates in pregnant women ranging from 0 to 12 percent in different regions.

In Vietnam, there is some evidence that the HIV/AIDS epidemic is primed to accelerate. Higher levels of infection among CSWs are concentrated in the southern half of the country, near the Cambodian border. How rapidly rates of HIV infection increase may be determined by the speed and effectiveness of prevention program implementation in 1997 and 1998.

Opportunities for Early Intervention

In other developing countries of Asia—Indonesia, Nepal, the Lao People's Democratic Republic (Lao PDR), Bangladesh, Sri Lanka, and the Philippines—high levels of sexual risk taking have been reported and correspondingly high rates of STIs other than HIV documented. However, HIV surveillance has not yet shown an advancing epidemic, as seen in other countries. These six countries, therefore, offer an excellent opportunity for primary prevention to forestall pending epidemics, as well as research opportunities to investigate why HIV has not yet progressed to epidemic levels.

An example of primary prevention at work may be seen in Nepal, where low levels of HIV prevalence have continued to be documented over the past several years. Although weaknesses in the country's HIV surveillance system may be inaccurately capturing existing levels, HIV prevalence rates among STI clients in five different sites around the country have remained less than 2 percent for the past 5 years. Based on these and other ad hoc prevalence surveys, 1997 projections of the number of HIV infections in the country were at approximately 15,000, with most new cases hypothesized to be returning CSWs from India. This number was actually *lower* than the number of cases predicted for 1997 during a similar exercise in 1993.

It is highly likely that AIDSCAP/FHI's efforts in Nepal have contributed to the continuing low prevalence of HIV. Because the country faces numerous public health challenges with few resources, AIDSCAP/FHI has been a major partner of the Ministry of Health's HIV/AIDS prevention efforts during the past 4 years, and its program was one of the few operating in the key Central region and border areas with India, where much of the country's commercial sex is believed to occur. AIDSCAP/FHI's activities led to increases in reported condom use during most recent sexual contact from 35 to 61 percent among CSWs, whereas a comparable control area reported no change (48 versus 47 percent).

Accomplishments and Results

The Asia regional program of AIDSCAP/FHI had the opportunity to implement and support interventions in the region primarily as part of the global AIDSCAP Project, but with significant augmentation by the Asia Near East Bureau (ANE) of USAID. Country-level programs in Thailand, Nepal, and Indonesia were able to demonstrate significant population-level improvements in risk-behavior reduction when compared with areas and time periods without AIDSCAP programs. In implementing ANE's

Table 11. Asia Regional Process Data

	1991–1997 Cumulative
Total People Educated	**2,086,786**
Total People Trained	**43,353**
Total Condoms Distributed	**15,828,851**
Free	**1,976,566**
Sold	**13,852,285**
Total Materials Distributed	**1,630,996**

Process indicators are used to track measurable data in a subproject. *People educated* includes number of people attending educational sessions or contacted through AIDSCAP interventions. *People trained* includes number of people attending training of trainers sessions. *Condoms distributed* indicates condoms sold through condom social marketing programs and condoms distributed for free. *Materials distributed* includes behavior change, condom promotion, and HIV/STI educational materials such as posters, pamphlets, handbooks, tapes, newsletters, and comic books.

regional strategy, AIDSCAP was able to do ground-breaking work in conceptualizing the special risks of mobile populations and implementing innovative interventions for these populations as part of the Area of Affinity Initiative. In addition, the ANE resources enabled the regional program to develop extensive training, epidemiology, and policy activities that made a valuable contribution to mobilizing Asian nations and communities to respond to the challenges of HIV/AIDS.

Responded to Contextual Factors Affecting HIV Prevention

The following five characteristics of the Asia region shaped the planning of AIDSCAP/FHI programs and activities in 1992:

- the regions large population;
- the relative immaturity of the epidemic and the resultant low prevalence rates;
- the presence of risk factor and risk behaviors in most countries in the region;
- significant seasonal and multiyear migration of workers; and
- the emergence of newly industrialized nations.

Population Size

It was evident that the international community could not muster the resources to fund prevention interventions on a scale necessary to have a significant impact on the huge populations in the region. Therefore, influencing policies at all levels of society in the target countries and capacity building of local public and private organizations became priorities. This demographic context required a strategy that would convince policymakers that the epidemiological situation in their country required the indigenous public and private sectors to collaborate with each other and to mobilize their resources to address the emerging epidemic. Concurrently, AIDSCAP/FHI developed intervention models that could be replicated, and strengthened the capacity of both the public and private sectors to design and manage such programs.

Policy activities sought to mobilize indigenous resources by exposing policymakers to the reality and the potential of the epidemic, by demonstrating the critical need for timely prevention interventions, and by developing analytical and communication skills among key groups.

- A policy workshop in December 1993 helped participants from six countries interpret epidemiologic data for policy advocacy.
- Regional and country journalist workshops provided basic knowledge of HIV/AIDS and the context of the epidemic to improve reporting on HIV/AIDS for a more informed readership.
- Epidemiology workshops in Nepal, India, and Cambodia assisted in improving existing surveillance systems and projecting trends in the epidemic among population groups for policy applications.
- Six policy study tours of public and private sector leaders from Indonesia resulted in heightened awareness of both the program and policy issues that need to be confronted. The Indonesian National HIV/AIDS Plan was subsequently drafted by alumni of the policy tours who called themselves the "Bangkok Group."
- National counseling and testing guidelines were developed and implemented in Cambodia.
- National STI treatment guidelines were developed and implemented in the Philippines and Cambodia.
- AIDSCAP/FHI steered the national response to focus on targeted intervention in Nepal, Lao PDR, and Bangladesh.

AIDSCAP's large country programs in Asia focused only on specific geographical areas. Through these demonstration areas, AIDSCAP sought to influence larger national programs in the public and private sectors. Although the demonstration model approach is difficult to assess, anecdotal evidence suggests that AIDSCAP/FHI has had a positive influence on the design of national programs in the region.

- The Bangkok Fights AIDS program in Thailand's capital was developed by AIDSCAP/FHI in collaboration with the Bangkok Metropolitan Administration, which continues to manage the program. The national program has adopted portions of the AIDSCAP/FHI surveillance methodology.

- The AIDSCAP/FHI program in Tamil Nadu state, India, was designed to influence other state governments in their response to the epidemic. Tamil Nadu is now recognized as the leading state in India for dealing progressively with HIV/AIDS, partly because of its collaboration with the USAID AIDS Prevention and Control Project (APAC), supported by AIDSCAP/FHI.

- AIDSCAP's strategic and implementation plan for HIV/AIDS prevention in Nepal's Terai region was approved by the National AIDS Program (NAP) in 1993; the NAP manager served on the steering committee. Public statements made by government officials indicate that they consider the AIDSCAP/FHI activities to be part of their national program.

- The USAID HIV/AIDS Prevention (HAP) Project, implemented by AIDSCAP and now by Family Health International, is working in North Jakarta, Surabaya, and Manado in collaboration with both the national and the provincial AIDS committees. A primary purpose of this new project is to demonstrate the effectiveness of policies and interventions.

The Asia Regional AIDS Training and Education Program focused on human resource development for HIV/AIDS prevention through training and education in behavior change communication, training skills, sexually transmitted infections, and policy. Centers of excellence were developed by strengthening the institutional capacity of three organizations so that they could continue their contributions, even after AIDSCAP/FHI support was terminated. The centers were the Institute of Population and Social Research of Mahidol University, the Asia-Pacific Development Communication Center of Dhurakijpundit University, and the Women's Studies Center of Chiang Mai University. The Asia-Pacific Development Communication Center continues to offer the courses developed with assistance from AIDSCAP, charging a fee to sustain the service.

Relative Immaturity of the Epidemic

The relative immaturity of the HIV/AIDS epidemic in Asia and the resulting low HIV prevalence rates had implications both for the design of the interventions and for fitting the interventions into the local framework of what was feasible and acceptable. AIDSCAP adopted an early epidemic model of interventions targeting groups at greatest risk of infection. This model also emphasized reducing all STIs and improving surveillance to track the spread of the infection among diverse groups in the population.

In each of the country and area of affinity programs (area of affinity programs address the cross-border spread of HIV/AIDS by way of mobile populations), interventions were designed following an assessment of the most prevalent risk behaviors contributing to the transmission of HIV. Program resources were then targeted on the population groups engaging in those behaviors. In the Bangkok Fights AIDS program, the target population was low-income young adults. In Nepal, the focus was on transport workers and the CSWs who serve them. In Indonesia the target populations were CSWs and their clients, partners of clients, and youth.

Evaluation data from Nepal indicate that the targeted interventions in the areas covered by AIDSCAP/FHI had a marked effect in reducing risk behaviors. Surveys in Bangkok document a reduction in risk behaviors as part of a national trend; this reduction cannot be attributed to the efforts of any one prevention program or project, but most likely reflects the combined effects of many prevention efforts.

The strategy of focusing on all STIs was chosen for the following reasons: (1) most governments in the region were reluctant to acknowledge the reality of HIV in their populations; (2) most nations in the region had unacceptably high STI rates; (3) the behaviors that put one at risk of the other STIs will also put one at risk of HIV infection; and (4) infection with other STIs increases the risk of HIV infection. By initiating interventions that reduce STI risk (including condom use and limiting high-risk sexual contacts), AIDSCAP/FHI sought to facilitate behavior changes that reduce HIV risk even before governments were prepared to recognize the magnitude of their problem and initiate HIV/AIDS control measures.

AIDSCAP's plan for the Asia region called for research on "etiologies of common STI clinical presentations and drug sensitivity patterns to allow development of treatment guidelines." This plan was implemented in four stages: (1) assess epidemiologic and antimicrobial sensitivity patterns of STIs in major urban centers in the region; (2) recognize common patterns of STIs among countries in the region; (3) develop standard treatment protocols, based on World Health Organization protocols, according to epidemiologic findings, as well as local laboratory and therapeutic circumstances; and (4) validate these protocols as needed in the field.

In Thailand, AIDSCAP assessed STI prevalence in Bangkok, national trends, and the role of STI therapies. In Papua New Guinea an assessment examined STI prevalence, risk behaviors, and program needs. Program needs identified by assessments in Mongolia and Sri Lanka were addressed by training health care providers, and microbial resistance studies resulted in modifications of national STI management protocols in the Philippines and Cambodia.

Activities conducted to strengthen surveillance activities in the region included an epidemiology roundtable discussion in India, consultations by an AIDSCAP/FHI advisor to Cambodia, Nepal, and India, and funding of the Cambodia Sentinel Surveillance Initiative. Epidemiology workshops in Nepal, India, Cambodia, and Indonesia modified national projections and working estimates of HIV prevalence.

BSS: Tracking Trends in Sexual Behavior

The BSS were used in Bangkok among blue collar workers from a variety of occupations throughout the city during 1993 to 1996. A typical interview lasted no longer than 30 minutes. Like epidemiologic surveillance, the BSS can serve as an early warning system, alerting policymakers and program managers to increases in risk behavior. They also can help guide prevention programs by identifying groups whose behavior makes them particularly vulnerable to HIV infection and the specific behaviors that need to be changed. For evaluation, the BSS provides a baseline for measuring the impact of prevention efforts and a series of cross-sectional snapshots of behavioral trends among vulnerable groups.

In the Bangkok BSS, interviews were conducted with 3,000 individuals every 6 months. (One-year intervals are now considered more appropriate to monitor behavior change trends.) The results helped document substantial increases in condom use and declines in male patronage of commercial sex. Data from the BSS convinced project managers of the need to direct prevention interventions to single, non-CSWs, sexually active women.

AIDSCAP/FHI believes the BSS fill two gaps in evaluation information by identifying the short-term effect of prevention interventions as well as the trends in risk behaviors among vulnerable groups. Even though the BSS cannot dissect the impact of different interventions, the tool can give an indication of whether a combination of interventions are working together to change risk behaviors. In Bangkok, the surveys enabled program managers to say that behaviors were changing for the better.

Risk Factors and Risk Behaviors

Behaviors that put one at risk of STI, including HIV, were identified in most Asian countries, portending high HIV infection rates. Given this high level of risk, even in the face of low HIV prevalence, AIDSCAP focused on behavior change and developed BSS methodology to measure that change.

Behavior change interventions were designed for specific communities, and were intended to be mutually reinforcing and supported by messages and influences from other sources. In the AIDSCAP-sponsored Bangkok Fights AIDS program, the behavior change communication (BCC) interventions encompassed workplace and other interpersonal outreach initiatives, mass communications, and public relations. These interventions were reinforced by community mobilization through the district AIDS committees and collaboration with NAP through the Bangkok Metropolitan Administration.

AIDSCAP developed the behavioral surveillance surveys for the Bangkok Fights AIDS program to directly track behavior change, the focus of the interventions. These innovative surveys tracked behavior change over time among key risk groups in Bangkok. They were also incorporated into AIDSCAP programs in Nepal, Indonesia,

and Senegal, and the national AIDS programs of Thailand and the Philippines incorporated modified versions of AIDSCAP/FHI's BSS into their national surveillance methodologies.

Migration Within Countries and Across National Borders

Significant seasonal and multiyear migration of male and female workers is common in the Asia region. Targeting populations for AIDSCAP/FHI interventions frequently required accommodating the reality of this mobility. Thus, it was decided that geographical targeting would need to be more precise to ensure that interventions would be absorbed by mobile populations. Assessments and pilot interventions, therefore, were conducted in strategic cross-border areas in many parts of the region.

A Logo for Both Sides of the Border

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

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

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

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

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

- The initial assessment of risk along the Thai-Lao border in December 1993 resulted in the design of the Lao PDR program. The assessment revealed that most HIV/AIDS cases were found in returnees and refugees from Thailand and in bar workers—the majority of them from provinces bordering Thailand.

- AIDSCAP/FHI commissioned an assessment along the Thai-Cambodian border in June 1994 that revealed the presence of a substantial number of Vietnamese CSWs, demonstrating the mobility in this regional industry.

- AIDSCAP/FHI commissioned an assessment of five provinces in Indonesia, which resulted in the selection of Manado as the third demonstration area of the HAP Project. The two other demonstration areas are North Jakarta and Surabaya.

- AIDSCAP/FHI staff rode trucks from Calcutta north to the Nepal border as part of the assessment that lead to the Bhoruka AIDS Prevention (BAP) Project, which serves truckers in India and complements the AIDSCAP/FHI/Nepal truckers' interventions.

- AIDSCAP/FHI pioneered the conceptualization of cross-border interventions. Other donors, such as Joint United Nations Programme on HIV/AIDS, UNICEF, and USAID, are now promoting a regional approach. Partner agencies are now using this approach for their own interventions (e.g., World Vision and CARE).

Newly Industrialized Nations

High levels of education in the Asia region had implications for communications initiatives as well as skilled staff availability for public and private STI/HIV/AIDS control activities. The relatively high levels of economic development also meant that certain critical commodities (e.g., condoms, lubricants, and STI drugs) were available in commercial markets. In addition, public resources were potentially available in many countries to support STI/HIV control initiatives that had demonstrated their value to policymakers.

The AIDSCAP/FHI strategy took into account the reality that the newly industrialized nations in the region (e.g., Thailand and India) could potentially bring more resources to bear on the epidemic than less developed nations (e.g., Nepal and Cambodia) and that different levels of development and preferences of national governments required different organizational configurations.

- Supplies of Condoms and STI Drugs: In Thailand and India, condoms and STI drugs have been readily available in the commercial markets and in public clinics and hospitals. Therefore, AIDSCAP/FHI built on these resources in mounting interventions in these countries. In poorer countries like Nepal and Cambodia, either AIDSCAP/FHI or colleague agencies were required to augment these essential commodities.

Condom supplies were made available in Cambodia by Population Services International through a mission-funded contract. In Nepal, AIDSCAP/FHI supported a local agency, Contraceptive Retail Sales, and arranged for technical assistance from the Futures Group.

- Models Relating to NAP: AIDSCAP/FHI's organizational structure adapted to the requirements of the national government and its programmatic demands, with guidance from the USAID Mission. In all cases, the AIDSCAP/FHI interventions were designed to support the NAP and were approved by the NAP manager. The following organizational models were adopted:

- Free Standing Program: In Nepal, NAP agreed that the AIDSCAP/FHI interventions would be managed as an autonomous program, supporting NAP staff through training and coordinating closely with agencies of His Majesty's Government. The NAP manager served on the AIDSCAP/FHI/Nepal steering committee.

- Technical Assistance Only: The APAC Project in the Tamil Nadu state of India is funded directly by USAID/India. The head of the state AIDS cell is also chairman of the APAC management committee. AIDSCAP/FHI was not directly involved in management and provided technical assistance only.

- Integrated into NAP: The HAP Project in Indonesia is part of the Ministry of Health (MOH); the project director is the director general of the MOH, Communicable Disease Control/Environmental Health. The AIDSCAP/FHI chief of party reports to the project manager, who is a civil servant within the MOH.

Reduced Risk Behaviors Among Target Populations

Thailand

Results from the BSS in Bangkok provide an aggregate view of trends in the target population of the AIDSCAP country program in Thailand. Five rounds of surveys were conducted from 1993 to 1996 and involved more than 20,000 interviews with lower-income women and men aged 15 to 29. Highlights of the BSS determined by comparing round 1 data (1993) to round 5 data (mid-1996), follow. All responses are based on self-reports during personal interviews and from self-administered questionnaires.

Single and married men

- The percentage of men who had had commercial sex in the past year decreased from 21 to 13 percent for blue collar workers and from 13 to 4 percent for vocational students.

- The percentage of men who had used a condom in their last commercial sex contact increased from 89 to 94 percent among blue

collar workers and from 92 to 94 percent among vocational students.

- The percentage of men who had had more than one noncommercial sex partner in the past year declined from 15 to 11 percent for blue collar men, but remained the same (13 percent) for vocational students.

Female CSWs

- The percentage of CSWs who had used condoms with every paying client increased from 87 to 97 percent for brothel-based CSWs and from 56 to 89 percent for indirect CSWs, who work out of cocktail lounges and night clubs.
- The percentage of CSWs who had had sex with nonpaying partners increased from 38 to 42 percent for brothel workers and remained at 51 percent for indirect CSWs.
- The percentage of CSWs who had used condoms with nonpaying partners was low, but it increased from 20 to 32 percent for brothel-based CSWs and from 23 to 28 percent for indirect CSWs over the project period.
- The percentage of CSWs who sought medical treatment for STIs remained high at 94 percent for brothel-based CSWs and increased from 91 percent to 96 percent for indirect CSWs.

Single and married women (non-CSWs)

- The percentage of single women who had had sex in the past year declined slightly: from 8 to 6 percent for blue collar workers and from 4 to 2 percent among vocational students.
- The percentage of sexually active single women who had used a condom during the last sexual contact remained low and constant at 19 percent.
- The percentage of married women who had used a condom during the last sexual contact increased slightly from 5 to 8 percent.

Nepal

- Among CSWs in the project area, 61 percent reported using a condom with their most recent client, compared with only 35 percent prior to the start-up of outreach activities.
- The percentage of CSW clients seeking services for urethral discharge who received advice from trained chemists on partner notification increased from 5 percent prior to intervention to 21.2 percent by the end of project.

- The percentage of CSW clients seeking services for urethral discharge who received advice from trained chemists on condom use increased from 13.7 percent prior to intervention to 23.1 percent by the end of project.

- The percentage of CSWs and the percentage of CSW clients from the Central region who reported perceptions of risk by the end of project were 92.3 and 77 percent, respectively.

- Extensive training of STI program managers and communication specialists from governmental and nongovernmental organizations (NGOs) resulted in a network of trained professionals in the region.

- The BSS was designed by the Bangkok Fights AIDS staff and collaborators, and was modified for other countries in the region and is now recognized by the international community as the state of the art in behavioral measurement.

Lessons Learned and Recommendations

Regional

- There continues to be a need for a unified regional program that complements bilateral support. The program should include a combined strategy of borderless activities linked to region-wide capacity building and coordinated with bilateral work.

- AIDSCAP/FHI, as AIDSTECH did before, moved from targeting CSWs to targeting the clients. Now is the time to aggressively reach out with prevention interventions to the spouses and partners of the clients. More work is needed on developing the messages and support networks for these groups.

- Although many countries in Asia have low prevalence rates, organizations of people living with HIV/AIDS can play a valuable role in speaking out on the human rights issues and raising the consciousness of the public and leaders regarding STI/HIV/AIDS.

India

- In India, it was found that an extremely large amount of work can be accomplished with small amounts of funds if the funds are channeled to the appropriate organizations. Some of the AIDSCAP rapid-response grant achievements (activities with a budget of less than U.S. $5,000) were extraordinarily cost-effective.

Indonesia

- In Indonesia, it was determined that the most productive role for donors in implementing politically sensitive activities and programs is that of a facilitator responsible for accessing technical expertise on relevant policy options. Smaller scale financial assistance directed to an

expressed government need and carried out in a timely manner can be the most effective way to influence policy outcomes as well as to increase ownership.

- NGOs frequently focus on field activities rather than management needs and skills. Day-to-day planning and activity management are important areas for capacity building, and management skills focusing on sustainability are essential for implementing agencies. The donor agency must assist NGOs' practical skill development and capacity building.

Nepal

- In Nepal, the integration of STI services at established, respected, quality family planning and family health care service delivery sites proved successful in Nepal's Central region. STI services should be further integrated at family planning and other health care delivery sites.

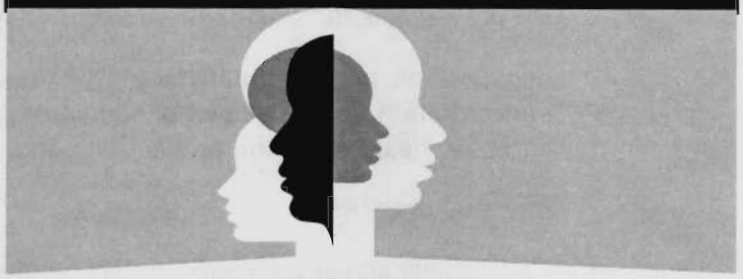
- BCC interventions are further strengthened when coordinated with other HIV intervention programming, such as community-based condom social marketing and STI service delivery initiatives. Condom promotion and complementary STI initiatives can be integrated to further strengthen BCC efforts.

Thailand

- There was considerable resistance to the syndromic management of STIs by government and private physicians in Bangkok. Also, it was considered unethical to send false patients to clinics to assess physician practices. Other programs need to anticipate this resistance and find constructive ways of encouraging the influential STI practitioners to support program strategies. For the Thailand program, AIDSCAP/FHI established a technical working group made up of AIDSCAP and local STI experts. Yet, this was not enough to overcome resistance to some of the STI strategies and policies promoted by AIDSCAP. Therefore, alternative mechanisms of leveraging support need to be sought.

- In Thailand, the behavioral surveillance methodology was the appropriate tool for evaluating the combined effects of linked interventions rather than the sum of individual subproject interventions. The disadvantage of the BSS methodology is that it is not possible to attribute improvements to AIDSCAP-supported subprojects directly. Inferences must be made about the contributions of the AIDSCAP activities recorded in process indicator reports to measured changes in risk behavior. Other comprehensive programs should use BSS for overall evaluation but should strive to locate a control area to enable more conclusive evaluation judgments.

Latin America & the Caribbean



AIDSCAP

Status and Trends of the Epidemic

As of September 1997, Latin America and the Caribbean (LAC) had reported more than 200,000 cases of AIDS, 13 percent of the total number of cases reported worldwide. Of the 470 million people in the 44 countries that comprise the region, it is estimated that between 1.6 and 2 million people have already been infected with HIV.

In a region noted for its tremendous diversity in culture, ethnicity, geography, climate, and economic activity, seven subregions can be identified, allowing for a more meaningful review of the epidemic's impact: Mexico; the Central American Isthmus (Guatemala, Belize, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama); the Latin Caribbean (Cuba, the Dominican Republic, Haiti, and Puerto Rico); the English-speaking Caribbean (Jamaica and 21 island nations); the Andean subregion (Bolivia, Colombia, Ecuador, Peru, and Venezuela); the Southern Cone (Argentina, Chile, Paraguay, and Uruguay); and Brazil.

The HIV/AIDS epidemic began in LAC in the late 1970s and early 1980s. Initially most infections occurred among men who have sex with men (MWM). Heterosexual transmission has since increased substantially, principally among bisexually active men and their female partners, and among female commercial sex workers (CSWs) and their clients. Injecting drug use has played a significant role in transmission in several South American countries, notably Brazil and Argentina, and is an increasing concern in Central American and Caribbean countries, principally Honduras and Jamaica. Nonetheless, sexual transmission of HIV accounts for 81 percent of overall transmission in the region, ranging from 66 percent in Brazil to 94 percent in the Andean subregion.

Four factors that contribute to the epidemic also explain the diversity of prevalence rates within the region:

- characteristics of sexual behavior (multipartnerism, bisexuality, and commercial sex),
- STI prevalence and treatment-seeking behaviors,
- demographic and economic factors (including migration, urban concentration, income, level of education, gender inequalities, and access to health care and prevention), and
- injecting drug use.

Patterns of sexual activity across the region reflect behaviors that place the population at risk for HIV. These behaviors include early onset of sexual behavior, cultural acceptability of multiple partners, especially for males, and low levels of condom use. National behavioral surveys in Haiti and the Dominican Republic, for example, have found average age of first sexual intercourse to be as low as 13. A relatively high proportion of men report having had sex with other men, and in many countries, a majority of men report having had multiple, concurrent sexual partners and paying for sex. Condom use has been historically very low and is generally opposed by religious institutions.

While the countries of LAC have established health care infrastructures, they are often plagued by inefficiencies and are inaccessible to low-income populations. Self-treatment of sexually transmitted infections (STIs) is common, and prevalence rates are high. In Haiti, for example, 47 percent of pregnant women in the Cité Soleil neighborhood of Port-au-Prince were found to have at least one STI. In a national survey in the Dominican Republic, 33 percent of women reported having had an STI in the past 12 months, and 48 percent of youth reported STI symptoms. Of Jamaican men reporting an STI in a national survey in 1996, only 54 percent sought appropriate treatment, and 33 percent did not seek any treatment at all. A study of Brazilian STI patients found that 70 percent had had symptoms for at least 1 month before seeking treatment.

The region's demographic and economic characteristics are conducive to the rapid spread of HIV infection. Migration, both among countries and to and from rural and urban areas, contributes to the spread of HIV/AIDS. Epidemiological evidence signals a rapid shift of new infections to younger ages, particularly toward individuals aged 15 to 24. Declining economic conditions, particularly in the Caribbean, have caused many women to become even more dependent on their male partners. Women's economic vulnerability has resulted in increased multipartnerism and commercial sex.

Injecting drug use is another important mode of transmission in South America, accounting for 26 percent of AIDS cases in Brazil and 29 percent of AIDS cases in the Southern Cone. Decreasing male to female ratios of AIDS cases and decreasing ages at diagnosis in these regions have been associated with this mode of transmission.

Mexico, the Central American Isthmus, and the Latin Caribbean

The number of new HIV infections and AIDS cases in Mexico, the Central American Isthmus, and the Latin Caribbean continues to rise. As of September 1997, 53,464 AIDS cases had been reported to the Pan American Health Organization from this region. Because of widespread underreporting, the true incidence of AIDS is estimated to be between 20 and 70 percent higher.

Although MWM continue to be the most affected group in Mexico, incidence in this population does not appear to be increasing as rapidly as it did in the 1980s. Transfusion-associated HIV infection and AIDS cases have been drastically reduced because of effective blood screening. Heterosexually transmitted HIV infection among women is slowly increasing. In Mexico, there are effectively two epidemics: (1) an urban epidemic, more mature and mainly affecting MWM; and (2) an emerging rural epidemic, spreading through heterosexual transmission.

In Central America, Honduras has only 17 percent of the region's population, yet it has 48 percent of AIDS cases. HIV seroprevalence levels among CSWs in Honduras have reached almost 40 percent. Sentinel surveillance of pregnant women in the city of San Pedro Sula has documented prevalence of up to 4 percent. Commerce, migration, and communication patterns within this subregion suggest that HIV is spreading within each country in well-established local epidemics, as well as across international borders. In contrast, Nicaragua, perhaps because of its relative isolation from tourism and trade in the 1980s, has very low documented rates of HIV prevalence. A study conducted in 1996 of Nicaraguan CSWs in three cities found an HIV prevalence of less than 1 percent. STI prevalence, however, was much higher.

In the Latin Caribbean, Haiti is of particular importance because it is the only country in the region with a relatively mature epidemic. Exacerbated by social, economic, and political instability, HIV prevalence rose from 2 percent in 1989 to an estimated 5 percent of the rural adult population in 1994. In urban areas, prevalence was estimated at 10 percent in 1994. HIV prevalence is particularly high among CSWs, STI clinic attendees, and tuberculosis patients. Although prevalence appears to have stabilized among the general population in the past 5 years, HIV incidence may be increasing. The Dominican Republic has seen a similar trend, with HIV prevalence appearing to have stabilized in the past 5 years between 1 and 2 percent among antenatal clinic attendees and between 7 and 8 percent among STI clinic attendees. HIV prevalence in the tourist zones of the north continues to increase, however, with rates rising from 3 to 8 percent among antenatal clinic attendees between 1994 and 1996.

Within this subregion, the structure and organization of commercial sex is very diverse, ranging from informal networks of individuals who engage in occasional commercial sex to established, thriving sex industries. Several countries import or export sex workers and organize sex tourism. International and intraregional travel, including tourism and employment seeking, also influence the dynamics of the Caribbean epidemic, increasing the potential for spread of HIV.

The English-Speaking Caribbean

The predominant mode of HIV transmission in the English-speaking Caribbean is heterosexual, but estimates suggest that homosexual transmission accounts for 14 percent of all new infections. Intercountry variation exists in AIDS incidence and prevalence, but in general, the number of cases is increasing in all countries. The doubling time for the annual number of new AIDS cases in this subregion is 4 to 5 years. Some Caribbean countries report AIDS incidence rates that are among the highest in the world. Among the many small countries of the Caribbean, the fact that some countries have very high incidence rates while others have very low rates demonstrates that there are many distinct HIV epidemics, rather than one regional pattern.

HIV is increasingly affecting individuals from marginalized groups, such as migrant workers, CSWs, and users of crack cocaine. AIDS has become the leading cause of death among young adult men in some Caribbean countries. On a more hopeful note, the extremely low incidence of HIV infection through contaminated blood represents a success story for the Caribbean countries.

Jamaica was identified in the late 1980s and early 1990s as a country on the verge of an explosive epidemic. With high rates of STIs, multipartnerism, migration, and poverty, it was believed that the 0.4 percent HIV prevalence found in 1992 among antenatal clinic attendees would quickly escalate. In 1995, however, HIV prevalence among this group was still less than 1 percent (0.9 percent). In Barbados, HIV prevalence among pregnant women has been documented between 1 and 2 percent.

South America: Andean Subregion, Southern Cone, and Brazil

The number of HIV infections and AIDS cases in South America is rising steadily. While Brazil has 75 percent of South America's AIDS cases, escalating prevalence in Argentina and Colombia will lower Brazil's percentage in the near future. As in other regions, sexual transmission is the most common mode of transmission of the 66 percent of all reported AIDS cases (42 percent homosexual and 24 percent heterosexual), with injecting drug use accounting for the remaining 34 percent.

Many countries in the Andean subregion and in the Southern Cone report low rates (below 0.5 percent) among the general population and higher rates (about 20 percent) among MWM, CSWs, and injecting drug users.

The HIV/AIDS epidemics in these subregions are at differing levels of maturity but are well established in most countries. Transition from epidemics centered in major urban areas to increasing involvement of smaller urban centers and rural areas is emerging. Epidemics are increasingly taking hold in specific population subsets, including adolescents, marginalized communities, and populations characterized by low socioeconomic status and lack of basic socioeconomic, educational, and health services.

Accomplishments and Results

Accomplishments

In the LAC region, AIDSCAP/FHI established comprehensive programs and fully staffed country offices in Brazil, the Dominican Republic, Haiti, Honduras, and Jamaica. AIDSCAP/FHI collaborated with other countries on a smaller scale, including Bolivia, Ecuador, Peru, Costa Rica, El Salvador, Guatemala, Nicaragua, and Mexico. The level of prevention and control conducted in these countries was determined by the local USAID Missions, and ranged from a single project to comprehensive national campaigns integrating the efforts of nongovernmental organizations (NGOs), the Ministry of Health (MOH), and the private sector.

Table 12. LAC Regional Process Data, 1991–1997

	Cumulative
Total People Educated	**5,282,195**
Total People Trained	**46,751**
Total Condoms Distributed	**125,104,164**
Free	**28,705,274**
Sold	**96,398,890**
Total Materials Distributed	**9,574,321**

Process indicators are used to track measurable data in a subproject. *People educated* includes number of people attending educational sessions or contacted through AIDSCAP interventions. *People trained* includes number of people attending training-of-trainers sessions. *Condoms distributed* is the number of condoms sold through condom social marketing programs and the number of condoms distributed free-of-charge. *Materials distributed* includes behavior change, condom promotion, and STI/HIV educational materials such as posters, pamphlets, handbooks, tapes, newsletters, and comic books.

During the 6 years of the project, achievements in the LAC region have been exciting and encouraging. AIDSCAP/FHI programs resulted in prize-winning advertising campaigns in the Dominican Republic, a national postage stamp in Brazil, a presidential commendation in Honduras, a world-touring theater troupe in Jamaica, promulgation of an AIDS law in Nicaragua, and continuing HIV/AIDS prevention efforts during political upheaval in Haiti. Activities expanded from a planned focus on five major country programs to include additional STI/HIV/AIDS prevention interventions in nine associate countries. In the overall region, where AIDS was once viewed as a homosexual disease and a disease of foreigners, governments are increasingly aware of the gravity and potential impact of the epidemic and of the importance of prevention in avoiding the level of crisis faced in other regions. The AIDSCAP Project, through its many local implementing agencies, has been largely responsible for this shift.

In addition to its high-profile achievements, the AIDSCAP Project has had numerous other successes. It conducted high-quality mass media campaigns for a wide range of target audiences and promoted syndromic management of STIs in the public and private sectors. In collaboration with subcontractors, AIDSCAP/FHI country offices initiated social marketing of condoms for STI/HIV/AIDS prevention. In several countries, gender-focused strategies were developed to respond to the shift in the pandemic to higher rates of infection among women. AIDSCAP/FHI effectively worked with the public and private sectors in the region, presenting impact analyses, mobilizing commitment, and leveraging resources. It also designed a rapid program implementation protocol for Honduras that jump started a national program in just 2 weeks.

Mass Media Campaigns

In the LAC region, sophisticated, high-quality media are an effective means of reaching the general populations, as most people have access to television, radio, and a variety of print media. AIDSCAP/FHI programs in Haiti, Jamaica, Brazil, and the Dominican Republic disseminated behavior change messages, making creative use of mass media channels. In Haiti, the jingle for Panther condoms was recited in the streets. The Jamaican program worked with a local public relations firm and succeeded in raising awareness and putting HIV/AIDS on the country's social agenda. The Brazilian magazine *Claudia,* with a monthly circulation of almost 700,000 copies, teamed up with AIDSCAP/FHI to educate its readership on HIV/AIDS through articles in each issue. Working with a Dominican advertising company, AIDSCAP/FHI crafted an award-winning ad campaign for adolescents. Not only did these campaigns reach a vast audience, but they created linkages with the private sector, resulting in millions of dollars worth of donated airtime and print space.

Syndromic Management of STIs

Another area of improvement in the region was in the diagnosis and treatment of STIs. Using guidelines developed by the World Health Organization for syndromic management, AIDSCAP/FHI focused on field testing and adapting them to local situations. As a result, new national guidelines were established in the five major LAC countries. Public and private sector medical professionals in these countries received training in syndromic management.

- In Haiti, the three main STI programs achieved consensus on standardized protocols, which were adopted by the MOH for national use. In addition, AIDSCAP funding to the Haitian Study Group for Kaposi Sarcoma and Opportunistic Infections (GHESKIO) supported the training of some 440 medical professionals in STI management.

- In Jamaica, training was provided through the MOH's Epidemiology Unit, the Medical Association of Jamaica, and the Nurse Practitioner Association of Jamaica. More than 1,700 medical professionals received training to strengthen STI services. In addition, the MOH produced and distributed more than 2,000 copies of a manual on STI case management and counseling.

Dominican Republic: Just Once

"Just one time I loved in my life, just one time and never again."

This lyric from the popular and traditional Mexican ballad "Solamente Una Vez" was the backdrop of a three-part mass media campaign in the Dominican Republic that has won international acclaim. Since this high-quality production of TV and radio spots aimed at Dominican youth was launched in September 1995, the young actors have become minor celebrities, being approached frequently with questions about HIV/AIDS. "Just Once" is transformed from a heartfelt declaration of love to a warning to youth to protect themselves from infection.

"Young people live in their own world," said Mr. Freddy Ginebra, president of the Dominican advertising company, Cumbre, that worked with AIDSCAP/FHI on the campaign. "They don't have fear; they take more risks; they're adventurous and rebellious. They don't think death exists, so we looked for a 'code' to challenge them and make them think."

In four separate phases, the campaign urged adolescents to learn about HIV/AIDS and to protect themselves and exhorted parents to discuss STIs and HIV/AIDS with their children. It garnered extraordinary support from the media, with donated airtime for the advertisements valued at more than U.S. $9 million.

- In Brazil, approximately 2,000 health care professionals were trained in syndromic management in Rio de Janeiro, Santos, Ceará, and Bahia. Approximately 10,000 copies of STI management guidelines and supporting materials, developed and translated into Portuguese with AIDSCAP/FHI funding, were distributed to polyclinics and medical professionals throughout the country.
- In the Dominican Republic, syndromic management course participants were directly involved in developing and validating instructional manuals. The STI training program was attended by more than 850 clinicians, bioanalysts, and health promoters nationwide.
- In Honduras, partially as a result of AIDSCAP/FHI-supported regional training for STI managers, word got out about syndromic management, and the medical establishment requested training before the MOH had completed preparations. By the end of the project, the guidelines had been published, and training had been initiated.

Condom Social Marketing

In 1992, lack of access to condoms was common in most of the countries of the LAC region. To address this constraint, AIDSCAP and its subcontractors initiated or strengthened condom social marketing programs in four of its major countries in the

region. These interventions sometimes had dramatic results, not only on sales of the socially marketed product but also on commercial sales and government policy. For example, during a 4-year project in Brazil implemented by DKT do Brazil, an affiliate of Population Services International, sales of Prudence—the DKT condom—totaled more than 71.5 million. Of this number, approximately 45.8 million were sold in AIDSCAP target areas. Prudence is the third largest brand in Brazil. Prior to this program, Brazil had one of the lowest rates of condom use in the world, with nationwide sales of approximately 50 million condoms in 1991. By the end of 1996, sales had more than tripled. A DKT position paper is also credited with the president's 1995 decision to decree a year-long tax holiday on the 60-percent duty charged on imported condoms. This holiday expired after a year, but the duty was lowered to 10 percent.

Gender Initiatives

Gender inequality is one of the greatest barriers to STI/HIV/AIDS prevention. The World Health Organization estimates that women are 10 times more vulnerable to STIs and HIV infection than men because of biological, social, cultural, and economic factors. The response of the LAC Regional Office to this critical need clearly evidenced the commitment of the regional programs to implementing gender-sensitive initiatives.

In addition to the major technical strategies of the global AIDSCAP Project, the AIDSCAP Women's Initiative worked with the project's LAC Regional Office to incorporate techniques to integrate gender into regional STI/HIV/AIDS prevention efforts. In Brazil, AIDSCAP conducted a study on the acceptability of the female condom. The study concluded that this method not only offered an alternative contraceptive for women but also increased the chances of safer sex and successful condom negotiation. Study participants liked the female condom, and they were sufficiently motivated to buy the device. In Haiti, an NGO used dialogue to get families and adolescent children talking about STI/AIDS in a gender-sensitive and constructive manner. Educational sessions created an open atmosphere in which sexual partners, mothers, fathers, and teenagers were able to share a basic understanding of sexual risk and the methods to prevent and control STIs and HIV, without the tension typical of such encounters.

One of the most significant steps taken toward institutionalizing gender in AIDSCAP/FHI programs was the development of a regional gender and STIs strategy. In this three-tiered strategy, each country office designed and implemented an STI research, intervention, or training pilot project; participated in gender-analysis training; and participated in a 2-day regional conference for partner countries. This workshop was attended by 25 participants, including AIDSCAP/FHI senior managers and implementing agency officials from the Dominican Republic, Honduras, Brazil, Bolivia, Peru, and Nicaragua. As a result, participants from AIDSCAP country offices who were establishing indigenous NGOs to carry on their work drafted value statements for their nascent organizations that communicated their beliefs about gender. Regional guidelines were also developed for implementing gender-oriented STI/HIV/AIDS prevention activities. Finally, partnerships were established between Brazil and Bolivia, and Honduras and Nicaragua.

Haiti: Don't Take a Hit

Although a military coup in 1991 sent Haitian President Jean-Bertrand Aristide into exile, and subsequent embargoes virtually shut down foreign aid for several years, AIDSCAP/FHI continued its HIV/AIDS prevention programs. The Panté condom jingle, "Pa pran gol" (Don't take a hit), could be heard everywhere, and a news program sponsored by Panté kept the public informed about political developments. Yet, this high profile was not without its problems. Dr. Eddy Génécé, former AIDSCAP resident advisor, recalled an evening meeting with CSWs: "The police broke in and insisted that the meeting was political and subversive and that we had to disperse." In spite of harassment and fuel shortages, the program maintained a strong network among those working with the HIV/AIDS program.

In fact, these adversities enhanced their resolve and cooperation. Dr. Génécé recounted, "We shared information: when one group found fuel for sale or discovered a district or town was blockaded, we let each other know. We learned to make each gallon go a long way by shipping several months' worth of condoms at one time." Another group turned long gas lines into an opportunity. Ms. Gessy Aubry, director of the NGO Groupe de Lutte Anti-SIDA, was only one example. "We took creative advantage of those hours spent in gasoline lines to talk to drivers about STI/HIV/AIDS prevention. We developed a portable presentation that could be delivered as we walked up and down the line, and even began to sell condoms to other customers."

Impact Analyses

The countries of the LAC region, unlike many of their counterparts in other regions, were able to intervene before HIV became a full-fledged epidemic. While HIV seroprevalence levels became epidemic in some urban areas, levels remained relatively low throughout most of the region. As a result, HIV prevention did not receive sufficient attention from either policymakers or the private sector in the early 1990s.

To provide policymakers with sufficient information about the potential impact of an HIV epidemic in the region, AIDSCAP/FHI conducted socioeconomic impact studies in the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Peru. With funding from the Colombian MOH and SIDALAC/Mexico and technical support from AIDSCAP/FHI, Colombia and Costa Rica conducted similar studies. The MOH in each country assembled a team of epidemiologists and economists who used computer and mathematical models to simulate the trajectory of the epidemic from 1995 to 2000 for both high and low transmission rate estimates and to estimate the

epidemic's economic impact. Every country projected that the incidence of HIV/AIDS would rise sharply between 1995 and 2000.

These impact analyses raised awareness of HIV as a multisectoral development issue, rather than merely a health issue. As a result of the impact assessment in Honduras, USAID decided to make Honduras a major country for prevention and control efforts under the AIDSCAP Project and secured a commitment from the Government of Honduras. In addition, a video production in Honduras was successfully used to initiate workplace prevention programs in the private sector. In both the Dominican Republic and Nicaragua, information from these studies contributed to the promulgation of new AIDS laws. The study in El Salvador led to increased funding for HIV prevention programs and to the creation of STI clinics in the workplace.

Private Sector Mobilization and Leveraging

Widespread support in mobilizing the private sector was obtained in the LAC region over the life of the project. Helping private sector companies understand the potential impact of HIV/AIDS on their workers was the key to leveraging financial support for prevention and care. In addition, considerable direct cash or in-kind contributions were made to support the prevention activities of governments and NGOs. Examples of these kinds of contributions included the following:

- AIDSCAP/Brazil leveraged approximately $4 million in investments to increase the sustainability of program activities. DKT International provided nearly $2 million worth of condoms to the AIDSCAP/Brazil project. Companies such as Levi Strauss and Unilever, publicity agencies, and several fashion magazines also provided in-kind contributions to further prevention activities.

- In the Dominican Republic, community-based distribution and private sector partnerships were negotiated to increase condom distribution nationwide. In addition, AIDSCAP/Dominican Republic also launched a national mass media campaign for youth that successfully leveraged approximately $9 million of both domestic and international free airtime for radio and television spots.

- A local public relations firm working with AIDSCAP/Jamaica and the MOH was able to leverage strong support from the private sector, evidenced by the more than U.S.$180,000 cash or in-kind contributions on behalf of the national AIDS control program. Furthermore, this firm secured free advertising time on television, on radio, and in newspapers valued at more than U.S.$1 million.

Results

AIDSCAP/FHI's HIV prevention programs in the LAC region have significant results to match their accomplishments. Results can be noted on several different levels, which are summarized in the following sections.

Strengthened Local Capacity to Respond to HIV/AIDS

The AIDSCAP Project provided support and training to local organizations, including NGOs, universities, and MOHs, through 180 subprojects with the objective of strengthening technical and management skills, management systems, physical resources, and interorganizational networks.

As a result of the project's effort, management systems (including financial, monitoring, and condom and STI logistic systems) were significantly strengthened in every organization. Program managers and staff reported a greater understanding and sophistication in the use of both technical skills (in peer education, behavior change communication materials development, evaluation methodologies, condom logistics, social marketing, and STI clinic upgrading) and management tools (strategic planning, financial management, monitoring, and reporting). Finally, by encouraging organizational crossfertilization and multisectoral collaboration, AIDSCAP/FHI was able to improve information dissemination and exchange of experiences. The project created informal and formal coalitions that were able to exercise political leverage and generate increased resources.

AIDSCAP/FHI capacity building efforts resulted in a significant number of local organizations managing sustainable interventions, which will continue to respond to target population needs beyond the initial geographic area and period of AIDSCAP funding. With AIDSCAP/FHI's support, many effective intervention models were developed and replicated in other contexts. In São Paulo, Brazil, for example, an intervention targeting adolescents attending evening remedial and high school classes developed a curriculum on HIV/AIDS that was accepted by the Ministry of Education and reproduced throughout the state, reaching more than 1 million youth. Successful intervention approaches with CSWs in the port of Santos, Brazil, were presented to local health officials and NGOs in the northeastern state of Bahia for replication. Worksite prevention programs in Haitian factories received ongoing funding from local factory owners and were able to expand coverage to additional sites. STI case management training, funded by AIDSCAP/FHI and offered in Jamaican public hospitals and clinics, is being expanded to include private sector practitioners.

AIDSCAP/LAC country offices led the effort to ensure the organizational sustainability of implementing agencies. They also ensured their own sustainability by becoming independent NGOs with diversified funding sources.

- In Honduras, the Fundación Fomento en Salud competed for and won a USAID/Honduras contract to continue interventions started under AIDSCAP.
- In Brazil, the Associação Saúde da Família received funding from the government, U.S.-based private foundations, and the private sector to continue its activities and implemented a high-profile HIV/AIDS fundraising campaign targeting the Brazilian general population.
- In the Dominican Republic, Fundación Genesis is currently in contact with U.S. and European donors, designing intervention projects targeting youth and women.

Jamaica: The First Face of AIDS

Teri Ann was 25 years old when her life fell apart. She was diagnosed with AIDS. Her husband, who had infected her, deserted the family. Her young son was sent to live with relatives in New York. Fearing violence and ostracism in her community, she sought the help of the Jamaican AIDS Support (JAS), a nonprofit organization offering prevention services and hospice care for people living with HIV/AIDS.

A beautiful woman with a model's cheekbones and a dazzling smile, Teri Ann became a gentle crusader, the first to publicly discuss her illness. She wanted to help others, to reach other Jamaicans with her story. Together with filmmaker Pat Lazarus and the supportive encouragement of JAS, Teri Ann chronicled her last 6 months with the hope that her message of prevention and protection could save lives. Her other most fervent wish, which she spoke of passionately on tape, was to see her son one last time.

JAS Executive Director Ian McKnight recalls the power of this story: "People could relate to Teri Ann. It impacted everyone, especially women. It was a real wake-up call!" Teri Ann died in September 1994 at the age of 28. She never did see her son.

The "Teri Ann" video continues to be widely used. JAS shows it in schools and churches, and TV stations have rebroadcast the story many times. "Tuesday Forum" hostess Elaine Wint-Leslie—the Jamaican Oprah Winfrey—credits Teri Ann with "single-handedly doing the most for HIV/AIDS education in Jamaica."

- In Haiti, Prometeurs Objectif Zerosida is working to organize an active coalition of local NGOs and has received a grant from Plan International to incorporate HIV/AIDS prevention into Plan's projects in four areas of the country.

Reduced Risk Behaviors Among Targeted Populations

AIDSCAP/FHI programs in the LAC region targeted diverse populations, including male and female CSWs, MWM, hotel workers, STI clinic attendees, residents of impoverished and marginalized communities, adolescents, factory and agricultural workers, college students, and general population adults. In every population, increased knowledge of HIV/AIDS transmission and prevention methods has been recorded. In addition, some positive measure of protective behaviors, such as increased condom use or decreased number of partners, has been noted.

Knowledge of two or more methods of preventing HIV transmission is nearly universal among both high- and low-risk target populations in many of the AIDSCAP major countries. Table 13 shows changes in knowledge of HIV prevention methods among various target groups in selected LAC countries.

Unfortunately, while knowledge of HIV transmission and prevention is high in most populations, deficiencies remain in terms of specific knowledge and belief in inaccurate means of HIV transmission (such as mosquitoes and social contact with HIV-positive individuals). Forty percent of adults in Jamaica named an incorrect means of HIV prevention in 1996. In the Dominican Republic, rates were even higher, with 26 percent of men reporting that a good diet could prevent HIV infection, 39 percent reporting not touching a person with HIV, and 63 percent reporting avoiding mosquito bites. Adolescents often report even higher levels of belief in incorrect transmission methods, poor knowledge of STI symptoms, and lack of understanding of the transmission of HIV by asymptomatic individuals. While target populations have accepted and understood information on HIV/AIDS conveyed to them by mass media campaigns, peer educators, and outreach workers, they have been slow to reject the persistent rumors, gossip, and sensationalistic news that convey misinformation.

In addition to improved knowledge, condom use has increased in every AIDSCAP LAC country, as shown in Table 14. While condoms have been accepted only moderately well among men and women over the age of 30 and in the context of regular relationships, 100 percent condom use is becoming a norm among female CSWs and, to a lesser degree, among MWM.

The high levels of condom use in these populations reflect the success of the AIDSCAP/FHI peer education efforts and the impact of condom social marketing programs. CSWs and MWM now universally report that low-cost condoms are available in a myriad of outlets, including pharmacies, supermarkets, bars, hotels, kiosks, and beauty salons.

In general populations targeted by AIDSCAP, significant increases have been noted in individuals' ability to discuss HIV/AIDS and negotiate condom use. For example, in 1994, 45 percent of urban youth in Haiti stated that they were able to discuss HIV/AIDS with their partners, and 23 percent reported that they were able to negotiate condom use. One year later, 75 percent reported that they were able to discuss HIV/AIDS, and 63 percent said that they were able to negotiate condom use. Despite these improvements, condom use with nonregular partners is much lower than it is for high-risk populations and has shown little change since baseline, as shown in Table 15.

The lower levels of behavior change in condom use among general populations may be due to their lower perceptions of risk of HIV infection. Another explanation may be that the more intensive interventions targeting high-risk populations were simply more effective.

One exception to low rates of condom use in the general population is Jamaica, where HIV/AIDS prevention campaigns have benefited from long-running family planning campaigns. Seventy-five percent of men in the general population with

Table 13. Changes in Knowledge of Two or More Methods of HIV/AIDS Prevention

Country	Target Population	Percentage Able to State Two or More HIV/AIDS Prevention Methods	
		Baseline	Follow-up
Brazil	CSWs	74% (1991)	93% (1996)
	MWM	71% (1993)	91% (1995)
DR[1]	Youth (15–19)	45% (1993)	100% (1996)
	MWM	94% (1992)	100% (1996)
	CSWs	91% (1992)	100% (1996)
Haiti	General population	71% (1990)	97% (1995)
Jamaica	General population	91% (1994)	95% (1996)
	Youth (12–14)	70% (1994)	95% (1996)
	MWM	85% (1993)	95% (1996)

[1]Dominican Republic

nonregular partners reported condom use during their most recent sexual intercourse. This high figure was unchanged between 1992 and 1996.

Throughout the LAC region, a high percentage of men in the general population report having changed their sexual behavior to reduce their risk of HIV infection (see Table 16). The most common steps taken by these men include having fewer partners, avoiding commercial sex, and selecting sexual partners more carefully. The extent to which these changes in sexual behavior have occurred, as well as the protective effect of this incremental behavior modification, is difficult to assess, but undoubtedly provides some degree of reduced exposure to and risk for HIV infection. A smaller percentage of women report changed behavior, primarily because of their lower rates of high-risk behaviors.

Behavior change strategies adopted by the general population varied greatly by age. For example, among men in Haiti citing behavior change, the strategy of having one partner was adopted by only 20 percent of men aged 15 to 19 versus 77 percent of men aged 50 to 59. In the same study, condom use was cited by 30 percent of men aged 15 to 19, 40 percent of men aged 20 to 24, and only 3 percent of men aged 50 to 59. Among women in Haiti, abstinence was cited by 57 percent of women aged 15 to 19 versus 8 percent of women aged 25 to 29.

Improved Policies and Changed Social Norms

Another result of the efforts of the AIDSCAP/LAC regional office has been an improved political and social environment for HIV/AIDS prevention. Governments' recognition of the costs of the HIV/AIDS epidemic and their commitment to providing resources to fund programs have increased, partly because of the socioeconomic impact studies sponsored by AIDSCAP. As mentioned earlier, model interventions with documented impact have been scaled up and supported by government resources. Important policy changes have improved the efficiency of HIV/AIDS prevention projects as well as the human rights environment for individuals at risk of, or already infected with, HIV.

Table 14. Reported Condom Use During Last Sexual Intercourse by Target Population

Country	Target		Population Baseline	Condom Use Follow-up
Brazil	CSWs		57% (1991)	97% (1996)
	MWM		21% (1993)	76% (1995)
DR	CSWs		65% (1992)	98% (1996)
	MWM		38% (1992)	63% (1996)
Honduras	CSWs			
		Tegucigalpa	N/A	94% (1995)
		Comayagua	N/A	100% (1995)
Haiti	CSWs		N/A	92% (1995)
Jamaica	CSWs		N/A	95% (1996)
	MWM		51% (1993)	78% (1995)

Examples of the improved policies include the lowering of duties on condom imports in Brazil, passage of AIDS laws in the Dominican Republic and Nicaragua, adoption of national STI guidelines in Honduras and Haiti, and development of a national HIV/AIDS 5-year plan (1995) in Haiti.

Many countries in the LAC region also have seen widespread changes in social norms. For example, the Catholic Church in Haiti has reached out to HIV/AIDS prevention organizations and has taken an active role in providing care and support for HIV-positive individuals. Today, individuals who die from AIDS may be buried in Catholic Church cemeteries; 5 years ago they were not allowed.

While these results in building capacity, reducing risk, and improving policies and changing social norms validate AIDSCAP/FHI's approach and attest to its persistent efforts, they do not provide justification for complacency. Many of these results represent only the initial steps toward completely sustainable organizations, fully protective behaviors, effective policies, and supportive social, economic, and political settings.

Table 15. Reported Condom Use with Nonregular Partners During Last Sexual Intercourse by Target Population

Country	Target Population	Condom Use			
		Baseline		Follow-up	
		Male	Female	Male	Female
Brazil	Youth (18–25)	4%[1] (1994)		2%[1] (1995)	
DR	Youth (15–19)	24%	10% (1992)	47%	17% (1996)
Haiti	Youth (15–19)	40%	21% (1996)		
	General Population	16%	6%[2] (1990)	32%	12%[2] (1995)
Jamaica	Youth (12–14)	16%	21%[3] (1994)	29%	35%[3] (1996)

[1] Use of condoms with casual partner in the past 6 months, no gender specified
[2] Ever used condoms
[3] Consistent (every time) condom use in the past 12 months

Lessons Learned and Recommendations

Behavior Change Communication

- Many members of high-risk populations are no longer considered to be at high risk because of their adoption of risk-reduction strategies. Therefore, the emphasis should be on reaching individuals within these groups who continue to practice high-risk behaviors, including low-income, occasional CSWs, subsets of MWM (for example, cross-dressers in the Dominican Republic), and migrant workers. Emphasis also should be put on improving the environmental and structural conditions that can sustain behavior change among those who have adopted lower-risk behaviors.

- The HIV/AIDS epidemic can be understood as a series of overlapping epidemics involving different populations at different times. Intensive efforts aimed at targeted populations in which the epidemic is spreading most rapidly are most cost effective and efficient over the long term for

slowing the overall epidemic. However, these efforts also initially require more costly formative research and labor-intensive intervention strategies. At the same time, broad general population campaigns can increase public awareness of HIV, social acceptance of people living with HIV/AIDS, and support for resources for HIV prevention. General population programs also reach individuals who do not identify themselves as members of one of the targeted populations, as well as partners of those being targeted.

- Adolescents represent an increasing percentage of HIV infections in the LAC region. As they become sexually active, sustained education interventions must be available to address their concerns. Reaching this group requires substantial support from a wide range of gatekeepers (for example, parents, schoolteachers, and religious officials) and frank recognition that ignoring adolescent sexuality is a deadly proposition.

Table 16. Rates of Behavior Change

Country	General Population	Behavior Change (1995–96)	
		Change	Specific Strategies Cited
DR	Male	85%	Have one partner (29%)
			Avoid sex with CSWs (26%)
			Reduce number of partners (25%)
			Use condoms (23%)
	Female	26%	Have a steady partner (23%)
			Have one sex partner (11%)
			Abstain (4%)
Haiti	Male	68%	Have one partner/be faithful (48%)
			Avoid occasional partners (36%)
			Avoid CSWs (35%)
			Use condoms (25%)
	Female	31%	Have one partner/be faithful (71%)
			Use condoms (11%)
Jamaica	Male	59%	N/A
	Female	47%	N/A

- It is important to integrate all institutions, both governmental and nongovernmental, from the outset in developing, planning, and implementing a behavior change communication strategy. This coordination creates a homogeneous team and a spirit of cooperation and collaboration that ensures consistency and enhances the effectiveness of the campaigns. In addition, working as a team can eliminate competition and duplication of efforts and increase cost effectiveness.

- In the LAC region, it is particularly important to produce professional-quality messages because most audiences have wide exposure to mass media. Polished productions are also better accepted by TV and radio stations and are more likely to generate donated airtime at highly visible times of the day.

- Peer education, while effective among some groups, was ineffective and impractical for street-based CSWs and some youth groups. Because of the transient life-style of street-based CSWs, training them in peer education was not an efficient use of resources. Turnover was high, and monitoring was difficult. In addition, other CSWs resisted the counseling and education from peers. They were suspicious of the advice given and feared losing customers if they followed it. These CSWs responded better to the intervention of professionals. Similarly, youth groups in Jamaica reported feeling more confidence in education provided by professionals rather than by their peers.

Sexually Transmitted Infection

- In the LAC region, STIs are still highly prevalent and can increase HIV transmission potential up to 40 percent. STI treatment-seeking behavior is poor, with a high percentage of individuals either treating themselves or not treating their STIs at all. Contact-tracing and partner-referral rates are low as well. Medical establishments have resisted implementing syndromic management protocols. Further interventions are needed to increase the use of syndromic management and to reinforce STI counseling, particularly among private sector practitioners, who treat up to 60 percent of STI patients in some countries.

- The ultimate sustainability of STI prevention activities depends on their integration into reproductive health programs. Given the high level of STI prevalence and the low level of treatment, a demonstrated need exists for improved screening capabilities in primary health care centers. Without this integration, the impact of STI campaigns will be limited.

- A large percentage of symptomatic men continue to seek STI treatment outside clinics. This population is an important target group for future service delivery efforts.

Condoms

- In Latin America, overcoming religious and social barriers to condom distribution and sales has been a challenge. Use of mass media and celebrity endorsements emphasizing the benefits of condoms have been an effective solution.

- Social marketing programs have been successful in the region; however, a number of issues must be considered when initiating programs of this kind.

- The move from obtaining free-of-charge condoms to purchasing condoms may not be easily achieved.

- Using existing distribution channels for social marketing of condoms is desirable; however, the willingness of private sector companies to be associated with a controversial product should be explored indepth before investing time negotiating agreements.

- Good logistics management and inventory controls are necessary to preclude leakage of donated condoms meant for free-of-charge distribution into the black market, where they are then sold.

Program Management

- To be responsive to changing needs in the field, programs should decentralize decision making. Subprojects of country programs suffered from delays in disbursements of funds and approval of amendments.

- The demands of submitting monthly and quarterly reports diverted staff from other program management tasks. New programs should strive to simplify reporting requirements, and reports should focus more on results than process.

- Larger subprojects are more cost effective and demand no more time from country and regional office staff than small projects. Therefore, where feasible, larger (perhaps umbrella) projects should be encouraged.

Evaluation

- Cross-sectional studies are still vital in sentinel and population-based surveys, but more emphasis should be placed on younger age groups and finer age stratification to identify risk-reduction strategies adopted. Coordinated and repeated behavioral surveys of multiple target populations—such as those conducted in Jamaica—provide an essential overview of trends. They can also establish the long-term effectiveness of intervention efforts and identify emerging risk groups or behaviors.

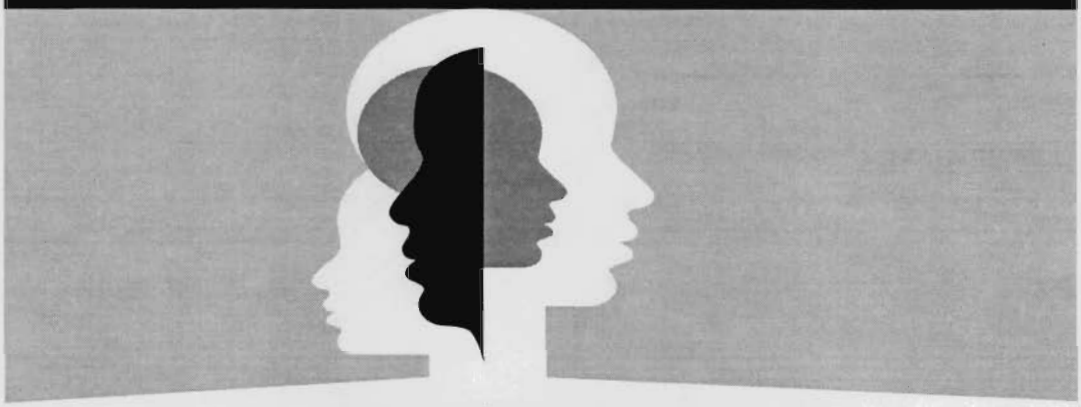
- The process of triangulating evaluation results (such as biological data with quantitative and qualitative outcome and process data) in annual evaluation reviews with program managers and evaluation researchers

can lead not only to improved, more insightful findings, but also to an improved understanding of and appreciation for the evaluation process and the means of applying evaluation results.

- A comprehensive evaluation framework should include the measurement of project coverage rates, such as the percentage of target audiences recognizing campaign slogans or materials on behavior change communication, and the percentage of target audiences contacted by peer educators or accessing outreach facilities. These kinds of surveys can be conducted with minimal questions, rapid training of interviewers, and limited analysis to ensure low-cost and rapid completion. The target population's access to condoms can also be measured to assess condom promotion and social marketing projects. Results from coverage surveys improve the triangulation of evaluation results and make it possible to attribute results to program efforts, complementing the information on trends uncovered by the behavioral studies.

- As our response to the HIV/AIDS epidemic continues to evolve, new program areas (e.g., care, counseling, and testing) demand new indicators. Additional indicators should also be identified to measure sustained behavior change.

Technical Strategies



AIDSCAP

Behavior Change Communication

AIDSCAP

Strategy Overview

Over the course of the AIDSCAP Project, behavior change communication (BCC) for HIV/AIDS prevention continued to evolve into a specialized field, drawing on and using experiences from family planning, social marketing, anthropology, psychology, education, and communication. Because prevention of an often fatal sexually transmitted infection (STI) is significantly different from other health promotion goals, AIDSCAP/FHI BCC programs sought to refine traditional communication approaches to address usually private and sensitive matters such as sex, trust, and death. This meant that BCC specialists had to broaden their focus from just disease prevention to include the social, political, and environmental factors that influence risk behavior. The technical strategy guides this process.

The goal of the BCC component of the AIDSCAP/FHI strategy was to make effective use of behavioral and communication theory and research to develop communication activities that would influence individual behaviors and the social context in which they occurred. The objective was to reduce the number of high-risk exposures for STI/HIV infection through (1) increased condom demand and use; (2) increased STI-related treatment-seeking and preventive behaviors; (3) decreased numbers of sexual partners; and (4) increased norms and policies that support HIV/AIDS prevention activities.

To achieve this objective, BCC interventions were based on a theoretical approach that took into account the complex connections between individual acts and the social settings in which those acts occurred. This approach focused on

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- developing interventions and messages acknowledging both the individual and the sexual partner(s).
- targeting social structures that provide the context, which influences an individual's knowledge, attitudes, and behaviors.

To maintain this focus, BCC planners were encouraged to investigate both the individual and the community when formulating a behavior change intervention. The community investigation included analysis of the demographic, economic, political, cultural, epidemiological, and developmental environments. The individual investigation explored the following issues as they affected the target audience:

- How do members of the target audience currently understand and practice HIV/AIDS preventive behaviors?
- What do they see as the benefits to practicing safer sexual behaviors?
- What information will motivate them to change their sexual behaviors or continue safer sex?
- What is their perception of the risk of becoming infected with STI/HIV?
- What are their perceptions of peer and social norms governing sexual behavior and HIV/AIDS prevention?
- Where are they in the process of behavior change?

AIDSCAP/FHI stressed that both the target audience and communities must be involved in developing behavior change interventions to ensure that their values, concerns, and needs are reflected in the program.

The BCC technical strategy also called for the use of multiple communication channels. Information about reach, cost, feasibility, appropriateness to the message, and effectiveness in changing behaviors determined which communication channels (i.e., interpersonal communication, institutional networks, mass media, and "small media") were selected.

As experience accumulated and as individuals became more knowledgeable and aware of their personal risk, the emphasis of the BCC technical strategy shifted to emphasize more interventions for couples, communities, and policymakers. Initially (and appropriately), many implementing agencies had aimed interventions at individuals (e.g., peer education programs). Later, when awareness raising activities had been successful, implementing agencies expanded their reach and developed dyadic-level activities (e.g., couple counseling and dialogue technique) and also activities seeking to modify social norms at the community and institutional level (e.g., condom social marketing, advocacy and consensus building, and private sector leveraging).

Accomplishments and Results

The BCC strategy was applied in more than 500 subprojects—both long-term and shorter rapid-response-funded activities. Implementing agencies had to commit to a strategy that was considerably more complex than traditional health education. In many cases, this required a new way of thinking about the design and implementation of projects. As a result, training in the principles and skills of BCC was often required and requested. Technical assistance was provided by the professional communication officers based in each AIDSCAP/FHI regional office or by BCC officers and consultants in the country office. Occasionally, BCC staff from headquarters participated in technical assistance activities.

Technical assistance was also provided in the form of small, practical "how-to" handbooks, which were developed and disseminated throughout the project to help the practitioners upgrade their BCC skills. Titles of the handbooks illustrate some of the skills that are required of a successful BCC practitioner in the era of HIV: *How to Create an Effective Communication Project*; *Behavior Change Through Mass Communication*; *How to Conduct Effective Pretests*; *Assessment and Monitoring of BCC Interventions*; *How to Create an Effective Peer Education Project*; *HIV/AIDS Care and Support Projects*; and *How to Create a Partnership with the Media*. During the project, 180,000 peer educators, health workers, religious and community leaders, and outreach workers were trained to provide STI/HIV/AIDS prevention information; approximately 18 million individuals were educated about STI/HIV/AIDS.

A database of the educational materials (small media) produced during the project contains more than 1,125 items, ranging from posters and leaflets to video productions and scripts for radio soap operas. The database had several purposes: (1) to keep track of all BCC deliverables; (2) to document information on how the materials were being used (e.g., Who is the target group? What message is being communicated? Was it pretested?); (3) to monitor the quality of the materials; and (4) to provide sample materials and ideas to AIDSCAP programs and to outside agencies who requested them.

Because peer education is a component of so many STI/HIV/AIDS prevention projects throughout the world, AIDSCAP/FHI encouraged implementing agencies and health officials to take a critical look at peer education projects. In an effort to better understand how, when, and where these projects can be most usefully used, AIDSCAP/FHI studied 21 peer education projects in 10 countries. The knowledge gained from the findings was the basis for a BCC handbook, which is now available to planners as a guide for planning and developing peer education projects and for selecting, training, and supervising peer educators.

AIDSCAP/FHI-sponsored training and support resulted in a network of committed volunteers and professionals with the necessary skills and with the appropriate educational and motivational materials for effective behavior change interventions. This large group of STI/HIV/AIDS prevention care workers achieved impressive results. In Cameroon, for example, the percentage of male students targeted by the program who reported having more than one partner fell from 53 percent in 1993 to

36 percent in 1996. Similarly, in Jamaica, the proportion of young people who reported having nonregular partners fell from 37 percent in 1994 to 19 percent in 1996. In Bangkok, the proportion of male blue collar workers who reported having more than one noncommercial partner dropped from 15 to 11 percent in 3 years.

Another primary AIDSCAP/FHI objective was to increase condom demand and use, and again, BCC practitioners achieved positive results. In Haiti, the percentage of men who used a condom rose from 16 percent in 1990 to 40 percent in 1995. In Jamaica, the percentage of women who said they had used a condom with their last nonregular partner rose from 37 percent in 1992 to 73 percent in 1996. In Cameroon, 88 percent of commercial sex workers (CSWs) reported using a condom in 1996, compared with only 28 percent in 1988. In Thailand, brothel-based CSWs reported 97 percent condom use with every client in 1996, compared with only 87 percent in 1993.

Lessons Learned and Recommendations

Beyond Awareness

- In addition to encouraging individual behavior change, BCC can and must help create environmental conditions that facilitate personal risk reduction.

In Jamaica, a communication strategy developed with a local public relations firm targeted religious institutions, the media, and private businesses to encourage (1) changed attitudes toward STI/HIV/AIDS education in the workplace, (2) public discussion of sexual issues on radio and television, and (3) increased compassion toward people living with HIV/AIDS. Each target required a different strategy and a different message.

These efforts created a more supportive environment in which individual Jamaicans received encouragement from many sectors to practice safer sex. Media gatekeepers became more receptive to covering HIV/AIDS issues, airing 63 radio and television programs, and publishing 121 newspaper and magazine articles on the subject in 2 years. Business owners and managers agreed to work with the Jamaican Ministry of Health (MOH) to establish workplace prevention programs. Some supported the programs with cash or in-kind contributions. The influential Jamaica Council of Churches endorsed a series of workshops that gave religious leaders a better understanding of STI/HIV/AIDS and helped them counsel their congregations about the disease.

> "When we started working, talking openly about sexuality on the radio was simply not done. It is not our culture. But we have watched that break down. People now talk about it on the radio." (Jamaica)

- Risk-reduction efforts need to address the behavior of both partners in a relationship, but particularly the partner who has the most control.

BCC efforts should focus on (1) motivating men to hear and heed the concerns of their female partners, and (2) encouraging partners to improve and use sexual negotiation skills.

AIDSCAP/FHI responded to this need by using a number of methods for encouraging partner negotiation. In the Dominican Republic, provocative theater (a type of street theater performed in bars or on the street that, unknown to the public, is rehearsed drama) is used to model situations in which women express themselves confidently and men learn to listen to their points of view about sexually related problems, such as STI symptoms or condom use. Three of AIDSCAP/FHI's eight "Emma Says" comic books provide models and scripts for sexual negotiation. Numerous videos and soap operas from Kenya, Zambia, Haiti, Brazil, Thailand, and Nepal illustrate men and women working through emotionally difficult discussions. AIDSCAP/FHI used these models to give women and men opportunities to rehearse and develop their own sexual negotiation skills.

> "A technique we've found useful and that encourages discussion between men and women is to get them into a group together. Then you bring them together and they speak through you as a chair. You know, they are asking you, the chair, a question that is really meant for the other sex. They're sort of shy for the first 5 or 10 minutes. Then it begins to get heated. Someone asks a question that provokes and eventually they just ignore the chair and are talking and arguing with each other. We've found this facilitation very useful." (Zimbabwe)

- If peer educators are trained only to provide STI/HIV/AIDS awareness information, they may not be effective in influencing later stages of behavior change.

In a study of 21 peer education projects in Africa, Asia, and Latin America, AIDSCAP/FHI project managers found it necessary to revisit the needs of the peer community periodically. If target audiences were already knowledgeable about STI/HIV infection, then peer educators needed advanced training on behavior change and maintenance.

To encourage behavior change, peer educators need to know when to enlarge the basic message, when to listen, when to empathize, and how to bring STI/HIV/AIDS into conversations about other issues. If peer educators do not have these skills, their

work may be useful only in the early phases of the behavior change process when they can promote awareness and impart knowledge.

Private Sector Collaboration

- Well-planned BCC can leverage private sector commitment and financial involvement.

In the Dominican Republic, an AIDSCAP/FHI campaign targeting adolescents attracted more than U.S.$9 million worth of free airtime from local and international media. AIDSCAP/FHI leveraged this media support by investing $53,000 in developing high-quality TV and radio spots and related print materials.

- In some settings, collaboration with local communication professionals may be more cost effective than training HIV/AIDS program personnel to perform specialized communication skills.

Working with public relations firms, advertising agencies, and media consultants can be expensive unless they donate their services, but is often worth the cost. Many local firms and consultants have the contacts, understanding of culture and trends, and professional expertise needed to develop effective BCC campaigns.

AIDSCAP/FHI's experience with such collaboration has been rewarding. For example, a Dominican advertising agency worked with AIDSCAP/FHI staff to design an award-winning mass media campaign for youth. A Jamaican public relations firm helped AIDSCAP/FHI and the Jamaican MOH design and implement a BCC strategy that created a supportive environment for individual behavior change. In Kenya, AIDSCAP/FHI worked with a Nairobi communications consulting firm to place a regular weekly column on HIV/AIDS in a national newspaper. Written by a well-known Kenyan journalist, the "AIDS Watch" column reached an estimated 700,000 people every week and generated thousands of letters from readers.

- There is a natural partnership between BCC projects and condom social marketing projects.

CSM projects often create excellent educational and promotional items, as well as mass media promoting brand recognition and condom use. These projects allow BCC interventions to concentrate on interpersonal communication. In addition, the ability of CSM projects to publicize their product helps desensitize the condom issue and in turn, lays the groundwork for more specific behavior change messages.

In Nepal, for example, the CSM program developed radio and TV spots and a film shown in cinema halls and from mobile film vans. The film showings were closely coordinated with intensive outreach efforts throughout the country. These mass media efforts made it easier for outreach workers to discuss HIV/AIDS with target audience members. In Ethiopia, Tanzania, and Haiti, condom advertising on radio and television were an integral part of national risk-reduction campaigns.

Communication Tools

- Despite the initial misgivings of some public health officials, well-planned and well-executed entertainment has proven effective in conveying serious behavior change messages.

Live and taped dramas were used throughout the AIDSCAP Project to show audiences models of behavior change situations as well as possible implications of their behavior. Themes and messages that lend themselves to a dramatic format include sexual negotiation, HIV/AIDS care and support, stigma, and discrimination.

AIDSCAP/FHI-sponsored folk theater, street theater, videos, radio and TV soap operas, and magazine and newspaper stories generated enthusiastic responses from audiences and serious discussions about HIV/AIDS. For example, a Kenyan radio soap opera prompted 27,000 letters from listeners with questions and comments on the topics addressed in the broadcasts. In Jamaica, publication of question and answer columns about safer sex in local newspapers and youth magazines generated 65 percent of the calls received by the telephone STI/HIV counseling service, "Helpline," over 2 years.

Examples of AIDSCAP/FHI's use of entertainment includes provocative theater in the Dominican Republic, the Miujiza Players drama group in Kenya, "The House of Charms" video in Thailand, monthly articles in *Claudia* magazine in Brazil, soap operas in Zambia and Haiti, a Nepalese video about a truck driver and his assistant, "Fleet of Hope" productions in five countries, and dramas produced by peer educators in Zimbabwe. A Jamaican communication officer noted that "community theater is the most effective tool we have" because it depicts everyday life and encourages discussion.

> "Performing plays helps the person to think and see what is applicable to real life. In a play it is easy to tailor a message for a specific target audience, for example students or factory workers. When they see you on stage talking about corruption, diseases, and then eventually to zero down to HIV/AIDS, it's really fascinating for them. After we have done the play and had a chance to ask questions, the audience normally opens up very easily." (Kenya)

- The concept of a behavior change continuum is a useful tool for BCC specialists, helping them develop messages and approaches that are appropriate to the stage of change of their target audiences.

The continuum adopted by AIDSCAP/FHI describes people's movement from awareness of a potential risk to motivation to change, trial of a new behavior, and adoption and maintenance of the behavior. An AIDSCAP/FHI study conducted in

eight countries used the behavior change continuum to question BCC officers and program managers about the impact of their work. An example of a typical response is the following, from Zimbabwe: "In the beginning we were at awareness they knew there was some problem, but they were not particularly concerned. And now I think we are bouncing back and forth between motivation and trial. We're distributing a lot of condoms—about 450,000 this year—so that's some trial."

Recognition that behavior change is a process and that messages must be appropriate to the stage of change requires considerable ingenuity from BCC specialists. In Cameroon, projects working with relatively cohesive and homogeneous groups, such as sex workers and military personnel, found that members of the target population generally moved along the behavior change continuum at similar rates. However, university students in the same country presented a greater challenge. Because they entered the university with different levels of understanding about HIV/AIDS, and because upper class students had more exposure to prevention education, this large target group was segmented according to their positions on the continuum, and messages and approaches were tailored for the various segments.

- Some BCC messages and materials have a universal appeal.

Although BCC messages and materials should always be pretested with members of the intended audience, it may not be necessary to develop new materials for each target group. In fact, some messages transcend culture and nationality. A study of several AIDSCAP/FHI materials used or adapted throughout the world found that these materials appealed to individuals from many different cultures because they addressed universal concerns.

In Tanzania, for example, a brochure on "The Fleet of Hope" was designed to help individuals and communities with diverse religious backgrounds and moral beliefs understand the impact of HIV/AIDS and assess their own risk. It advises readers to board one of three "boats"—abstinence, monogamy, or condoms—to save themselves. This metaphor and the options it offers has proved popular and effective in at least eight countries. It has been used in folk media, video, poster, presentations, and other materials. Another example is "Emma," a West African comic book character who has spread STI/HIV/AIDS prevention and care messages in 20 countries. AIDSCAP/FHI encouraged such crossfertilization of messages and materials by sharing model materials from its computerized BCC database with communication officers in the field.

Capacity Building

- Capacity building in BCC is critical, even for experienced health educators.

The concept and techniques of BCC are not easy to grasp and apply. Because approaches to STI/HIV/AIDS prevention continue to evolve, donors must recognize and address the need for new knowledge and skills.

AIDSCAP/FHI found that one cost-effective way to build capacity is through the use

"Emma Says"

All over the world, people listen to what Emma says. The star of AIDSCAP/FHI's "Emma Says" comic book series has dispensed practical, compassionate advice about STI/HIV/AIDS prevention and care to tens of thousands of people in Africa, Asia, Latin America, and the Caribbean.

Originally developed by AIDSCAP/FHI's predecessor, the AIDSTECH Project, as a character in a flip chart for peer education sessions with West African women, Emma has become a trusted source of information about STI/HIV/AIDS in more than 20 countries. Since the creation of the first comic book in 1994, eight different "Emma Says" have been translated into six languages, and 171,000 copies have been distributed. Thousands of people have seen dramatic presentations about Emma performed by local organizations in Tanzania, Ethiopia, Nigeria, and Cameroon. In Rwanda, she became a film star when AIDSCAP/FHI's social marketing partner, Population Services International, received funding from UNICEF to create an "Emma Says" video and a companion photonovella.

As an aunt, a neighbor, and a friend, Emma deals directly with difficult issues facing individuals, families, and communities in the era of HIV/AIDS. In her first three comic books, she talks to women about how to introduce condoms into a relationship and about the importance of getting prompt, effective treatment for STIs. She also addresses HIV/AIDS care and support in the series by helping neighbors accept and care for their HIV-positive son, showing people how they can assist coworkers and friends living with HIV/AIDS, and motivating a community to organize a care and support network. The final books in the series find Emma helping a 16-year-old friend seek treatment for an STI.

of practical handbooks that guide the reader through the various steps of the BCC process. Project managers and BCC officers report that AIDSCAP/FHI's series of BCC handbooks are useful as teaching aides, reference material, sources of new ideas, and check lists.

For example, managers of AIDSCAP/FHI-supported projects in Ethiopia used one of AIDSCAP/FHI's six handbooks, *How to Create an Effective Peer Education Project*, as the framework for developing all their peer education projects. In Kenya, the government distributed photocopies of the AIDSCAP/FHI handbook on creating an effective HIV/AIDS communication project to 200 MOH communication officers, who were instructed to use it as their guide. In the Lao People's Democratic Republic, chapters of two of the handbooks were translated and used in workshops to develop STI/HIV/AIDS prevention messages for projects in three different sites. One BCC officer reported that the three working teams found that the two books provided them with the clearest framework for communication and BCC intervention.

Challenges for the Future

Change in Social Norms

The art of designing and implementing communication programs to change community norms and values is not yet well understood. We know that mass media can play an important role, but questions remain about its relative value compared with other channels of communication, the timing of BCC campaigns, the synergy of different channels and messages, and the appropriate duration of BCC campaigns. Research is needed to explore the best ways to use communication to support or change social norms and to measure such change.

Maintenance of Behavior Change

Maintenance of safer sexual behaviors over time has not received much attention to date. Some behaviors are expected to change as an individual's life changes. For example, condom use may no longer be necessary when an uninfected person enters a monogamous relationship with another person who is HIV-negative. However, other changes—or relapses to behavior that is less safe—may invalidate the previous safer behavior and lead to HIV infection. Strategies and messages that motivate people to maintain safer sexual behaviors need to be investigated.

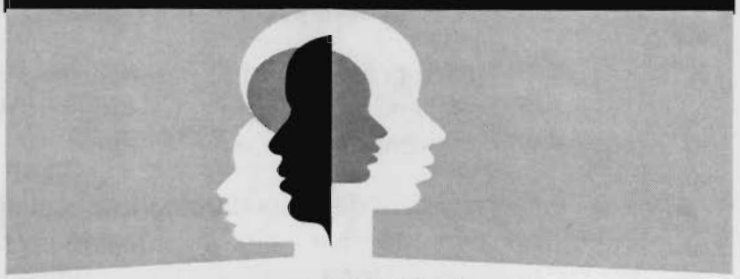
Stages of Change

Several popular models of the process of behavior change illustrate stages that individuals are likely to go through as they respond to information, make decisions, and try new behaviors. At each stage in the process, individuals need different kinds of information, emotional support, and skills. The ability to track a target audience's movement through these stages in a timely manner would allow program planners and communication specialists to target messages more precisely to the needs of the audience. Research is needed to clarify societal, rather than individual, indicators of change.

Challenges of Reaching Mobile Populations

Research is needed to identify ways to communicate with individuals who are socially marginalized, including migrant workers, refugees, and those who are homeless and may be living on the street. Highly mobile populations pose special challenges for BCC campaigns because they are particularly difficult to continue to reach with consistent messages.

Condom Distribution



AIDSCAP

Strategy Overview

AIDSCAP/FHI's contribution to condom programming for STI/HIV/AIDS prevention has been substantial. By enhancing the targeting of condom distribution in areas that already had programs or marketing efforts in place and by introducing condoms where they were relatively new, the program made high-quality, affordable condoms available to millions of people.

The program's objective was to make condoms more accessible to high-risk target populations. It was essential that these condoms were convenient to purchase, that is, routinely available at all hours of the day and night in areas where high-risk sexual behavior occurs.

This objective was met by using three primary strategies—improved condom distribution and logistics, effective promotion campaigns, and strengthening of incountry entities to undertake condom programs—and continually refining them as more experience was gained in the field.

Implementing and Refining Strategies

Social Marketing

Social marketing has been applied to a wide range of programming, including contraception, oral rehydration, and malaria prevention.

The basic approach commonly consists of the following components:

- The physical product (if any) is packaged, priced, and presented to appeal to the tastes of the target market.
- The market channels (the retail trade system, including both wholesalers and retailers) appropriate to the target market are prepared and engaged with conventional trade promotions.
- Messages are developed from the articulation of benefits of the desired behavior (whether a change in previous practices or in the purchase of the product) for a particular target audience and from the identification of barriers to the adoption of that behavior.
- Media are identified that will deliver the messages most effectively and efficiently to the target populations—both promotion to consumers and policy objectives to decision makers and opinion leaders.

Social marketing has been most successful in international family planning where massive quantities of contraceptives—mostly condoms and oral contraceptives—have been delivered. It has used the existing logistics system to supply goods to the retail outlets already delivering most commodities. Social marketing has depended on subsidized products to ensure affordable retail prices for the majority of individuals in developing countries; the literature on social marketing shows that this market segment is sensitive to price. Mass media have been used extensively to promote these contraceptives, resulting in less resistance to public promotion of condoms (and, to a lesser extent, oral contraceptives).

Advantages of social marketing operating entirely within the public sector, especially in the distribution of condoms, include the following:

- With a properly directed sales force, and with incentives to the retail trade, where needed, areas of special interest can be saturated with the product.
- The product is available to those wishing to purchase it wherever demand is sufficient to make it worthwhile to the retail trade.
- Distribution costs, from intermediate warehousing to the actual delivery of the product to the user, are borne not by a donor or by the public health system, but by the purchaser through retail price margins.
- The commercial transaction, which begins and ends with the exchange of money and product, is patently voluntary and relatively private, even anonymous.

The use of social marketing to promote and deliver condoms for the prevention of HIV and other STIs has not differed fundamentally in technique from the family planning efforts, especially in its basic, mass marketing approach. As suggested, social marketing is better able to deliver condoms to persons at risk wherever and

whenever these individuals are likely to want or need them than are conventional public health or family planning systems, provided sufficient demand has been created. Messages have, of course, been modified to emphasize the desirability of protecting oneself against infection. Innovations also have been made in adapting traditional commercial logistics systems to provide reliable supply to otherwise difficult-to-reach groups and individuals at high risk.

Condom Logistics

In addition to extensive efforts in social marketing, AIDSCAP also assisted in making condoms more readily available through the public sector, through distribution at government facilities and by nongovernmental organizations (NGOs). While accounting for a smaller proportion of the total AIDSCAP condom distribution (approximately 13 percent), these condom distributions were important because (1) they were free, which made them accessible to the poor; and (2) they were distributed to individuals who were at high risk of infection.

John Snow, Inc. (JSI) was the AIDSCAP partner for ensuring a reliable condom supply through public sector systems. Although faced with such obstacles as an inadequately motivated bureaucracy, inadequate financing and facilities, and technically complex problems that linked condoms (and STI drugs) with other commodities, JSI demonstrated conclusively that these systems can be rationalized. With the appropriate training, equipment, and software, commodity needs can be projected with reasonable accuracy, shipments can be tracked and accounted for, and supplies needed to control the epidemic can be made available.

Accomplishments and Results

Condom Sales and Distribution

In the context of this report, condom sales mean condoms sold through condom social marketing (CSM) programs, and distribution means condoms distributed free-of-charge through NGOs. For CSM programs, sales are the bottom line. It is the measure by which the program is considered either a success or a failure. Some argue that sales do not translate into use, but Demographic Health Survey results suggest that purchased condoms are much more likely to be used than condoms acquired free-of-charge at a government clinic.

The AIDSCAP Project exceeded its original expectations, selling and distributing over one-quarter of a billion condoms. As of July 1997, the total number of condoms sold through social marketing programs and distributed free-of-charge by NGOs was 254 million. The eight social marketing projects accounted for over 87 percent (222 million) of this total figure (Table 17). By a wide margin the Population Services International (PSI)/DKT Do Brasil CSM project in Brazil led all other projects in condoms sales, with 82 million sold from the project's inception in July 1993 until AIDSCAP/FHI support to the project ended on March 31, 1997.

Table 17. Condom Sales by Country

Country	Condoms Sold
Brazil	82.0 million
Ethiopia	44.0 million
Tanzania	39.0 million
Cameroon	24.0 million
Haiti	16.3 million
Nepal	12.0 million
Rwanda	2.6 million
South Africa	2.0 million

Measures of Success

The effectiveness of AIDSCAP/FHI support to the CSM programs can be determined by comparing the programs' sales performance prior to AIDSCAP/FHI involvement with their sales performance in the final months of the AIDSCAP Project.

Condom sales for the PSI Ethiopia CSM project were 829,000 per month when AIDSCAP/FHI funding began. When funding ended in September 1996, sales totaled 2 million per month, an increase of 141 percent.

The PSI Haiti CSM project was averaging 250,000 condom sales per month in September 1992 prior to AIDSCAP/FHI support. By the closing date of April 1996, the project was averaging 540,000 per month—a 116 percent increase. The Futures Group CSM project in Nepal was averaging 465,000 condoms sold per month prior to AIDSCAP/FHI support in February 1994. The current average is 1 million per month, a 115-percent increase.

As these figures indicate, each CSM project enjoyed a surprising increase in sales performance following AIDSCAP/FHI support. These impressive sales figures were achieved despite formidable obstacles and problems that arose in almost every country. In Ethiopia, for example, the PSI project was forced to ration condoms due to a 2-month stock out. The internecine war in Rwanda claimed the lives of four PSI staff, disrupted sales, and prompted PSI to distribute condoms free-of-charge in refugee camps. Political violence and an economic embargo in Haiti also posed safety concerns and logistical challenges to the PSI project there. Brazil has been plagued by both tariff and nontariff barriers, which have constricted sales and complicated the administration of the project.

The ability of the CSM projects to overcome these challenges and record such remarkable successes is a testament to the resilience and pragmatism of the social marketing approach. It also indicates the continued need for condoms in many countries throughout the world. AIDSCAP/FHI's experience suggests that providing convenient access to affordable condoms is the most effective way to meet that demand.

Another useful indictor of sales performance is the number of condoms sold per sexually active male for a 1-year period (see Table 18). This indicator illustrates the condom coverage of a target population.

Lessons Learned and Recommendations

- NGOs can become important partners for social marketing.

The association between NGOs and social marketing is not a natural one. The latter deals in the commercial sector (a social marketing operation often appears to differ little, if at all, from a commercial sales organization), and ordinarily speaks little of the language of volunteerism and altruistic objectives. NGOs generally define their purposes in providing assistance to the poor and may object philosophically to selling at a profit to their clients or members.

Recognizing the importance of ensuring a reliable condom supply for the clients or members of NGOs working in STI/HIV/AIDS prevention, AIDSCAP/FHI has worked to define productive relationships between social marketing projects and NGOs. Two successful models have emerged. In Haiti, NGOs became significant retailers of condoms. Faced on the one hand with an ineffective supply of government condoms (a supply that ceased during periodic political crises), and on the other with the importance of their messages encouraging condom use, NGOs began buying

Rwanda: A Symbol of Hope

In the center of Kigali's most congested traffic circle stands a kiosk. Once a newspaper stand, the modest structure was a mute witness to one of this century's bloodiest tragedies: the 1994 slaughter of more than half a million Rwandans by their fellow citizens. Less than 1 year later, the kiosk—freshly painted with a rainbow design—became one of the first small businesses to reopen. In the midday heat, many stop here to buy cold drinks, but also take the opportunity to ask the nurse behind the counter about AIDS or buy packets of Prudence condoms. In its new role, the kiosk has become a bright symbol of hope in a nation desperate to renew itself.

This tiny sales outlet is just one of hundreds throughout Rwanda created for CSM. By using commercial marketing techniques, affordable pricing, and existing retail networks to promote, distribute, and sell condoms, the AIDSCAP Project's nonprofit CSM programs—designed and managed by PSI—created an enormous demand for these preventive devices, even in areas where resistance to them was once so strong they couldn't be given away.

Table 18. Number of Condoms Sold per Sexually Active Male

Country	Total Condoms Sold	Number of Sexually Active Males	Number of Condoms Sold per Sexually Active Male
Haiti	1,259,720	1,440,000	0.87
Tanzania	6,047,224	5,700,000	1.06
Cameroon	4,448,640	2,700,000	1.64
Brazil	20,788,986	9,800,000	2.76

condoms from the PSI social marketing project at wholesale prices and selling them to their high-risk clients at retail. As a result, NGO members saw that the (highly subsidized) retail price was acceptable to their clients, they experienced the superior performance of the private sector delivery system, and they began generating funds through the trade margin they received. Skeptical at first of the ability of NGOs to handle retail products, though aware of the need to deliver condoms to the populations served by them, the social marketing managers saw the NGOs account for an increasing share of their sales, reaching 25 percent of the 35 million condoms sold in the year of the AIDSCAP/FHI close-out in Haiti.

- Social marketing proved to be an enormous stimulus to the commercial condom market in general.

For example, the Brazilian market, dominated by two large national manufacturers, was stagnant prior to the launch of the DKT condom. By aggressively promoting its brand in public and by challenging barriers to imported condoms, the DKT program was primarily responsible for a sudden growth that tripled the market to 135 million condoms by 1995. Moreover, it spurred competitive marketing activity that resulted in the market gaining five additional condom importers.

In both Brazil and Haiti (as well as in general), the programming costs, in terms of funding and of time, to achieve adequate logistical support in condoms sales were less than the amount required for the public sector to perform the task. In Brazil, in particular, where AIDSCAP/FHI invested significantly through JSI to enhance the government's delivery system, the constraints to effective delivery were so fundamental that improvements were considered marginal. One reason for this conclusion was the government's finally putting only limited quantities of

commodities into the system.

- Social marketing can successfully target its marketing efforts with a dedicated sales force.

In Brazil, a country so large that AIDSCAP/FHI was able to focus its program on only two states, the CSM project could not rely on NGO sales agents because of a law barring NGOs, as nonprofit organizations, from the retail trade. As a result, AIDSCAP/FHI provided separate funds to the social marketing project to ensure that sales efforts were especially intense in the geographic areas of the NGOs. Social marketing projects (as any sales operation) usually concentrate their resources on the most efficient (i.e., lowest cost) sales. In Brazil, as in the United States, that would have meant large sales to chain stores or the largest retail outlets. With the incremental resources provided by AIDSCAP/FHI, the social marketing operation was able to deploy a dedicated sales force to stock low-priced condoms in areas served by NGOs, even in small outlets.

Other countries also deployed dedicated sales forces to increase access to target populations. In Nepal, for example, a separate sales force concentrated its effort on the highways from India through the Terai, a known route for HIV transmission, resulting in adequate stocking and sales substantially higher than anywhere in the country. To accomplish this, every retail outlet along the highway was mapped and eventually visited by a sales team. The number of outlets stocking condoms went from 3 (pharmacies) to 56 retail outlets (tea shops, liquor stores, and cigarette shops) in 3 years.

- The climate for mass media messages about HIV/AIDS and condoms has substantially improved over the past 5 years.

Bishop Desmond Tutu's endorsement of condom use on South African television not only shocked some viewers, but also surprised social marketers who for years had tried to gain access to the mass media. As recently as 1990, the word condom was prohibited in advertising by the government of Kenya, requiring a wide range of subtlety and creativity on the part of social marketers. Today, more explicit advertising is permitted there and in many other parts of the world. In Nepal, a condom cartoon character stars in TV ads, and 18-foot inflatable condom replicas appear at public events. This increased freedom to use the public airwaves has yet to be fully exploited.

- Encouraging condom use through mass media facilitates their adoption by marginalized groups.

The increased ability to portray condom users openly in the media as happy, successful, "normal" people enables those whose lack of acceptance in society has been a barrier to condom use. Target marketing has sometimes been misunderstood to mean developing brands and advertising messages that appeal directly or even exclusively to commercial sex workers and their clients or to men who have sex with men. That approach requires those whose behavior is condemned by society to identify themselves as practicing that behavior. With the media carrying the message

that everybody uses condoms, members of marginalized minorities can purchase condoms without identifying themselves as members of such a group.

- Although condom social marketing has a positive impact on social norms, the degree to which it does and mechanisms through which it operates are not well understood.

Most developing countries are much less saturated with media messages than is the United States; as a result, the positive messages on condoms placed by social marketing are virtually the only messages about condoms publicly promulgated. When properly crafted, these messages may be even more persuasive than private conversations about condom use. Because messages encouraging positive behavior change have little competition, and because of the mass media's expanded ability to address the threat of HIV/AIDS more explicitly, more resources should be devoted to mass media today than in the past.

Challenges for the Future

Beyond Condoms

The ability of social marketing to move physical goods within the convenient reach of target audiences and to create an effective demand for them has yet to be fully exploited, at least in part because of donors' hesitations about becoming further involved in commodity supply. For example, using social marketing to make supplies of latex gloves available near medical facilities and promoting the idea that it is a client's responsibility to supply the gloves might be less costly than making the investments in public sector logistics systems required to ensure adequate supplies to physicians. As other HIV/AIDS prevention products become available, such as female condoms, appropriate virucides, and STI and HIV/AIDS drugs, social marketing may provide a more efficient means of delivery than traditional public health systems.

Prevention Marketing

Throughout the world, advertisements for toothpaste, soap, and cars show happy, attractive people seeking to enjoy the thrill of being alive, conspicuously helped by the product of the moment. The same approach has made condom use less problematic in areas with strong social marketing programs, and it could also be used to promote less tangible "products," such as safer sex. HIV/AIDS prevention programs need to tap the power of the media to influence behavior by marketing healthy sexual behavior as an attractive lifestyle.

Condom Supplies

Meeting the demand for condoms created by social marketing is a major challenge. For years, USAID has been the only donor providing significant condom supplies for public health and family planning programs. Although additional donors (notably the European Community and the German development agency) have recently entered this area, most are reluctant to support commodity supply—particularly when the commodity is considered controversial.

The efficiency of social marketing projects and their ability to recover costs tempt donors to make them entirely self-sustaining. But it is donor support that allows social marketing to sell condoms at an affordable price. For example, in Nepal, where social marketing is an important component of the AIDSCAP/FHI program, the retail price for a condom is less than U.S. $0.01. In Brazil, on the other hand, subsidies are not available and government taxes and regulations discourage condom imports. There the cost is $0.30 per condom, largely because management is forced to sell them at a price that finances new supplies. This price makes it highly unlikely that Brazil's poorest citizens will buy condoms.

Increasingly, the world over, AIDS is a disease of the poor. In order to deliver the only physical means of protection against the virus, condoms need to be made available in greater numbers now. Condoms must also be made available to the poor at a price that is attractive to them.

STI SERVICES

AIDSCAP

Strategy Overview

Since the AIDSCAP Project began in 1991, the importance of its sexually transmitted infection (STI) control and prevention strategy has been reinforced by studies that established the synergistic relationships between STIs and HIV. These studies include the Mwanza study, which demonstrated that syndromic STI treatment in a community decreases HIV transmission. Studies conducted in Malawi and Côte d'Ivoire showed the effect of STI treatment on genital concentration of HIV. Treating STIs constitutes both primary and secondary prevention of STIs and HIV, and there is an increasing recognition that the provision of accessible, acceptable, and effective STI services requires structural, biomedical, and behavioral interventions.

The goal of AIDSCAP/FHI's STI strategy was to reduce the rate of STIs through three broad program areas: (1) biomedical and behavioral interventions for the prevention and control of STIs; (2) institutional strengthening for STI control; and (3) biomedical and behavioral STI-related research. The strategies chosen for achieving this goal were to strengthen STI case management services at the point of first encounter between the patient and the service provider and to prioritize STI interventions for groups whose behavior puts them at high risk, such as individuals in high-density urban areas with high STI prevalence.

The syndromic approach to care at a patient's first visit in settings that lack laboratory and examination capabilities works well in men with urethritis, with men and women with genital ulcers, and for pelvic inflammatory disease, but less well in women with vaginal discharge. AIDSCAP/FHI's strategy also addressed the extensive morbidity in women caused by lower genital tract infections. Efforts to decrease this morbidity

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included education of women to improve symptom recognition, community education to improve treatment seeking, improved treatment of men, partner management strategies, and support for efforts to develop new diagnostic methods for STI in women.

AIDSCAP/FHI successfully implemented the syndromic approach to STI management in several countries. One key element of this process was the generation of local data on STI prevalence and antibiotic susceptibility as the basis for consensus meetings with providers and managers on national guidelines. The data generated by these studies convinced local decision makers and providers to adopt the syndromic approach. This change in providers' clinical practice constitutes a significant and difficult behavior change.

Time and resources were necessary to train providers, conduct requisite studies, and produce materials and for evaluation, follow-up, and supervision. The degree of capacity strengthening that was possible in a particular country was limited by the country's absorptive capacity, making it necessary to tailor efforts to each country's level of capabilities and needs.

A growing body of evidence shows that failure to seek prompt care for STIs has a significant impact on HIV rates. In response to this evidence, AIDSCAP increasingly emphasized developing STI-related behavior change communication (BCC) materials and activities. These STI/BCC materials, as well as research and training interventions, helped address such issues as the failure to seek prompt care (due largely to stigma), the lack of understanding of STIs, and the poor quality of STI services.

Accomplishments and Results

AIDSCAP/FHI's primary accomplishment was to establish a rational, effective approach to the institutionalization of national STI case management guidelines in several countries. The prevalence studies conducted in these countries provided, in many cases, the only available data on STIs for these countries. AIDSCAP/FHI made significant contributions to further developing and promoting the syndromic approach to STI management by accomplishing the following:

- Demonstrated that STI prevention/treatment is an important public health and policy reform issue.
- Advocated for the syndromic management approach to STIs through local studies, the published literature, and presentations at international meetings. (Because of advocacy by AIDSCAP/FHI, the World Health Organization (WHO) Global Programme on AIDS, the Joint United Nations Programme on HIV/AIDS, the European Community, and others, the syndromic management of STIs is much more widely accepted.)
- Developed national guidelines for improved care at points of first encounter between the patient and the service provider in 18 countries, including Cameroon, Lesotho, Ethiopia, Malawi, Nigeria, Senegal,

Tanzania, Rwanda, Kenya, Zambia, Morocco, and Madagascar in Africa; Mongolia, Sri Lanka, Thailand, Nepal, Indonesia, Cambodia, and the Philippines in Asia; and Jamaica, Haiti, Honduras, Brazil, and the Dominican Republic in Latin America and the Caribbean.

- Supported regional STI program management training courses for STI/HIV/AIDS managers from Asia, Africa, Latin America, and the Caribbean. As a result of this effort, AIDSCAP published *Control of Sexually Transmitted Infections: A Handbook for the Design and Management of Programs,* the first book to address STI management issues in resource-constrained settings.

- Monitored the clinical services provided for STI patients by performing facility assessments based on the protocol provided by WHO on prevention indicators (PIs). The indicators for evaluating STI case management are PI6 (the number of individuals being treated for STI infection in health facilities who are assessed and treated according to national standards compared with the number who are not assessed and treated correctly) and PI7 (the number of individuals receiving STI care in health facilities who received advice on condom use and partner notification compared with the number of those individuals who did not receive such information).

Because of local constraints, AIDSCAP often altered the method of obtaining the assessment data. For example, several health care providers, especially in the private sector, refused to have their records reviewed or to be observed. In these situations, the health care providers and their patients were interviewed. Sometimes trained individuals posed as mystery patients complaining of an STI. In some situations enhanced reporting forms were used.

While the format and range of topics covered in the WHO guidelines were useful, implementing the evaluation uniformly across countries was difficult. As a result, cross-country comparisons were not valid. However, the individual PI scores, as well as the data that were generated from these evaluations, provided valuable information to training and supervision programs.

- Developed a rapid ethnographic methodology for qualitative research of STI health-seeking behavior to provide the information needed to improve STI services and communication between STI providers and their clients and potential clients.

- Published a targeted intervention research (TIR) manual for use in conducting TIR studies, developed in collaboration with the Johns Hopkins University.

- Conducted TIR studies with community members in Senegal, Ethiopia, the Republic of South Africa, Morocco, Malawi, and, in collaboration with UNICEF, Benin, Swaziland, and Zambia. A TIR also was conducted with sex workers in the Philippines.

- Conducted 17 STI-related studies in 14 countries, published more than 20 articles on STIs in refereed journals, and presented more than 40 abstracts at international and regional conferences.

Lessons Learned and Recommendations

Strengthening STI Services: A Process

Engaging the commitment and resources of STI managers and providers requires significant effort, technical assistance, and consensus building. Through its experience in many countries, AIDSCAP/FHI identified a process that includes data gathering, consensus, implementation, evaluation, and reinforcement. These steps, proposed as a comprehensive, rational approach to establishing improved STI service delivery at the point of first encounter, are described in more detail as follows:

- Gather existing data and/or conduct studies that describe local STI prevalence and identify antimicrobial susceptibility patterns.
- Gather existing data and/or conduct formative research/rapid ethnographic studies that describe local STI beliefs and practices.
- Gather existing data and/or conduct studies that describe local STI prevalence and antimicrobial susceptibility patterns of STI pathogens.
- Convene local health personnel to review data and reach a consensus on national STI treatment guidelines.
- Design, conduct, and evaluate training of local providers.
- Design, pretest, and produce materials for patients and providers based on the findings of formative/ethnographic research.
- Design and pretest messages on STIs for community members based on the findings of formative/ethnographic research.
- Provide follow-up supervision for trained providers and evaluate service provision.
- Implement and evaluate program management training for regional, national, and local managers.

Partner Management Programs

Establishing partner management programs is the key to improving STI control and to solving the dilemma of identifying and treating asymptomatic women. Partner referral and treatment has been a neglected component of STI management in most countries. AIDSCAP/FHI improved partner management systems in Haiti and Rwanda, achieving a partner referral rate of 25 to 35 percent.

Improving Partner Referral

In Rwanda, where partner referral in clinics was minimal, AIDSCAP/FHI found it possible to implement a "passive" partner referral program and identified steps to make it more effective. Providers treated, counseled, and provided partner referral coupons to all patients who entered the clinics with symptoms of STIs. A total of 248 patients, mostly women, received coupons, and 110 partners were treated at the clinics. More women than men accepted the coupons and successfully referred partners. The study findings showed that better counseling and education could increase the number of partners successfully referred for treatment.

Establishing STI Guidelines in Haiti

In Haiti, local providers were impressed by studies showing how ineffective the current STI management practices were when compared with the gold standard laboratory test. The process of developing guidelines began in 1992 with a study in primary care centers in Cité Soleil showing that 90 percent of clinicians treated urethritis with penicillin or ampicillin, antibiotics to which at least 60 percent of gonococcal strains were resistant. The clinicians also failed to treat chlamydial infection, refer sexual partners of STI patients, and screen pregnant woman for syphilis.

Because of limited laboratory facilities, the STI management guidelines were based on the syndromic approach. There was initial resistance to this approach, which included treating chlamydial infection when patients sought treatment for urethritis and cervical infections. The process that followed facilitated the providers' acceptance of this new approach to STI case management.

Studies that tested the WHO syndromic management guidelines in local situations were completed in 1993. The study findings, along with the findings about STI management practices, were shared with local health professionals and program managers, who subsequently reached a consensus about national guidelines. This was followed by provider training. An evaluation conducted 2 1/2 years later showed significant improvement in providers' management of STI cases.

STI Communication

Community STI control demands a multilevel community and clinic communication program. HIV programs have concentrated on raising awareness and knowledge about HIV and decreasing the stigmatization of those infected. As a result, the level of knowledge about HIV is high in most developing countries. The same cannot be said for STIs. A lack of understanding of the modes of transmission, symptoms, treatment, and complications of STIs still exists. Ideally, services should be improved before there is an increased demand for STI control, and the increased demand will be the result of a community's response to a well-crafted communication campaign about STIs.

One hypothesis for the decrease in HIV incidence after improved STI treatment was offered in the Mwanza, Tanzania, intervention trial is that there was a decrease in the duration of infection in patients with STIs. This finding makes it incumbent on STI programs to emphasize that early treatment is critical not only in preventing complications and infection of others but also in decreasing the likelihood of acquiring HIV.

Targeted Intervention Research

The AIDSCAP Project developed the TIR methodology to study community perceptions, beliefs, and practices about STIs as the basis for developing messages and more effective service delivery approaches. The findings of these studies on community perceptions of STIs proved valuable in determining the types of messages and education needed to improve STI control in communities.

The need for these studies resulted from AIDSCAP's recognition that the primary source of treatment for community members with STI symptoms is not established medical facilities. Instead, most people with STI symptoms, especially men, treat themselves with drugs purchased from patent medicine dealers or pharmacies or acquired from friends; many go to traditional healers. Furthermore, the relationship between patient and provider at the clinics is often not good, as TIR studies revealed, because patients experience a lack of privacy, a judgmental attitude from providers, long lines, and ineffective or no antibiotics.

The Client Perspective

Key informant: "I know that a lot of us [older people] will go directly to a pharmacist that we know well. At the health center, the wait is very long and there are many people; there isn't any *soutoura*." (*Soutoura* can be translated as "discretion" or "respect of privacy.")

> "...this is why when I really need a nurse, I go to someone who is retired or working out of his own home at night...."

> "Going to the clinic where everyone is seeking help for something wrong with one's genitals will create gossip where everyone knows everyone."

(From the Targeted Intervention Research Study in Senegal

Alternatives to Clinic-Based Care

TIR results and experience in many countries with limited resources and infrastructures for STI care suggest that alternative non-clinic-based approaches should be considered to help address the critical STI control problems in resource-poor countries.

Many aspects of the STI control model of specialized treatment and referral centers developed in industrialized countries may not be appropriate, feasible, or transferable to resource-poor settings. In these settings it is common for STIs to be

treated by primary health care workers who have received little or no training in STI management. Therefore, STI control must compete for resources with other important and less stigmatized health problems.

The quality of STI care is often in questioned as well. The results of AIDSCAP-sponsored prevalence and antibiotic susceptibility studies showed that the drugs prescribed by health providers are often ineffective. These studies attributed drug ineffectiveness to a lack of laboratory data, a lack of available antibiotics, and the absence of national guidelines based on data.

Individuals tend to receive ineffective antibiotics whether they receive care from established clinics, self-medication, or the informal sector (i.e., pharmacies or retired or off-duty health personnel); therefore, an approach to make effective drugs more available should improve the control of STIs.

Two approaches to addressing this problem—training pharmacy workers in syndromic management and promotion of prepackaged therapy and prevention for urethritis—have been field-tested by AIDSCAP.

STI Treatment Seeking in Africa

In Ethiopia, 61 percent of the men and 41 percent of the women interviewed had sought treatment at a pharmacy or from a local injector or traditional healer before consulting at a health center.

In Cameroon, as many as 50 percent of male patients with a history of acute urethritis in the previous 12 months decided not to seek care in the formal health sector; they self-medicated instead. The reasons for their actions were long lines at clinics, the cost of lab tests, and long waits for test results and prescriptions, as well as the cost and ineffectiveness of the drugs prescribed. (Trebucq 1994).

Training Pharmacy Workers

The training of pharmacy workers is particularly relevant in settings where the health infrastructure is weak and where pharmacy personnel are often the only accessible recourse for medical advice and treatment. Enlisting pharmacy workers in STI management acknowledges the significant though informal role this sector plays in providing STI treatment, patient education (prevention education, instructions on medication use, and partner treatment), and condom promotion and distribution.

This approach, however, does not overcome the problem of patients purchasing partial prescriptions because of lack of funds. Furthermore, it is often difficult in a public business setting to guarantee confidentiality and the privacy necessary for gaining customer trust. Public health authorities and members of the medical profession usually do not object to enlisting pharmacy personnel in patient education, but often oppose training these individuals in STI syndromic management. These officials and practitioners must be engaged as partners in the intervention from the onset.

Nepal Pharmacy Project

In Nepal, where the medical infrastructure is limited, pharmacy personnel were taught to dispense antibiotics using the syndromic approach and to provide clients with preventive education and condoms. A baseline evaluation using a mystery shopper with urethritis symptoms found that 81 percent of the drugstore personnel suggested medications to treat the STI symptoms. Of these individuals, only 0.8 percent suggested effective medication to treat urethritis, 14 percent advised condom use, and 5 percent advised partner treatment. After the training, 45 percent suggested effective urethritis medication, 23 percent advised condom use, and 21 percent advised partner treatment.

Prepackaged STI Therapy

The advantage of attending a clinic for treatment compared to direct purchase of a prescription is minimal because the diagnosis of many STI syndromes is straightforward, especially in diagnosing urethritis in men. The prepackaging of antibiotics for urethritis, along with prevention materials (condoms, partner referral cards, instructions) and educational materials, could well be an appropriate strategy to address the problem of improved STI management through a social marketing approach.

Social norm change, in the form of improved STI management practices by providers and improved treatment-seeking by those with STIs, can be stimulated through prepackaged STI therapy. The package and its contents can shape provider and patient perceptions of STI care by emphasizing the following facts: (1) STIs must be prevented; (2) STIs must be treated quickly with specific drugs; (3) partners must be treated; and (4) condoms must be used to prevent STIs. The use of prepackaged therapy can also reinforce the use of syndromic management by providers and patients.

AIDSCAP/FHI piloted a prepackaged therapy project—*Mstop*—in Cameroon. Ten months after the project started, only 1,421 kits had been sold. Reasons for low sales included lack of access to the kit and the failure of physicians and nurses to prescribe it. Evidence of this failure came from mystery patients. Only 27 percent of the trained health care providers actually prescribed *Mstop* to mystery patients who visited the providers. The other providers requested lab tests first or prescribed other antibiotics that were either prescribed incorrectly or needlessly.

Lessons from Mstop

Assessment of the following options for prepackaged therapy is critical prior to launching a prepackaged therapy initiative: placing the product only in pharmacies with or without the requirement of a prescription; making the product available in STI, maternal and child health/family planning, primary care, or other clinical sites with or without a prescription; and making the product available by prescription only.

Mstop Project in Cameroon

Situation: High incidence of urethritis in young men, high levels of self-treatment, widespread use of inappropriate and ineffective drugs by physicians and pharmacies, and widespread undermedication through partial prescription filling.

Objective: Make effective STI drugs both available and affordable in primary health care facilities and private pharmacies, improve compliance with drug treatment, increase knowledge of STIs in male STI patients, train health care providers in syndromic management of urethritis, and improve partner notification by using attractive referral cards.

Treatment and prevention kit: Included antibiotics for the two major causes of male urethritis, STI education leaflet, eight condoms, and two partner referral cards; obtained by prescription only at U.S.$17; and piloted in a few health care facilities and three pharmacies in Douala and Yaoundé, Cameroon.

Results: Only 1,421 kits were sold in 10 months; only 50 percent of the providers gave prevention advice. Follow-up patients who used the kit showed high levels of satisfaction: 98 percent took the two tablets for gonococcal infection, 83 percent took the 10 days of medication for chlamydial infection, 84 percent used condoms while on treatment, and 44 percent used their partner referral cards.

The feasibility of these approaches depends on the health infrastructure in the country; current response to demands for diagnosis and treatment; sufficiency of the current system or the need for an alternative one; availability and acceptability of STI services to the general public; availability of drugs; current use of alternative sources of care; use of social marketing approaches in other areas such as family planning, midwifery, and condoms; current dispensing practices; the policy environment; availability of STI data; and the receptivity of local collaborators.

- Provider acceptance of syndromic management increases the chances of provider support for prepackaged therapy. Ministry of Health support is essential. Cameroon's drug registration laws were a major issue, and the promotion of *Mstop* available without a prescription was disturbing to the medical community.

- Although the Cameroon project did not achieve the anticipated level of success, the rationale for marketing syndrome-selective kits for STI treatment and prevention remains valid. The final consensus on this approach should be reserved until after it has been thoroughly tested. The concept of packaging effective drugs (ideally single-dose drugs) and prevention material for managing STI syndromes could be modified for specific country situations. Some examples include the following:

- A syndromic package of generic drugs and prevention materials could be sold in public sector clinics as part of a cost-recovery scheme. If sales were limited in the public sector clinics where drugs are often supplied free of charge or for a nominal cost, the pharmaceutical industry might be less resistant.

- A syndromic management kit of effective drugs and prevention materials could be marketed to health care providers through the usual and accepted routes of current pharmaceutical marketing, thus ensuring consistently effective treatment for STI syndromes and reinforcing the syndromic management approach.

- A syndromic management kit could be marketed to pharmacists to be made available by prescription. Drugs that are single-dose and orally administered are preferable because injections would require a return trip to a health care facility. This approach would reinforce syndromic management by health care providers.

- A syndromic management kit could be marketed to the public as an over-the-counter product available without prescription. This approach would be appropriate only for male urethritis, since genital ulcer disease requires an injection and vaginal discharge in women is a nonspecific symptom. This avenue deserves careful study before it can be promoted.

Challenges for the Future

Additional Strategies

The syndromic approach to STI management is not the complete solution for controlling STI. Syndromic management—the recognition of a group of clinical findings and patient symptoms—was developed as a tool that would allow health care workers to effectively manage patients with symptoms without sophisticated laboratory tests, without specialized skills, and within the time frame of a single clinic visit. It works well for urethral discharge in men, genital ulcer disease in both men and women, and pelvic inflammatory disease in women, but is less than optimal for managing vaginal discharge.

Additional components to a comprehensive STI control strategy include the following:

- Targeting services to high-risk populations, which is especially important because resources are often limited.

- Implementing comprehensive syphilis screening and treatment programs in antenatal clinics and referring and treating partners of seroreactive women.

- Developing rapid, inexpensive diagnostics for gonococcal and chlamydial infection to improve the management of symptomatic women and to identify asymptomatic infection.

Improving STI Care for Women

STI prevention and management can be integrated into maternal and child health/ family planning settings even though the case management methods available and the existing health infrastructures have limitations. All clinics should be able to provide prevention services whereby health care providers are able to (1) counsel for the reduction of high-risk behavior, including condom demonstration; (2) recognize and refer women with findings suggestive of an STI found on routine examinations; (3) refer symptomatic women; and (4) discuss STI prevention and contraceptive options.

Better health care for women can also be achieved through syndromic management of symptomatic women and women with clinical findings of STIs; linkages with clinics treating female partners of symptomatic men; screening and treatment of syphilis; and presumptive treatment in high-prevalence settings.

In addition, if laboratory services are available, specific testing for STIs can be done. Clearly, the integration of STI services into reproductive health settings is a challenge that will require a significant amount of operations research.

Innovative Approaches

The critical constraints in resources and infrastructure that are typical of most developing country settings make improved and creative approaches to STI control an urgent need. Periodic empirical treatment of selected STIs among high-risk populations (often referred to as mass treatment) is a potential strategy to achieve a rapid decrease in a community's reservoir of STIs. This approach offers the advantages of achieving a decline in STIs more quickly than sexual behavior changes alone and providing treatment for asymptomatic individuals who would not otherwise seek it. Several potential risks associated with this approach include (1) the antibiotic resistance of STI pathogens and other important pathogens in the community; (2) the disruption of an individual's normal flora and subsequent natural resistance; and (3) an increase in high-risk sexual behavior. Careful research is needed to evaluate this approach. It will also be important to implement and carefully evaluate prepackaged STI therapy and prevention kits and STI prevention marketing.

Antibiotic Resistance

One of the major problems encountered in the management of STIs is resistance against antibiotics, especially for gonococcal infections. Since resistance patterns against antibiotics may differ substantially by region and by country, the adaptation of STI guidelines for country and regional use is hampered by a lack of reliable and representative data on gonococcal antimicrobial resistance. Furthermore, high-level quinolone resistance has been identified in Asia, and it is only a matter of time before quinolone-resistant strains become a global problem.

The establishment of a global network of laboratories using a common methodology for regional and global gonococcal surveillance would greatly facilitate guideline development and updating. In addition, the quality of locally made antibiotics– both the concentration of active ingredient and the bioavailability– should be monitored routinely to ensure that these antibiotics are not contributing to the emergence of gonococcal antimicrobial resistance, especially in Southeast Asia. The availability of effective antibiotics remains a constant challenge.

STI Communication

STI messages must address more than treatment issues. They should promote behavioral risk recognition, partner referral, condom use and other preventive measures, symptom recognition, and treatment-seeking behavior. Furthermore, cost-effective methods should be developed for provider training and supportive supervision to create truly national STI control programs with strong communication components.

Policy

Strategy Overview

A policy is the framework within which an organization makes decisions about planning, operations, and processes. Policies are statements of intent and expected behavior and may be supplemented with laws, regulations, guidelines, and procedural rules. AIDSCAP/FHI viewed policy as relevant and applicable to national and local governments, businesses, and associations, religious groups, and nongovernmental organizations (NGOs).

AIDSCAP/FHI's technical strategy for implementing policy activities was to maintain a supportive environment for effective behavioral change communication, sexual transmitted infection (STI), and condom interventions. The strategy was implemented through a combination of technical assistance to governmental sectors and NGOs in the application of specific policy tools and capacity building of local organizations to engage in the policy development process.

The technical tools used by AIDSCAP/FHI included policy assessments that provided qualitative reviews of major HIV/AIDS issues, existing policy responses, policymaking processes and structures for addressing new issues, and opportunities and constraints for expanding appropriate policy responses to the epidemic. Epidemiologic and demographic modeling projected the future course of the epidemic and its impact, in the absence of effective prevention interventions and policies, on society; socioeconomic impact assessments projected the economic impact of the epidemic on specific sectors, the national economy, and individual households; and cost analysis assessed the overall cost of specific prevention interventions, contributing to decision making on resource allocation and supporting agencies implementing interventions.

AIDSCAP/FHI's technical strategy for policy included six program areas; these did not change appreciably during the project. Several areas, however, were complemented with additional activities.

Accomplishments and Results

Policy Assessments

Policy assessments were completed in eight countries to identify structures and processes within several sectors: government, private-sector businesses, NGOs, and religious. This comprehensive approach to policymaking identified gaps in and opportunities for supporting STI/HIV/AIDS prevention interventions. Policy assessments are valuable for promoting STI/HIV/AIDS prevention, consolidating diverse views and interests, and prioritizing issues.

AIDSCAP/FHI conducted three retrospective assessments of policy responses of the epidemic. Studies conducted in Thailand, Brazil, and Kenya placed both policymaker attitudes and policy actions within a 10- to 15-year context. General comparative findings from the studies emphasized the political and historical uniqueness of each country's response, the strong influence of local pressure groups and internal activists, and how political considerations override even sufficient epidemiologic data.

Preparation of national HIV/AIDS policies or strategies occurred at an early stage of the epidemic in some countries (Indonesia, the Philippines, South Africa) and much later in other countries (Kenya, the Dominican Republic, Zimbabwe). Among the factors that influenced the timing of national policies and strategies are the following:

- The internal cohesion and bureaucratic and political strength of governmental public health services that staffed or supported national AIDS control programs.
- An activist community that formed or coalesced in the absence of governmental responsiveness and took advantage of a "historic moment." For example, gay activists in Brazil took advantage of the country's return to civilian, democratic rule to pursue an agenda emphasizing care and destigmatization. In South Africa, the collapse of the apartheid government allowed public health specialists and anti-apartheid activists to join together in creating a draft national policy, which was adopted by the new government after it took office.

Policy Identification

Identifying both policy issues and appropriate policies is a standard process, but discussing the issues and adopting the policies usually require significant time, sustained analytical input, and focused advocacy, as demonstrated in the adoption of STI syndromic management in Cameroon, Tanzania, Brazil, and Haiti. This adoption of a new approach to STI management by national medical communities was a policy decision and, in many countries, was preceded by validation of the approach and adoption of appropriate guidelines for practitioners.

AIDS in Kenya

In Kenya, policy development included assessments and socioeconomic impact analysis. An important, well-publicized event occurred with the publication of the AIDSCAP/FHI/USAID book, *AIDS in Kenya: Socioeconomic Impacts and Policy Implications*. The book was published in mid-1996 and was officially launched in October 1996. Kenya's vice president was the keynote speaker at the launch, which also featured the U.S. ambassador, the country representative of the World Health Organization, and the director of medical services at the Kenyan Ministry of Health as supporting speakers. The book featured 10 articles by Kenyan and North American specialists, including two senior editors who were AIDSCAP/FHI staff members.

The launch was extensively publicized in both print and electronic media. In addition, the book and various findings were mentioned in articles and editorials in the English-language press. For example, an article in the *Kenya Times* (October 26, 1996) said:

"Although Kenya is in many ways ahead of other countries in understanding the epidemic, the country, however, lacked a cohesive program document before the launching of the book. It is hoped that new policies coupled with recommendations from the book will be pursued in order to prevent the further spread of HIV and to mitigate its impact."

An original printing of 2,000 copies of the book was quickly distributed throughout Kenya and other countries. A subsequent printing of 5,000 copies permitted wider distribution, including hundreds of copies to such organizations as the National AIDS and STI Control Programme, the United Nations Population Fund, and the Kenya AIDS NGOs Consortium.

AIDS in Kenya was the first book-length study in Africa to address the multiple implications of the HIV/AIDS epidemic. Chapter topics included the impact of the epidemic on households, on orphans, on the formal business sector, and on the national economy. A series of case studies focusing on women drew particularly strong attention during the national launch ceremony and in follow-up media coverage. The major finding of the assessment was that although multiple issues surrounding HIV/AIDS concerned many people in Kenya, there had been minimal national leadership and little public debate or involvement in addressing the epidemic.

The policy process can also contribute to building a constituency for development of a longer-term policy, as demonstrated in a project conducted by the Kenya AIDS NGOs Consortium. The project staff solicited policy issues from district and provincial implementing agencies, refined the issues into policy recommendations, and presented the recommendations to the appropriate national authorities.

AIDSCAP/FHI aided the program by including advocacy as a technique to highlight issues and motivate decision makers. In Brazil, advocacy by activists resulted in federal elimination of taxes on condoms, making them more affordable for everyone. In the Dominican Republic, an advocacy strategy to influence the outcomes of national legislation included a timely presentation to high-level policymakers of modeling projections of HIV/AIDS impacts.

Social and Economic Policy Development

The absence of mitigation policies to protect socioeconomic groups from losing their savings by caring for family members with AIDS has become evident as more people move from HIV into full-blown AIDS. Discrimination and stigmatization remain real factors in many communities, perpetuating vulnerability, social instability, and divisiveness. In many cases, policy rhetoric among governmental and religious leaders has not been translated into effective mechanisms that will address discrimination, both formal (e.g., blood tests for insurance coverage) and informal (e.g., some pastors refusing marriage services without HIV tests).

AIDSCAP/FHI was recognized as the lead organization for expanding the scope of economic impact analyses and integrating economic analyses into policy development. Socioeconomic impact assessments were conducted in eight countries with technical assistance from AIDSCAP/FHI, raising awareness of the economic implications of the epidemic. In the Dominican Republic and Honduras, for example, the analyses were presented to senior policymakers and were followed up by local specialists, resulting in legal reform and increased resource allocation for STI/HIV/AIDS prevention.

Policymaker Education

Numerous policymakers in government, religious, and business communities have been poorly informed about HIV/AIDS and its many implications for national welfare and economic development. There are two sides to this finding. First, incomplete data and analyses about the epidemic precluded policymaker education. Second, many policymakers have resisted understanding the epidemic, its transmission patterns, and its long-term impact on local and national institutions. Denial is the catch-all term used to describe these reactions, although the term obscures as much as it illuminates. Effective policy development attempts to understand and address the rationale for denial.

Policymakers often are prepared to act on suggested recommendations for STI/HIV/AIDS prevention when presented with clear and precise information. For example, South Africa's minister of health adopted as national policy a comprehensive NGO-prepared draft of a national response to HIV/AIDS. Policymakers are less likely to act on vague, unsubstantiated recommendations (e.g., "youth should be educated"). Specificity and reference points to familiar data or related issues can facilitate policymaker actions.

Training provided by AIDSCAP/FHI in socioeconomic impact assessments in El Salvador, Guatemala, Honduras, and Nicaragua was directed toward technical and policy specialists, who then were able to influence policymakers. In Senegal, Islamic and Catholic representatives recommended that assistants and spokespersons for religious leaders be engaged in initial dialogue to help guide policy responses.

AIDSCAP/FHI demonstrated the effectiveness of using several policy tools to inform policymakers. Early in the project, epidemiological modeling was seen as most effective in sensitizing policymakers. Midway through the project, socioeconomic impact assessments—building upon epidemologic modeling and economic impact

projections—were found to be a more comprehensive and forceful tool. In turn, socioeconomic impact assessments have evolved to include information on sectoral, household, gender, and national economic impacts.

Policymakers in the private and religious sectors, too, must be sensitized and informed to ensure their involvement in prevention efforts. Surveys of business leaders in several African countries found they were aware of and concerned about the impact of AIDS on business operations but lacked guidance on adopting appropriate policies and prevention programs. Christian policymakers in Kenya collaborated to adopt a public statement endorsing the creation of STI/HIV/AIDS prevention policies within their respective denominations.

Policy Interventions

AIDSCAP/FHI recognized and supported international guidelines on STI/HIV/AIDS prevention but did not directly intervene in the policy process within countries. Rather, through policy assessments, training, and technical assistance, AIDSCAP/FHI supported the efforts of governmental and nongovernmental organizations to inform and influence policy development in government, NGOs, or business and religious organizations. AIDSCAP/FHI also facilitated research, dialogue, and consensus building, which provided information about international and national experiences on specific policies and policy approaches.

Study tours sensitized and informed policymakers. For example, visits to Thailand by Indonesian policymakers helped inform the preparation of Indonesia's national strategy. Even though study tours and other educational efforts targeted policymakers directly, AIDSCAP/FHI emphasized the training of policy "influencers"—the technical and policy specialists inside and outside the government who inform and advise policymakers. Through this training, many people who had believed that policy was not their responsibility realized that they had important roles to play in policy development.

Policy Collaboration

Local organizations need to identify their policy needs and guide the process of policy development. However, most NGOs and business, worker, religious, and community organizations consider "policy" to be a governmental or political function, not their responsibility. AIDSCAP supported the efforts to train these nontraditional groups in policy skills so that they could have a stake in policy outcomes and a role in the policy development process.

Some large businesses showed concern about the impact of HIV/AIDS on productivity and profitability. However, only a few companies initiated prevention programs or adopted prevention policies. Workers' associations also have been slow in making HIV/AIDS a workplace issue, although exceptions exist. Cost-effectiveness data were particularly useful in convincing business owners and managers to support workplace STI/HIV/AIDS prevention policies and programs. AIDSCAP/FHI's Private Sector AIDS Policy package, which has been used in more than 10 countries, includes spreadsheets and examples to help managers calculate the potential financial impact of HIV/AIDS on their workplaces and the cost of a workplace

prevention program. The project worked with hundreds of companies in 27 countries to establish STI/HIV/AIDS prevention interventions for employees and to encourage the adoption of supportive workplace policies.

Collaboration has been a concern of many national AIDS control programs, donors, and NGOs. However, mechanisms to foster collaboration and coordination often are weak, as are mechanisms for interministerial collaboration. Collaboration often arises unexpectedly. A series of study tours by Indonesian policy and technical specialists to review Thailand's response to HIV/AIDS resulted in most of the participants subsequently forming an informal group that helped guide Indonesia's response during the formative months.

AIDSCAP/FHI, together with USAID in Washington, initiated an informal network of economists and other specialists concerned about the economic impact of HIV/AIDS. The AIDS and Economics Network held eight meetings in the AIDSCAP/FHI headquarters, attended by 25 to 50 people representing USAID, the World Bank, the United Nations Development Programme, the Joint United Nations Programme on HIV/AIDS, and several other federal offices and NGOs. A variety of topics were presented and discussed, ranging from the impact of HIV/AIDS on households and tourism to the economics of commercial sex.

Assessing the Impact of HIV/AIDS on the Private Sector

AIDSCAP/FHI conducted studies of 17 African, formal sector businesses to learn about private-sector responses to HIV/AIDS. The findings from this business case study illustrate the key role of this sector.

Most of the managers of the 17 companies reported that after prevention programs had been introduced, they experienced significantly fewer cases of STIs and absenteeism. Many managers commented that the prevention programs helped create a more tolerant and accepting attitude among workers toward HIV-positive employees, resulting in positive effects on morale and productivity.

The managers of the companies recognized the value of the prevention programs. AIDSCAP/FHI's analysis of the financial impact of HIV/AIDS and the cost of prevention for several of the companies confirmed that program costs tend to be about half of losses from AIDS. Other studies also have demonstrated that prevention is cheaper than the losses incurred by businesses as a result of disruptions in production and the increased health and benefit costs associated with HIV/AIDS.

Table 19. Stages of the HIV/AIDS Epidemic and Policy Responses

Categories of Countries	Country Examples	Examples of Existing Policies	Approaches to Stimulate Further Policy Action
Countries with low-scale epidemics and little policy awareness or action	Indonesia, Egypt	NACP created, but lacks resources and adequate staff	Surveillance for accurate data and modeling, study tours, policy assessments
Countries with major epidemics, an outline of a policy plan or strategy but only a limited response by policymakers in one or more sectors	India, Malawi, Burma, Nigeria, Zimbabwe	National plan or strategy exists or drafted, but funding primarily from several donors	Socioeconomic impact studies; studies of youth sexual behavior; examples of other countries; increased media coverage; engaging one or more of the nongovernmental sectors (religion, NGOs, businesses)
Countries with major epidemics, informed policymakers, but without significant policy responses in all sectors	Kenya, South Africa, Tanzania, the Dominican Republic, Jamaica	National strategy or policy exists, some specific laws enacted or considered, all sectors involved	Development of local policy and advocacy capacity; extensive and accurate media coverage; legal and legislative provisions for specific issues, especially for vulnerable populations
Countries with major epidemics and significant policy responses	Thailand, Uganda	National strategy implemented, national funding and other resources committed, specific prevention policies enforced	Maintaining BSS, ensuring ongoing implementation of policies and development of new policies, especially for mitigating impact in special needs populations
Countries with apparent major epidemics, and a few concerned policymakers, but overwhelming resource or conflict constraints that hinder policy responses	Mozambique, Cambodia, Rwanda	National recognition of problem and broad policy statement framed, but minimal national resources available or committed	Policies and strategies for displaced and/or refugee populations, strong promotion of minimal prevention packages

Lessons Learned and Recommendations

- Policy assessments provide a baseline and a context for designing and implementing prevention interventions, preparing case studies, and consolidating incountry thinking and actions on policy issues.

- Policy assessments also may offer recommendations, which must be presented with substantiated information and within the policymaking context of the country and institution concerned.

- Both general and sector-specific policy assessments can offer valid insights and important information for subsequent policy development and advocacy work.

- Given the diverse pattern of the epidemic throughout the world, no predetermined policies can accommodate all countries. AIDSCAP/FHI developed a matrix (as shown in Table X) that reflects this diversity as a guide for policy activists to identify stages of policy responses and tools to facilitate the response.

- Public health responses to HIV/AIDS, no matter how logical and timely, may not be readily adopted by government, political, religious, and business policymakers. It may take 1 to 5 years for policymakers to adopt an initial public health recommendation.

- Unless a compelling economic or political argument exists, efforts to gain public policy guidance on promotion and distribution of condoms, especially to youth, should be avoided or given a low profile. Reactions may make such efforts counterproductive. Social marketing techniques have been effective in stimulating demand and sustaining supply.

- Although social and economic factors contributing to HIV vulnerability and transmission are easy to describe in general terms, little data exist to fully make the case. For example, while poverty is often cited as a risk factor (e.g., women engaging in survival sex and lack of access to information and health care systems), confirming evidence is only anecdotal and may become a point of diversionary argument by policymakers.

- Public-sector resource allocations for STI/HIV/AIDS prevention—either in-kind allocations or allocations obtained through traditional mechanisms, such as delivery of health care services—have been low, except in Thailand and Uganda. Resource allocations have been hindered by the lack of political acknowledgment of HIV/AIDS and the lack of political commitment to prevention programs. Also, competing demands for limited national resources and weak HIV/AIDS bureaucracies have curtailed adequate resources for prevention programs. Several countries, however, have received loans from the World Bank to finance these programs.

- Few mitigation policies have been enacted by national governments. De facto national policies on access to health or medical care have permitted people living with HIV and demonstrating symptoms of AIDS to use no-cost or low-cost public health facilities. Religious-based medical and development organizations have provided treatment and some support for community-based mitigation efforts. A growing number of middle-income countries are subsidizing the purchase of antiretroviral drugs for individuals who are infected with HIV, although unanswered policy questions remain about availability of and accessibility to antiretroviral drugs and related medical care.

- AIDSCAP's experience across regions affirms that policy development is rarely a quick or direct process. It involves engaging political processes that may be vague, time consuming, and even threatening. The processes require negotiation and compromise and may result in outcomes that are unexpected or different than originally envisioned.

- With limited policy capacity, a focus on policy development within government institutions is understandable. However, where governmental and nongovernmental sectors have policy or advocacy capacity, or both, religious and private sector organizations need to be incorporated into discussions and into the formulation of appropriate policy responses to the epidemic.

- Policymakers in any sector are often sensitized by graphic representations of data illustrating the likely impact of the epidemic. They may even ask how the projected impact can be prevented. That sensitization, however, usually will not translate into policy initiatives unless:

  - presentations of the projected impact of HIV/AIDS are accompanied by specific suggestions and recommendations for policymaker discussion and action;

  - recommendations are specific, clear, and practical and can be substantiated with convincing data, including (where possible) indications of the costs associated with recommended actions; and

  - a single presentation (such as the AIDS Impact Model for policymakers) is followed up with additional information, reminders of the proposed actions, and advocacy;

- The value brought by an external agency, such as AIDSCAP/FHI, to national or sectoral policy development is primarily comparative perspectives—what has or has not worked in other countries and in other situations. Even technical expertise is most valuable when offered with comparative examples.

- Policymakers, policy influencers, and technical specialists prefer data and analysis compiled from their own countries or sectors, or both. Occasionally, individuals from each group have resisted conclusions drawn from "similar situations" and have demanded locally relevant data.

- Collaboration is an inexpensive way to expand the advocacy constituency for STI/HIV/AIDS prevention and to share information and experiences. At the same time, organizational collaboration does not just happen; it must be fostered by mutual self-interest.

- HIV/AIDS networks have proliferated, some with AIDSCAP/FHI assistance and others through AIDSCAP/FHI implementing agencies. Several networks are strong and effective—such as the Kenya AIDS NGOs Consortium and the National AIDS Convention of Southern Africa—while others exist in name only. External efforts to stimulate network formation often failed or did not last beyond initial funding. The effective networks succeeded because they served the needs of a diverse membership, had committed and skillful leadership, and had diversified funding sources at an early stage and maintained that diversification. In addition, they provided a service for members and the government, and they engaged in both policy and advocacy activities rather than focusing exclusively on program development and outcomes.

Challenges for the Future

- To identify areas for policy development and to build constituencies for STI/HIV/AIDS prevention, policy assessments should be conducted at the start of a project. The assessment should be as multisectoral as possible. To strengthen advocacy around HIV/AIDS issues, policy assessments should be widely distributed or reported.

- Policy development for STI/HIV/AIDS prevention will yield lasting and informed policy outputs when it focuses on processes. These processes incorporate the following elements: collecting issues from diverse constituencies to test their viability and applicability to different interest groups; prioritizing issues into a short list manageable by organizations, since not all issues can be addressed at once; refining issues with supporting data into viable policy recommendations; and increasing awareness and demonstrating constituent concern by using a variety of education and advocacy techniques.

- Policy specialists should be included, even informally, in the planning or strategizing of condom social marketing campaigns and STI syndromic management adoption.

- The relationship of the HIV/AIDS vulnerability to poverty—or to levels of wealth—and to the causes of poverty are assumed but not sufficiently

described or analyzed. Socioeconomic data on specific groups of people—both high and low risk—are needed to clarify the relationship between HIV/AIDS vulnerability and poverty and to link HIV/AIDS with multisectoral development.

- Many policy tools are needed to increase the ability of local policy influencers to engage policymakers. Such tools include policy assessments and retrospective reviews of policy responses; socioeconomic impact studies and presentations; epidemiological modeling and presentations; prevention tools specific to particular interest groups, such as the Private Sector AIDS Policy materials designed for private-sector managers; and core groups, or teams, of technical and advocacy experts.

- At least 1 year is required to lay the groundwork for informing policymakers and motivating them to action. Thus, realistic timelines and accompanying staff and resources are needed to achieve policy successes.

- Projects like AIDSCAP/FHI must monitor policies, policymaking processes, policy gaps, and opportunities across many countries to facilitate the sharing of information and experiences. Also, AIDSCAP/FHI can encourage countries and organizations to review and adapt internationally sanctioned guidelines. It is inappropriate, however, for external organizations to direct, coerce, or pressure countries or organizations to adopt policies.

- Networks are an important element in HIV/AIDS policy development and advocacy. Effective networks can be supported and strengthened, but not created, by external organizations. Similarly, informal collaboration that serves a specific purpose or that exists for a limited time can be supported by external organizations. Where collaboration is weak, it can be fostered through meetings, study tours, workshops, and similar activities that provide a focus for common discussions and work.

- Policy technical assistance that is overly directive, uses expatriates as spokespersons to senior officials and policymakers, or lacks sensitivity to the multiple factors that influence policy development should be avoided.

Behavioral Research

AIDSCAP

Strategy Overview

Understanding the behaviors that put people at risk of HIV infection remains one of the fundamental challenges of HIV/AIDS prevention. To curtail the HIV pandemic, these behaviors must be changed. However, our understanding of risk-taking behaviors and how they are influenced by community and culture is limited. Behavioral research under the AIDSCAP/FHI Project recognized the twin needs for significant research about human behavior change and research to enhance interventions.

The goal of the behavioral research component of the AIDSCAP Project was to contribute to the scientific understanding of high-risk behaviors through the application of social and behavioral science and to provide methods for modifying sexual behavior to be incorporated into AIDSCAP/FHI prevention activities. The objectives of the behavioral research were to contribute to the basic knowledge of the contexts of behaviors associated with the transmission of HIV, the determinants of these behaviors, and the methods for modifying them; test and analyze the acceptability and sustainability of new behavior change interventions on sexual behavior and condom use; and support the development of the capacity of social scientists from developing countries and from institutions in priority countries to conduct HIV/AIDS behavioral research.

To achieve these objectives, behavioral research conducted under the AIDSCAP Project was facilitated by a set of guiding principles that included advancing the scientific understanding of the AIDS-relevant behavioral, social, and cultural issues; developing proactive research; and adhering to the highest ethical standards.

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Three mechanisms were used to further the objectives: thematic grants, commissioned research, and program-related research. The thematic grants program provided opportunities for theory-based research and capacity building. Each competitive grant was awarded to a collaborative partnership of researchers from developing and developed countries. Commissioned research resulted from discussion and consultation among AIDSCAP/FHI staff, scientists, policymakers, and program implementers. It addressed gaps in knowledge related to the prevention of sexually transmitted infections (STIs) and HIV/AIDS. Program-related research contributed to the design, implementation, and evaluation of specific interventions in priority countries.

Under AIDSCAP/FHI, behavioral research examined issues central to both global and local prevention efforts. Research projects ranged from small, rapid, program-related studies to large-scale, multisite efficacy trials. Reflecting the growing consensus that STI/HIV/AIDS prevention research should move away from solely descriptive research toward rigorous tests of the efficacy of interventions, AIDSCAP/FHI behavioral research not only explored the context and antecedents of behavior, but increasingly emphasized intervention research.

In response to shifts in the epidemiology of the HIV/AIDS pandemic, strategies for conducting behavioral research have changed during the past 6 years. The issues related to the epidemic in most countries are changing rapidly, and information is needed quickly for program and scientific purposes. While long-term thematic grants were favored at the beginning of the AIDSCAP/FHI Project, studies that could provide high-quality information quickly or meet major gaps in knowledge increasingly received priority. The focus shifted from repetitive studies of knowledge, attitudes, and behavior toward studies that provided tangible, program-relevant, and realistic information about how people change.

As the epidemic shifted and expanded, behavioral research also evolved from studying the behavior of traditional high-risk groups to focusing on research with populations not previously deemed to be at risk, such as adolescents and women. In addition, as the numbers of people with HIV/AIDS increased, understanding the risk behavior of those who are HIV-positive and testing interventions to support their behavior change received increasing attention.

Accomplishments and Results

As part of its commitment to building the capacity of local researchers and institutions, behavioral research within AIDSCAP/FHI (including behavioral research as part of evaluation) enhanced the capacity of more than 150 social scientists from developing countries and more than 100 institutions to conduct HIV/AIDS behavioral research in Latin America, Africa, and Asia. In addition, as part of the training in behavior change communication, AIDSCAP/FHI built capacity in conducting formative research with which to design behavioral interventions. Support for the Visiting Scholar's Program, implemented by AIDSCAP/FHI's partner, the Center for AIDS Prevention Studies at the University of California at San Francisco, provided another model for strengthening local research skills. These approaches encouraged the transfer of knowledge and skills, enhanced the acceptability of research results,

Building Practical Research Capacity

Each year as many as 10 scientists participate in the Visiting Scholar's Program at the Center for AIDS Prevention Studies of the University of California at San Francisco. While in San Francisco, they attend seminars on epidemiology, research design, data management biostatistics, and the behavioral and psychosocial aspects of the HIV/AIDS epidemic. But the program's main emphasis is helping the scientists design STI/HIV/AIDS prevention research projects to carry out in their own countries. AIDSCAP/FHI has supported scientists' participation in the program since 1991. Recent behavioral research projects include the following:

- Evaluation of the impact of a social network-focused intervention on beliefs and attitudes about HIV/AIDS and condom use among young, unmarried women in Senegal.
- Comparison of HIV risk behavior and migration among female sex workers in East and West Indonesia.
- Assessment of risk behavior among male clients at a Bombay STI clinic and formative research to design an intervention for HIV-negative STI patients.
- Cross-sectional examination of the barriers to services, including prevention services, for HIV-positive women in Brazil.

Results of these scholars' studies were published in special supplements of the journal *AIDS*.

and gave local researchers a stake in ensuring that their findings were used to improve prevention programs.

The AIDSCAP/FHI behavioral research program contributed to the scientific knowledge of HIV prevention through peer-reviewed scientific articles and presentations at national and international scientific conferences. This contribution includes more than 50 articles in such journals as *AIDS, Journal of the American Medical Association,* and *Social Science & Medicine* and more than 75 presentations of papers at international and regional conferences.

AIDSCAP/FHI behavioral research also demonstrated that theoretical behavior change models developed in the United States provide useful frameworks for examining HIV risk-taking behavior in a variety of cultural and social milieus. The diverse use of different formal theories on HIV risk-taking behaviors confirms that theory can be a valuable and flexible tool for HIV/AIDS prevention in developing countries. Education, information, and persuasion may be changing the HIV-related behaviors of some individuals, but without a theoretical framework, the reasons why some individuals change their behaviors and others do not remain elusive.

Behavioral research under the AIDSCAP Project addressed critical issues of emerging global prevention, such as the role of structural and environmental interventions in reducing HIV incidence and transmission among women in stable relationships and linkages between HIV prevention and care.

AIDSCAP/FHI behavioral research results were used to design effective interventions in many countries. Two examples of these types of interventions are described as follows:

- An application of the health belief model and the theory of reasoned action to an analysis of consistent condom use with commercial sex workers among a sample of 1,472 men living in northern Thailand revealed that both models provided useful frameworks for examining condom use. The theory of reasoned action however, was more useful because it more accurately incorporated peer group effects with sexual risk taking.

- The success of a controlled intervention trial targeting poor young adults (aged 18 to 25) completing their primary and secondary education at night schools in São Paulo, Brazil, led to the development and implementation of a school-based STI/HIV/AIDS prevention program for adolescents in 2,800 public secondary schools in São Paulo state. A total of 300,000 manuals based on the curriculum of this demonstration project were printed and distributed to students throughout São Paulo.

A pilot intervention trial with the Thai military, using the Royal Thai Army's formal command structure as well as informal friendship networks among conscripts, was adapted by the military to provide STI/HIV/AIDS prevention for all recruits.

Lessons Learned and Recommendations

- STI/HIV/AIDS prevention requires a multidisciplinary approach to research.

Research for prevention should not focus exclusively on behavioral issues. Answering many of the most important research questions requires perspectives from such disparate fields as STI management and treatment, social marketing, medicine, counseling, psychology, sociology, epidemiology, communications, and family planning. AIDSCAP/FHI's HIV counseling and testing (C&T) efficacy study provides a good example of a multidisciplinary research project where psychological, behavioral, epidemiological, operations, and cost-effectiveness issues were examined.

- Collaboration with international institutions generates support and a high profile for research.

This collaboration, which brings together highly skilled and experienced researchers, although time consuming, facilitates acceptance of findings because key institutions have been involved in the research process. For example, AIDSCAP/FHI's C&T study

was managed by an executive committee that included local principal investigators, AIDSCAP/FHI and CAPS scientists, and collaborators from the Global Programme on AIDS and UNAIDS.

- Large multisite intervention trials have important and specific roles to play in STI/HIV/AIDS prevention.

Such projects can create opportunities to share resources, make cross-site comparisons, and even pool data to enhance statistical power. However, large-scale

HIV Counseling and Testing for Prevention

Anne, a 22-year-old woman living in Nairobi, decided to get tested for HIV. When she enrolled in the AIDSCAP/FHI C&T efficacy study, Anne received not only an HIV test but also one-on-one personalized counseling. Her negative test result and counseling experience made an impact on her life. As Anne stated, "I used to have many sexual partners before I was counseled and tested for HIV. When I got my results, I decided to get married instead."

The effect of voluntary C&T on the risk-taking behaviors of participants like Anne is exactly what researchers conducting the AIDSCAP/FHI C&T efficacy trial want to determine. By comparing a group of people receiving C&T to a group receiving only standard health information, this multicenter, randomized controlled trial will provide valuable information on the efficacy, cost, and side effects of HIV C&T.

Anne was just one of the 4,298 volunteers who participated in the study at the AIDSCAP/FHI-funded sites in Kenya and Tanzania and at the site funded by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Trinidad. Data were collected on sexual behavior, psychological status, knowledge and attitudes about HIV/AIDS and other STIs, and care-seeking behaviors for STIs, and HIV. Preliminary results include the following:

- A high demand for HIV C&T exists in Kenya and Tanzania, as demonstrated by the daily appearance of several people seeking service at the sites after recruitment for the study ended.
- Many individuals tested for HIV do not return for their results. However, in this study, 85 percent of those participants receiving the C&T part of the study returned for results within 1 week.
- Counselors reported that although couple counseling was challenging, it was also rewarding because it offered an opportunity to assist couples in negotiating behavior change.
- More than 50 percent of the study participants reported that they would be willing to pay up to the equivalent of U.S.$2 for services.

research projects should be reserved for testing technologies and approaches that have not been rigorously evaluated for efficacy and that have global significance, important policy implications, and complex intervention components.

- Rapid, well-designed, and relatively inexpensive studies are useful for projects that are (1) linked to interventions under development, (2) of local or regional interest, (3) associated with interventions that are culturally specific or that vary by population type, or (4) adaptations of successful interventions from other regions or target populations.

For example, a 9-month qualitative study conducted in Nicaragua identified factors and motivations for risk behaviors among commercial sex workers, their clients, and men who have sex with men. Results provided information critical to the development of a national communication strategy for reaching these groups with prevention messages.

- Matching local research institutions with NGOs that implement interventions is an effective way to organize research.

Such partnerships can provide a sustainable source of technical assistance for NGOs. They also help strengthen local research capacity. For example, a Tanzanian NGO collaborated with a researcher from Muhimbili University on a study on the effect on risk behavior of care and support services for people newly diagnosed with HIV. This collaboration enabled the NGO to continue focusing on providing HIV/AIDS services, while the research consultant provided technical assistance in research methodology and data analysis.

- Ethical review of behavioral research protocols by local review boards ensures that the research is culturally sensitive and responsive to the needs of the communities where it is carried out.

Proposals for research should be reviewed and approved by an ethical review committee whose members are thoroughly familiar with the customs and traditions of the community. A local committee typically offers the best perspective on local sexual and social mores and practices, and often has greater credibility with local scientists than committees overseas. Technical assistance to develop viable and appropriate ethical review committees in host countries contributes to research development.

- Research that helps target audiences identify solutions to their own problems can lead to extremely effective program development.

Such research is particularly useful for designing programs and policies to remove or overcome structural and environmental barriers to behavior change. For example, the Thai "100 percent condom policy" has been hailed as an example of the kind of structural and environmental intervention needed to reduce barriers to individual risk reduction. But would the policy work in other countries? An AIDSCAP/FHI pilot 100 percent condom study in the Dominican Republic involved commercial sex workers,

brothel owners, and clients in developing a system of incentives and sanctions that encouraged voluntary compliance with the policy from all involved parties.

- Easy to use research tools—particularly those that help managers adapt and implement interventions—can make important contributions to HIV/AIDS behavioral research.

AIDSCAP/FHI developed a module that guides program managers and researchers in organizing focus group discussions and using the data from those discussions to improve interventions. AIDSCAP/FHI also developed a targeted intervention research package that helps STI program managers at the community level conduct formative research to gain a better understanding of the health-seeking behaviors of clients and the attitudes of providers.

- Formative research, which is often an important tool for program development, can also provide information critical to the development of behavioral studies.

For example, formative research conducted in Tanzania for the HIV C&T study showed that it was not possible to accurately measure depression using psychometric scales validated in the United States and western Europe. An alternative scale was developed to more accurately measure depression using physical manifestations that local psychotherapists noted are more common in East Africa.

Challenges for the Future

Biological Indicators

Interest is growing in the use of biologic data, such as STIs and HIV serostatus, as a proxy measure of risk behavior. Data on self-reported behavior may be biased as a result of poor recall and the social stigma associated with reporting risk behaviors. However, the collection of biological data has its own unique set of problems, including the social and psychological impact of receiving positive HIV and STI results, the need to provide STI treatment (which may function as a strong intervention itself), misclassification bias because of the limits of STI diagnostic capabilities, the inability of HIV serostatus to accurately reflect short-term behavior change, and the high costs of biological testing and associated counseling and treatment. Research is needed to determine how biological outcome indicators can best be used to assess behavioral change.

Integrated Reproductive Health

The shifting focus of the pandemic to women and adolescents requires an expanded response incorporating STI/HIV/AIDS prevention into broader reproductive health programs, but few studies have examined how to do so effectively. Little is known about the policy implications of integrating STI/HIV/AIDS, family planning, and maternal and child health services (MCH); about conducting effective risk assessments in family planning and MCH clinics; about how best to expand such services to adolescents; or the potential impact of integration on family planning outcomes, such as fertility rates. Operations research should be conducted to develop

the best means of expanding family planning, adolescent health, and MCH services to include STI/HIV/AIDS prevention and services.

Prevention and Care Linkages

Individuals living with HIV/AIDS often experience severe social and psychological stress, particularly soon after learning that they are infected. Study results suggest that individuals who are infected with the virus are more likely to infect others when there are few social and psychological services are available to assist them in coping with their HIV status. As the numbers of infected people increase, more research is needed to understand what types of HIV/AIDS support services that are effective in reducing secondary transmission of HIV infection to others.

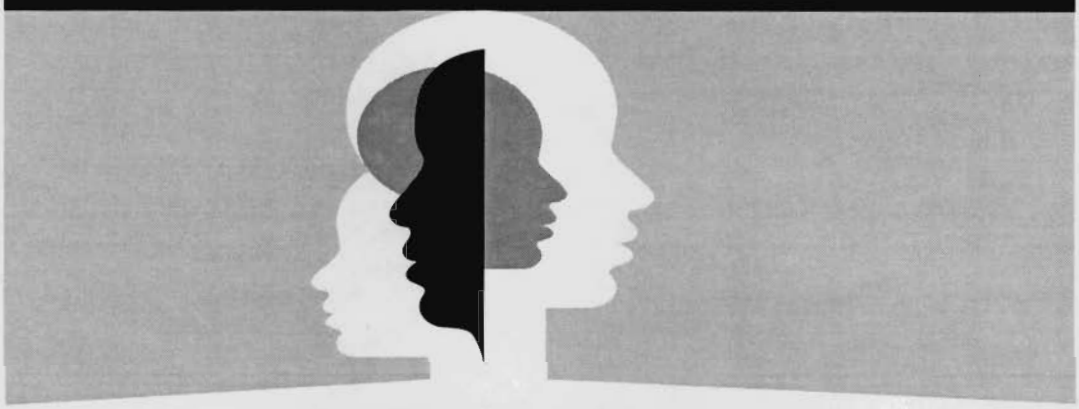
Rigorous Behavioral Research

In an environment where indigenous behavioral researchers are in short supply, where HIV prevention remains desperately underfunded, and where rates of HIV infection are increasing, research is needed to identify the interventions that really work so as not to waste already scarce resources.

Beyond Individual Change

Most behavioral research has examined and targeted behavior change at the individual level. While these studies and the resulting interventions have demonstrated some success in changing individual behavior among certain groups, interventions need to focus on levels of social organization beyond the individual. Research is needed to develop tools that measure contextual change, and other societal-level changes.

Program Support Strategies



AIDSCAP

Program Evaluation

AIDSCAP

Strategy Overview

Program evaluations are not only important for the improvement of ongoing interventions, but also enhance the success of future initiatives. At the same time, however, research priorities must be sensitive to the reality of limited funding and an environment where evaluation can be considered a luxury in the face of the immediate human cost of a rapidly growing epidemic. The job of the evaluator, therefore, is to match research and evaluation approaches not only to the nuances of particular populations and areas, but also to resource constraints.

Determining the type of information and amount of data for an evaluation involves difficult methodological decisions and a trade-off between the quality and utility of the research. AIDSCAP/FHI used multiple quantitative and qualitative data collection methods to address diverse evaluation needs. From the beginning of AIDSCAP/FHI, evaluation was considered fundamental to the success of the project and was incorporated into every phase of the project beginning with the design phase. In addition, AIDSCAP developed and adapted customized approaches for each country program and subproject, and continued adapting these approaches to incorporate lessons learned.

Accomplishments and Results

AIDSCAP/FHI has been an innovator in developing evaluation methodologies for HIV prevention and control programs. Based on its experience of implementing and advancing comprehensive evaluation activities in 18 large country programs, the AIDSCAP Project developed, used, and disseminated tools, methodologies, and lessons learned. These include guidelines for qualitative, quantitative, and process

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data collection; a standardized set of prevention indicators (PIs) that were developed in collaboration with the World Health Organization/Global Programme on AIDS (WHO/GPA), USAID, and the Centers for Disease Control and Prevention (CDC); a larger set of reproductive health indicators developed in collaboration with the USAID Office of Population; a core set of knowledge, attitudes, beliefs, and practices (KABP) survey instruments with complementary focus group guidelines; guidelines for conducting behavioral surveillance surveys (BSS), which are repeated surveys of target groups that track trends in HIV/STI-related behaviors at the country program level; and a methodology for evaluating capacity building, which includes instruments to assess organizational needs and the outcome of capacity building.

In the past six years, the AIDSCAP Project has gathered an enormous amount of evaluation data, particularly, behavioral outcome data (Table 20). The details of evaluation research from specific countries are presented in the individual country overviews (Volume 2).

Lessons Learned and Recommendations

Prioritizing Research Designs

Evaluations of the effectiveness of HIV/AIDS prevention programs should examine short- and intermediate-term program effects (program outcome) and long-term program effects (program impact). Examples of program outcome and impact

Table 20. Overview of AIDSCAP/FHI's Evaluation Research by Year

Year/ Category	KABP Surveys[1]	FGD Studies[2]	Studies Using Indepth Interviews	Assessed Capacity Building	Assessed STI Services (PI6 & PI7)	Condom Audits
1992	8	3	2	0	0	0
1993	20	12	3	0	0	3
1994	22	15	6	0	4	7
1995	39	33	11	0	0	4
1996	61	58	26	5	8	6
1997	17	23	13	4	4	3
Cumulative	167	144	61	9	16	23

[1] Knowledge, attitudes, beliefs, and practices

[2] Focus group discussion

indicators for the different stages are illustrated in Table 21. For interventions designed to reduce sexual transmission of HIV, accurate knowledge about HIV risks, reduction of risk behaviors, and adoption of protective behaviors are considered appropriate short- and intermediate-term outcome indicators. Long-term effects include impact on HIV/AIDS trends, sustainablility issues, and improved societal response.

Table 21. Potential Program Outcome/Impact Indicators

Program Outcome (Short- and Intermediate-Term Effects)	Program Impact (Long-Term Effects)
Changes in HIV/STI-related knowledge	Sustained changes in HIV/STI-related risk behaviors
Changes in HIV/STI-related attitudes	Changes in HIV/AIDS trends
Changes in HIV/STI-related risk behaviors	Improved capacity of community
Changes in STI trends (e.g., gonorrhea)	Reduced individual and societal vulnerability to HIV/AIDS
Increase in social support/community response	*Sustained changes in societal norms*
Changes in societal norms	

It is difficult to disentangle the net effects of a prevention program from the gross outcome and impact observed. Such estimates cannot be made with certainty, but only with varying degrees of plausibility. A general principle applies here—the more rigorous the research design, the more convincing the resulting estimate. However, resources for evaluation activities are limited, and rigorous designs are not always feasible or appropriate for a particular project. From its experiences, AIDSCAP/FHI learned that different research designs are appropriate for different levels of evaluation, and the best practices for program evaluation have changed to reflect what is appropriate and feasible at these levels.

AIDSCAP found that a three-level framework for differentiating evaluation approaches was the most useful and efficient. These three levels are the subproject, country program, and global levels. The subproject, or service delivery level, does not require rigorous research designs to determine effectiveness unless a subproject is a new intervention or a response to an unanswered research question. At this level, evaluation research should be limited to process monitoring, capacity building assessment, and formative evaluation (when needed for project planning). Only in the case of a demonstration project, would there be justification for a more rigorous research design.

At the country program level, AIDSCAP carried out evaluation research on technical intervention strategies and policy and socioeconomic impact. One of the lessons learned at this level is that in a situation where multiple donors are conducting multiple interventions with overlapping target groups, certain types of evaluation are not appropriate at the subproject level, but are appropriate at the country program

Table 22. Quantitative Indicators to Measure Stages of Behavior Change

Stage 1 - Awareness

- Percent of target population who know that HIV-positive persons do not always manifest symptoms.
- Percent of target population who doubt that AIDS exists.

Stage 2 - Knowledge

- Percent of population who can cite at least two acceptable methods of HIV prevention (PI1).
- Percent of population who have easy access to condoms.
- Percent of population who can cite at least two gender-specific signs and symptoms of STIs.

Stage 3 - Risk Assessment

- Percent of population who can state their risk of becoming infected with HIV and who have appropriate justification.

Stage 4 - Action

Indirect

- Percent of population who have discussed STI/HIV/AIDS with their partner (by type of partner).

Stage 4 - Action

Direct

- Percent of target population with at least one nonregular partner during the past 12 months (PI4).
- Percent of target population who used a condom during their last sex act with a nonregular partner (PI5).
- Percent of population who sought appropriate treatment (diagnosis and source of medication) for their last STI screening or HIV testing.

level. Areas for country-program-level evaluation include the technical strategies, including behavioral trend analysis of different target groups using behavior surveillance surveys (BSS), condom social marketing issues, and STI case management; policy and socioeconomic impact assessments; and epidemiologic impact modeling. To conduct these types of evaluation at the country program level, especially in the area of behavior surveillance, is not only cost efficient, but also effective in situations where the particular effects of individual projects implemented by different donors cannot be determined.

The priority at the global level should be to develop new evaluation methodologies and to address global issues with large-scale and rigorous research. New methodologies should include development and testing of new indicators and the use of modeling to evaluate the effects of HIV interventions. Using this multilevel approach (subproject, country, and global) to prioritize the degree of rigor needed to evaluate programs and projects has enabled AIDSCAP/FHI to develop programs that can provide data on worldwide and national epidemic trends while also remaining flexible enough to respond to needs at the subproject level.

Moving Beyond Prevention Indicators

The original AIDSCAP/FHI evaluation strategy stipulated the measurement of behavioral indicators specific to target groups. In the early stages of the project, evaluation plans called for the use of core measures similar to those being developed at the time by WHO/GPA, USAID, CDC, and AIDSCAP. These PIs were intended to measure program impact at the country program level, using a standardized protocol that would allow for comparisons among and between countries. AIDSCAP/FHI used these indicators, but adapted them for specific target groups. The indicators focused on knowledge of prevention (an early stage of behavior change) and later stages of behavior change related to sexual partner networking (contact with nonregular sex partners) and condom use with high-risk partners.

As the project evolved, however, these initial end-stage indicators were perceived as insufficient for evaluating trends in sexual behavior among various target groups. In response to this insufficiency, AIDSCAP/FHI shifted to gender- and target-group-specific evaluation indicators that represented behavior change as a continuum between knowledge of prevention and actual sexual behavior change, including partner reduction and condom use (see Table 22). These indicators continue to be evaluated.

Triangulation: Assessing Progress in Cameroon

AIDSCAP's final evaluation of its HIV/AIDS program in Cameroon illustrates how data gathered using a variety of evaluation methods can enrich our understanding of the outcomes and impact of prevention efforts. Process data, complementary qualitative and quantitative behavioral data, and a limited amount of biological data were used to assess the outcome and impact of AIDSCAP's activities.

In 6 years, the AIDSCAP program in Cameroon, through peer education and community-based outreach, reached more than 180,000 youth, university, and

secondary school students, commercial sex workers, military personnel, transport workers, and owners of bars and hotels. Almost 2,000 peer educators were trained to teach their families, friends, neighbors, and coworkers about HIV/AIDS and to refer them for STI treatment and other prevention services. An aggressive social marketing project sold more than 35 million condoms, with monthly sales in 1996 exceeding the total number of condoms sold in 1989, and more than 1 million educational materials, including videos, radio and TV spots, and printed materials, were disseminated. These process data show that prevention activities occurred on a sufficient level to affect behavior.

The program focused on changing sexual behavior by promoting abstinence for young adults, fidelity for couples, partner reduction, and condom use. Results of pre-post KABP surveys conducted with members of target audiences showed significant increases in knowledge of HIV/AIDS prevention methods among all groups, and indicated significant decreases in the prevalence of high-risk behavior among most of the groups.

One of the program's most important achievements was an increase in the number of persons seeking appropriate treatment for STIs, as STI prevalence is a serious health problem that also contributes to the HIV/AIDS epidemic in Cameroon. The percentage of those reporting that they had sought STI care from a health-care professional rose among university students, military personnel, and commercial sex workers and their clients. For commercial sex workers, there was a dramatic 4-year increase from 32 to 86 percent among. These results suggest that the program's emphasis on improving STI services at health care facilities and referring people to those services was successful.

Training to change providers' attitudes toward STI patients was instrumental in improving STI treatment-seeking behavior, according to Dr. Mpoudi Ngolle, the chief of Cameroon's national AIDS control program. "Now everybody knows how well people are treated in the hospital," he said. "And as a result, they won't hesitate to go there."

Attitudes toward condom use also changed, as condom use rose among female university students, commercial sex workers and their clients, and military personnel, with a particularly significant increase during commercial sex. The percentage of sex workers that reported ever using a condom rose steadily from 28 percent in 1988 to 88 percent in 1996, and the proportion of clients who had ever used a condom also increased, from 55 percent in 1990 to 81 percent in 1996.

Interviews and focus group discussions with commercial sex workers and their clients provided further evidence of a dramatic shift in attitudes toward condoms. "There has certainly been a change in behavior because most of the sex workers today, you will notice that they all use condoms," said one Yaoundé sex worker. "Ten years ago you could not see such a thing in this country. These condoms which have been so decried, so condemned at one time, are now appreciated."

Sex workers reported significant increases in consistent condom use, from 52 percent in 1990 to 75 percent in 1996, but only with men who were nonregular clients.

Triangulation and the Role of Qualitative Research

In practice, AIDSCAP/FHI used nonexperimental observational methods to evaluate behavioral outcomes. It is important to recognize, however, that while a pre-post evaluation design may be useful for assessing a prevention program's proficiency in delivering services, it is not an effective approach for measuring program effectiveness, since the inference of cause and effect from pre-post evaluation data does not take into account alternative explanations for behavior change over time. Behavior change interventions designed to reduce risk behavior must be evaluated and analyzed in such a way that accounts for the social and cultural context within which the intervention program is operating.

The rationale for the AIDSCAP Project's multiple methodology technique for evaluating sexual behavior change is simple: sexual behavior is an extraordinarily difficult area of human behavior to research and understand. Therefore, the use of multiple techniques, or triangulation, to document and interpret reported behaviors helps project managers design better HIV prevention programs. With the multiple technique methodology, findings from qualitative evaluation research and results from quantitative KABP surveys were analyzed together to assess changes in sexual behavior among target groups targeted by AIDSCAP/FHI interventions.

To complement quantitative research methodologies, AIDSCAP used qualitative methodologies to understand the context in which target group-based behavior change is tracked. In a qualitative approach, the contextual interpretation is based on the words of target population members, as direct quotations from transcripts are collected using different qualitative methodologies. Evaluators and implementing agencies working on AIDSCAP/FHI projects used focus group discussions, individual (key informant) interviews, and rapid ethnographic studies to collect qualitative data.

While triangulation is ideal, it poses problems for evaluators' limited budgets and time frames and is further limited by political, social, and cultural realities. Nevertheless, most evaluation experts agree that using qualitative research to complement quantitative data greatly reduces the effect of systemic bias on the data.

Behavioral Surveillance Surveys (BSS)

Quantitative estimates of expected behavioral outcomes require precise assessments of baseline levels and an understanding of how much change is meaningful in the selected intervention settings. Without this knowledge, the tasks of setting sensitive targets for expected levels of change in a pre-post design is difficult.

In response to these limitations, AIDSCAP/FHI moved toward a behavioral surveillance approach, which was first implemented in Bangkok in 1992 and later used in India, Senegal, and Indonesia. Behavioral surveillance is a monitoring and evaluation system designed to track trends in knowledge, attitudes, beliefs, and practices related to HIV prevention in various risk groups within the overall population. Such a system allows for monitoring of decreased risk in some groups and detection of emerging or increasing risk in others. It also helps program managers and stakeholders evaluate program success while reassessing programmatic needs in a changing environment.

AIDSCAP/FHI's behavioral surveillance methodology

- provides more targeted information than systems that collect data on general populations only.
- eliminates the need to collect data separately in a multitude of projects that reach the same target groups.
- ensures comparability and a degree of standardization not necessarily present when data is collected by a variety of different implementing agencies.
- provides data at regular intervals to guide interventions during a project instead of only at the beginning and the end.
- moves focus away from the measurement of unpredictable levels of change toward monitoring trends in various target groups.
- allows evaluators to add or withdraw different target groups from data collection, which ensures an element of flexibility.

Measuring the Potential Impact of HIV/AIDS Interventions

Given the difficulties and high costs associated with direct measurement of the impact of HIV prevention programs through large-scale incidence studies, more emphasis has been placed on developing other methods of assessing impact. These methods involve the use of multiple techniques for examining the relationship between available biological, behavioral, and sociodemographic data. The focus is on establishing linkages between outcome data from program interventions and patterns of HIV prevalence and incidence and on estimating cost-effectiveness.

Assessment methods can be categorized in several ways. Methods include the application of models to estimate the number of HIV infections that were averted because of prevention activities; application and validation of models to estimate HIV incidence rates and prevalence in selected populations; application of methodologies for linking behavioral and biological data; and the expansion of effectiveness analysis to cost-effectiveness analysis.

BSS: Results and Experience from Senegal

When AIDSCAP/FHI first began work in Senegal in 1994, HIV/AIDS-related quantitative data were not available to help programmers design appropriate prevention programs. Only one 1989 survey from Dakar and some Demographic and Health Survey (DHS) data from 1992 existed, and they did not include much information useful for HIV/AIDS prevention strategies. Data on indicators related to knowledge about STI and HIV/AIDS, sexual partner networking, and condom use were needed to plan interventions and to serve as a baseline for future evaluations. With the multitude of interventions serving multiple and overlapping target groups in Senegal, however, it was not practical or efficient to gather baseline data for each one of them.

In 1995, inspired by the success of the BSS in Thailand and other Asian countries, AIDSCAP/FHI decided to apply the methodology in Senegal, its first introduction into Africa. In Asia, the BSS had proved the best means of tracking trends in sexual behavior among target groups, allowing implementing agencies to better gauge the gaps in understanding and behavior to be addressed by interventions. For Senegal, introducing BSS meant that a large amount of previously unavailable information about HIV/AIDS-related knowledge, attitudes, beliefs, and practices in the population would be collected and used to guide HIV/AIDS prevention and control efforts.

In Senegal, as in Asian countries, the first step was to build consensus for the BSS by involving all stakeholders early in the planning stage. The input of the national AIDS control program, AIDSCAP/FHI implementing agencies (IAs), USAID, and other international partners was critical to determining the locations and target groups for BSS and ensuring that the information gathered would be relevant for their programs. At first, some stakeholders were skeptical of the viability of the BSS, but interest slowly grew among the various partners and developed into enthusiastic support as the first round of data collected became available.

Among the valuable information that became evident from the first round of the BSS was the following:

- Although knowledge and awareness about HIV and how to prevent it are quite high, there is a general lack of information about signs and symptoms of STIs, prompting discussion among stakeholders on the need for a shift in BCC strategies.
- Most of the surveyed target groups believe that their risk of becoming infected with HIV is low, and qualitative studies conducted during questionnaire development confirm that most people have never seen a person with AIDS.
- In the target groups surveyed, high-risk sexual activity is fairly uncommon, which seems to partially explain the low levels of HIV found through sentinel surveillance.
- Since five out of six of the target groups surveyed in the first round were low-risk groups (secondary and university students and workers), it is clear that more information about higher-risk groups, such as truckers, merchants, and clandestine commercial sex workers, should be gathered in future rounds of the BSS to help public health planners assess the potential danger of the epidemic in Senegal.

The success of the first round of the BSS led the head of the national AIDS control program to promote its expansion to all regions of Senegal and actively encourage other partners and donors to participate in this effort. One important donor, UNICEF, has already solicited a draft proposal from ISADE, the research firm that implemented the first round for AIDSCAP/FHI, to conduct BSS in other regions of the country.

For example, the newly developed AVERT model is used to estimate the impact of subpopulation-specific behavior changes observed in AIDSCAP/FHI projects on the number of primary HIV transmissions averted. These estimates provide a better understanding of the effect of existing HIV prevention strategies and are also useful to program managers and other stakeholders in their efforts to set priorities for future HIV programming.

AIDSCAP's AVERT Model: A Case Study

HIV/AIDS programs typically measure progress by assessing changes in behavior among target audiences. But financial, logistical, and technical constraints usually make it impossible for them to answer the most important question about a prevention intervention: did the reported behavior change lead to reductions in HIV transmission?

AIDSCAP's AVERT model is an excellent tool for answering that question. This computer model was designed to estimate the number of infections averted through behavior changes resulting from prevention efforts.

AIDSCAP used AVERT to gain a better understanding of the impact of one of the first pilot studies of targeted periodic presumptive STI treatment in the developing world. Such treatment has been proposed as an option for reducing STIs in groups at high risk of infection—particularly high-risk women—who often do not experience STI symptoms and may not seek treatment otherwise.

The study offered free monthly examinations, treatment and counseling, and community-based peer education on STI/HIV prevention, to women engaged in commercial sex and others at high risk of STIs in a South African mining community where migrant employees live away from their families for much of the year. All the women who used the services were treated for the most prevalent STIs in the area with a single-dose antibiotic.

Study results showed that this approach was effective, resulting in dramatic decreases in STI prevalence among the women using the service and their miner partners After just 9 months of intervention, overall STI prevalence had dropped by 30 percent among the commercial sex workers and by 20 percent among their miner clientele.

Since prompt, effective STI treatment and peer education are key HIV/AIDS prevention strategies, the researchers and the mining company managers were interested in estimating the impact these interventions might have had on HIV transmission. Estimates produced by the AVERT model showed them just how powerful an HIV intervention presumptive STI treatment could be in such a high-risk environment.

The model incorporates the most current research on the probability of HIV transmission under different conditions, such as the presence or absence of STI. By modeling pre-post intervention scenarios of high-risk behavior among pairs of target populations, AVERT can produce estimates of the subsequent difference in new HIV infections.

For the analysis of the pilot study in South Africa, AIDSCAP researchers constructed pre-post intervention scenarios based on reported behavior and STI test results. These scenarios included the average number of sexual partners and sexual contacts per partner, overall prevalence of ulcerative and nonulcerative STIs, and condom use. They assumed that the 400 women who had regularly used the STI treatment and counseling services had had sexual contact with 4,000 miners living in the nearby hostels—an assumption based on the conservative estimate that only 40 percent of the miners were engaging in commercial sex.

After 9 months, it was estimated that the overall prevalence of genital ulcer disease (GUD) had dropped by 30 percent and nonulcerative STI rates had fallen by 32 percent. The women had reduced the number of clients by 20 percent, and reported condom use by the clients had increased from 13 to 19 percent. Modeling these scenarios, AVERT estimated that the intervention had averted a total of 237 new HIV infections for the year—40 among the women and 195 among the miners.

The model was also used to project the potential impact of continuing the intervention. It showed that if the project goals of 50 percent condom use in

Table 23. Modeling the Impact of an Intervention in South Africa: AVERT Assumptions and Results

Assumptions	Scenario 1	Scenario 2		Results
avg. annual partners (women)	40	32		
avg. annual contacts per partner (women)	10	10		
avg. annual contacts (miners)	4	3.2		
avg. annual contacts per partner (miners)	10	10		
GUD prevalence	10%	7%		
non-GUD prevalence	25%	17%		
condom use	13%	29%		
Results			Difference	Percent
probable HIV infections (women)	103	62	41	-40%
probable HIV infections (men)	405	209	196	-48%

commercial sex and an 80 percent reduction in STI rates were achieved during the next 2 to 3 years, the estimated annual cumulative incidence of HIV would decline from 52 to 12 percent among the women and from 13 to 29 percent among their miner clientele.

AVERT estimates enabled the researchers to do a cost-benefit analysis showing that for every dollar spent on presumptive treatment and peer education, the mining company had saved more than eight dollars in treatment costs for HIV-related illnesses among its employees. This conclusion persuaded the Harmony Mine management to continue and expand the intervention.

Challenges for the Future

During the 6-year project, AIDSCAP/FHI designed, implemented, and developed evaluation research methodologies capable of bringing qualitative and quantitative data together to help assess the efficacy and cost-efficiency of HIV/AIDS prevention and control programs. The challenges of evaluation and assessment, however, will continue in the next phase of USAID's worldwide HIV/AIDS prevention and control interventions.

Efficacy of Intervention Strategies

There remains a need for a limited number of well-designed efficacy trials of existing intervention strategies, especially behavioral interventions designed to reduce the sexual transmission of HIV and other STIs. These studies must be of sufficient size to yield clear results and should be designed to allow inferences about cause-effect relationships.

Contextual Analysis: Linking Behavioral and Biological Data

Program evaluation is intrinsically complex due to the temporal evolution of epidemics and our poor understanding of how different behaviors and epidemiological factors influence epidemic patterns as they move from an epidemic phase to an endemic state. Changes in HIV prevalence may be indicative of the long-term impact of multiple HIV/AIDS prevention interventions, but it is very difficult to prove that observed decreases in prevalence trends are the result of HIV prevention programs. Other factors such as mortality, migration, and saturation of the population at risk can also account for such changes.

There is an emerging consensus among evaluation experts that prevention programs need to investigate trends in infection alongside trends in behavior that may lead to that infection. To this end, HIV/STI serosurveillance data have to be collected in conjunction with behavioral, socioeconomic, and sociodemographic data. The combined analysis of these sets of data will provide the necessary context and range of information for an interpretation and explanation of the epidemiological data collected by sentinel serosurveillance surveys.

Data Quality

In the next phase, USAID-supported prevention and control programs need to focus

on improving the quality of collected data. Because AIDSCAP/FHI's commitment to capacity building resulted in the involvement of local organizations and researchers in collecting evaluation data, the quality of the data was expected to vary among the different countries. In addition, comparing data from studies and making general conclusions are difficult when studies use different outcome measures or different wordings in survey instruments.

Data collection systems require substantial attention and maintenance to ensure the integrity of the data collected. Besides local capacity building for the collection, analysis, and dissemination of evaluation data, an additional challenge for prevention programs should be the identification of implementing partners dedicated to the quality of evaluation results. Planning evaluation in a participatory fashion is essential for achieving the delicate balance between practical needs and methodological desirability. Active participation of key stakeholders who have a vested interest in the quality and reliability of the results produced by data collection systems is probably the single most important factor for ensuring that data produced by these efforts will be reliable, of good quality, relevant, and timely.

Self-Reported Behavior

The validity of survey data on sexual behavior is very difficult to establish because a limited range of evidence can be collected to provide independent corroboration of the validity of self-reported behaviors. However, it should be emphasized that the quality of data also depends on the level of detail of information elicited by the survey instrument. For example, it is not sufficient to know whether respondents have ever used condoms or whether they have begun to use them. It is also important to determine the frequency of use and to ascertain the conditions that influenced use. This example underscores the need to collect data that are not only valid and reliable but also meaningful.

Emphasis on Sustained Behavior Change

HIV/AIDS prevention programs operating for some years may experience increasing difficulties in detecting changes in outcome variables since the interventions have reinforcing rather than new effects. As a result, the size of potential program effects is becoming smaller, and the sample sizes necessary to measure these effects will increase accordingly. Maintenance of reported behavior change should receive greater emphasis in future evaluations.

Cross-Cutting Issues

Evaluation systems should address cross-cutting issues. In particular, evaluation research should emphasize improved approaches to evaluating capacity building, policy and gender initiatives, social marketing concepts, and alternative nonclinical care strategies.

Program Management

"AIDSCAP has made an outstanding contribution in STI/HIV/AIDS prevention around the world. It is extremely gratifying to see what has been done in six and a half years."

Dr. Helene Gayle, CDC

Program Management

Managing a project the size and scale of AIDSCAP presents unique challenges and unique opportunities. This section of the report examines the workings of the project's management structure, program design, and management processes; special challenges that the project faced; and special programs developed by AIDSCAP/FHI.

Accomplishments and Results

Management Structure

As originally designed, the AIDSCAP Project had a multilayered management structure. It consisted of a strong headquarters (HQ) office with technical, managerial, and administrative support systems; four regional offices (ROs)—one in Asia, one for Latin America/Caribbean (LAC), and two in Africa—with comparable levels of resident expertise; and skeletal (3-person) country offices. Early in the project launch, FHI proposed creating only one regional office in Africa, and USAID agreed. As the following table shows, FHI established its headquarters, all three regional offices, and eight country offices within the first year.

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Table 24. AIDSCAP Offices Established by Year

Year 1	Year 2	Year 3	Year 4	Year 5
HQ				
Asia RO in Bangkok	Africa RO			
	moves to Nairobi			
Africa RO in HQ				
LAC RO in HQ				
Kenya, Brazil, Thailand, South Africa, Haiti, the Dominican Republic, Tanzania, Cameroon	Jamaica, Nigeria, Rwanda, Ethiopia Malawi, Senegal, Nepal, India Lesotho, the Philippines	Honduras, Zimbabwe	Indonesia	Mozambique

Over the life of the project, AIDSCAP/FHI established one headquarters in Arlington, Virginia; three regional offices (in Bangkok, in Nairobi, and at HQ for LAC), and 22 country offices employing a staff of 265 people, of whom 75 percent were field-based. Illustrative of AIDSCAP/FHI's commitment to working in partnership with local human resources, fully 80 percent of resident advisors, AIDSCAP's top field-based managers, were host country or third country nationals from the region and nearly all field staff members below resident advisor were host country nationals.

The role and size of each of these levels evolved over time. As the project was originally envisioned, HQ would provide global technical and managerial leadership, which included managing the initial country program design, serving as the major information dissemination and program/financial reporting centers, and controlling financial disbursements. The ROs would provide technical, managerial, and financial support to the country offices. The country offices, staffed with a resident advisor, administrative assistant, and financial officer, would coordinate the country program with the support of their respective ROs.

While the centralized structure promoted technical quality and fiscal control, it also presented many constraints, which were identified in a 1995 external management

review. These constraints included longer lead times for multilevel program and technical reviews, a frequently overwhelming demand for RO technical support from resident advisors, insufficient monitoring support at the country level, and delays in disbursing funds to field-based implementing agencies (IAs). To address these constraints, AIDSCAP/FHI instituted many structural changes, including a strategic buildup of country office staff and expansion of local consultant use according to the needs of each country program; decentralization of country program design and technical reviews to the ROs; and, where possible, direct disbursements of IA funding by country offices.

Program Design and Management Systems

AIDSCAP/FHI designed comprehensive, multiyear programs in 20 countries around the world. The project used a three-step strategy for program design that incorporated participation by all individuals involved in HIV/AIDS prevention, such as village-based clients, local and national stakeholders, globally recognized leaders, and technical experts.

Step 1. As its foundation the project developed a set of technical strategies incorporating the global lessons and best practices of the time. Technical working groups composed of participants from around the world were convened to guide the design of each technical strategy.

Step 2. At country level, programs were designed using a collaborative, participatory process that identified critical gaps in effective national programs and applied best practices to address country-specific needs. AIDSCAP/FHI used a participatory process to conduct its initial needs assessment in HIV/AIDS prevention, which involved gathering tactical information from and by host country stakeholders and developing a strategic plan for country support.

Step 3. The strategic plan was expanded into a comprehensive implementation plan that specified objectives and anticipated results, incountry implementing partners, technical support needs, a time frame, a budget, and an evaluation plan.

AIDSCAP/FHI followed these steps in designing diverse programs, such as a primarily grassroots nongovernmental organization (NGO) program to address prevention, care, and orphan support in Tanzania; a program that supported and was housed in Jamaica's national AIDS control program; a program in South Africa to address the international isolation and lack of program exposure the country's community-based organizations had experienced; and global HIV/AIDS prevention programming. Most of these programs had annual budgets ranging from $1 to 3 million.

AIDSCAP/FHI also designed smaller programs, with budgets ranging from $50,000 to $1 million, and provided technical assistance in more than 25 other countries. These programs and activities, which provided targeted expertise to national efforts, included strengthening sexually transmitted infection (STI) services in Morocco, conducting a program needs assessment in Papua New Guinea, and evaluating a USAID bilateral STI/HIV/AIDS prevention program in Uganda.

During the project, AIDSCAP/FHI worked with more than 500 local agencies, from small, community-based groups to larger NGOs to local, regional and national government agencies. These groups implemented nearly 800 subprojects, from $500 rapid-response community awareness initiatives to $400,000 multiyear efforts, to effect behavior change among target audiences in communities.

Table 25. AIDSCAP/FHI Implementing Agencies: a Typology

Type of Agency	Total Number of Projects Implemented
Nongovernmental organization	306
Ministry of Health	57
Private voluntary organization	121
For-profit firm	15
Other government agency	3
Other	18

As Table 26 shows, the vast majority of AIDSCAP/FHI subprojects involved the promotion of behavior change. Most of these subprojects also included direct condom distribution or were linked to national condom social marketing (CSM) efforts, and either provided or more often had linkages to STI services.

Table 26. Subproject Program Elements

Technical Strategy	Sole Focus of Subproject	Number of Subprojects
Behavior Change Communication		
Counseling and testing	3	39
Integrated family planning programs	1	2
Mass media	12	70
Materials development	35	167
Outreach	6	98
Peer education	3	166
Theater/drama	7	67
Training	10	77

Sexually Transmitted Infections		
Referrals to STI treatment	0	85
Research	35	18
STI clinic upgrading	2	29
STI management	7	75
Condom Distribution and Logistics		
Condom distribution, free	0	131
Condom sales, non-CSM	0	30
Condom social marketing	13	72
CSM links	1	54
Condom logistics	1	26
Policy	24	23
Behavioral Research	12	7
Evaluation	16	4
Behavioral surveillance	8	5
Women's Initiative	11	6
Program Design and Management	8	7

In addition to special programs to increase participation of community-based groups in HIV/AIDS prevention, AIDSCAP/FHI launched the following program initiatives to address distinct programming needs:

- a competitive grants program that fostered partnerships between U.S.-based private voluntary organizations and developing country NGOs for large ($400,000), multiyear program awards;
- a "domestic areas of affinity" program, which brought together NGOs in the Dominican Republic and Haiti with U.S. AIDS service organizations reaching Dominican and Haitian populations in the United States to encourage sharing lessons and foster collaborative ties;
- the Rwandan refugee program, which demonstrated the importance and feasibility of introducing HIV prevention services into refugee camps and has been used by such groups as the United Nations High Commission on Refugees as a model of such programming; and

- AIDS care and management grants, which pilot tested community-based models for care and prevention programming in resource-poor settings.

Managing the country program was the primary responsibility of the country office's resident advisor and his or her staff. Country offices were responsible for effecting the implementation plan, including negotiating and monitoring subagreements with implementing agencies, coordinating technical support, and tracking progress in implementing the overall country plan.

AIDSCAP/FHI used many mechanisms to monitor subproject results and country program implementation. First, it developed an evaluation plan for each country program at the time of implementation planning. Second, in partnership with implementing agencies, AIDSCAP/FHI identified process and outcome indicators for each subproject and mechanisms for periodically tracking both types of indicators over the life of the project. Finally, AIDSCAP coordinated ongoing oversight and feedback from country, regional, and headquarters levels, including a joint incountry program management review midway through each country program.

The program management review involved representative senior managers from all levels of AIDSCAP in collaboration with USAID central and Mission-level staff and incountry implementing agencies. Their job was to review the implementation plan for continued relevance, examine the level of human and financial resources available to the program, identify problems, and propose necessary modifications and solutions. Program reviews resulted in practical, critical changes, including increasing the emphasis on STI activities in Senegal, broadening the Jamaica program to include western parishes, and reconfiguring or augmenting country staff in many countries. In short, AIDSCAP/FHI's design process—from initial strategic planning to subproject design and program updating—was an ongoing, iterative effort.

Subproject Design Process

Designing subprojects was also an ongoing activity. Although AIDSCAP was a 6-year project, some country programs existed over a much shorter time frame, and subprojects within those country programs had even less time for design and implementation. For example, in Tanzania AIDSCAP/FHI began managing program activities in Tanzania that were continuing from the previous AIDSCOM and AIDSTECH projects. However, the country program was completely reconfigured in AIDSCAP's third year with the launch of the USAID mission's newly designed Tanzania AIDS Project.

Program efforts in Indonesia and Honduras were not initiated until the fourth year four of the AIDSCAP Project. To allow these late-starting programs maximum implementation time, AIDSCAP/FHI tested three mechanisms for "jump starting" the subproject design process. The processes included individual community-based IA strategic planning, joint training of all IAs in effective prevention and care program design, and joint training in proposal development. On the basis of the intensive technical support provided to IAs during the process, AIDSCAP/FHI was able to abbreviate its subproject's technical and financial review process and accelerate its initial disbursement of funding to the IAs. Using these mechanisms AIDSCAP/FHI launched between 10 to 15 subprojects in each country within 3 months.

The advantages of this participatory process included rapid start-up of country programs, team building of all partners in the implementation of the country programs, strong formal and informal linkages between subprojects and AIDSCAP IA partners, and opportunities for joint planning of follow-on technical training and materials development. The process, however, greatly intensified the demand for country office technical support and monitoring.

Capacity Building

A major focus of AIDSCAP/FHI's efforts was building the capacity of partner organizations from developing countries to effectively develop, implement, manage, and evaluate HIV/AIDS prevention programming. Capacity building efforts addressed four major areas: technical skills building, management skills building, organizational systems development, and networking. AIDSCAP/FHI developed tools for assessing the capacity of IAs, including a process enabling IA staff to assess their own organization's strengths and weaknesses, for evaluating the results of capacity building efforts, and for conducting strategic planning. During the life of the AIDCAP Project, 186,967 individuals were trained.

AIDSCAP/FHI not only developed the capacity of the organizations with which it collaborated, but also created strong, effective prevention management teams in its country offices. Acknowledging the value of these critical resources to incountry programming, AIDSCAP/FHI launched its NGO Partnership Initiative in 1996. Under this initiative, the project assisted several of its country offices to register as new, independent NGOs and provided training in business planning, strategic planning, grants management, and financial management. Seven countries—Brazil, Cameroon, the Dominican Republic, Ethiopia, Haiti, Honduras, and Zimbabwe—became independent organizations continuing to provide needed services and support in their countries.

Special Issues

AIDSCAP/FHI faced many unique management challenges during its life, most notably the conversion from a cooperative agreement with USAID to a contract in the second year of the project and the impact of USAID's major reengineering of philosophy and procedures in the fourth year.

The decision by USAID to convert the AIDSCAP Project from a cooperative agreement to a contract created a significantly different relationship between AIDSCAP/FHI and its USAID counterparts. The change inserted an "arms-length" distancing between former collegial partners, narrowing the scope of dialogue permitted by USAID Missions with AIDSCAP/FHI, particularly open consultation about potential program design questions and financial parameters. It also diminished the flexibility that the Missions and AIDSCAP country offices enjoyed to easily and quickly adapt a country's program design in response to lessons learned, emerging opportunities, and the evolution of the epidemic. The conversion caused significant project delays in many because Missions were precluded from joining or augmenting funding to AIDSCAP programs during the extensive conversion process. (For example, Senegal's program start-up was delayed for more than 1 year, and the

Building Sustainable Local Partnerships

Building local capacity involves more than training NGOs in material development and budget development and management. Critical to organizational sustainability is the capacity of institutions to create linkages with local resources to improve impact. Two such models include the NGO and government clusters in Tanzania and the focus site intervention teams (FSITs) in Ethiopia.

In the Ethiopia model, AIDSCAP/FHI encouraged the formation of an FSIT in each of its four major urban program sites. FSIT members included the Ethiopian NGOs funded by AIDSCAP/FHI; the local Ministry of Health units, including the STI clinics upgraded through the program; and the CSM manager for the area. Under the USAID/Ethiopia-funded program, each organization managed its own project and resources, but as community members of FSIT, these groups met regularly to coordinate activities, informally share resources, and lend their support to each other's programs.

In Tanzania, a country with hundreds of local NGOs, the cluster concept provided a mechanism for encouraging formal partnerships among community-based institutions. Under this strategy, NGOs working in HIV prevention and AIDS care in a region were encouraged to develop a joint project that would build on the unique strengths and interests of each organization. A lead or "anchor" organization was elected to coordinate the monthly representational steering committee meetings, disburse project funding according to the joint work plan, and meet donor reporting requirements.

Over time, the clusters broadened and formalized their relationships with local government agencies. To date, nine clusters comprising nearly 200 NGOs have been formed in Tanzania under the USAID-funded Tanzania AIDS Project. The clusters and the FSITs have resulted in less competition, stronger collaboration, and a more sustainable community response.

conversion contributed to Malawi's decision to withdraw from AIDSCAP.) Finally, the conversion required FHI to significantly revise management systems and develop a number of ones and, in some instances, required rescinding policies that encouraged decentralization.

Lessons Learned and Recommendations

AIDSCAP/FHI lessons in program management address four major areas: planning and monitoring, forging partnerships, mobilizing communities, and sustainability.

Planning and Monitoring

- A systematic, participatory planning process articulates a clear vision for a program and provides a framework for implementing programs and assessing their progress. This process needs to be as wide-reaching as possible, involving stakeholders, clients, and other influential people and, most important, the target audience.

- Joint planning by all organizations that will be involved in implementing a country program results in more effective individual projects and encourages valuable collaboration and synergy.

- Effective project monitoring requires intensive on-site support and can be facilitated with easy-to-understand tools that help programs track critical benchmarks and progress toward identified targets.

- Mechanisms for reviewing and revising project objectives, strategies, and activities are essential to ensure that HIV/AIDS interventions remain responsive to the evolving epidemiology of the epidemic and the changing needs of target audiences.

- Ensuring regular input from clients in project design, implementation, and evaluation is essential for effective programming.

Forging Partnerships

- Formal collaborative relationships among all the organizations working on HIV/AIDS prevention in a region can strengthen prevention efforts, create opportunities to share resources, and reduce unnecessary duplication of effort.

- Linkages between international and U.S. domestic HIV/AIDS organizations can be mutually beneficial, particularly when the organizations work with similar populations. Lack of financial support, however, can jeopardize the sustainability of such partnerships.

Mobilizing Communities

- Working with existing organizations—even with groups that have little or no health experience—is generally more effective and sustainable than setting up new ones. Their established constituency bases, service delivery mechanisms, and organizational structures increase the likelihood of their sustainability.

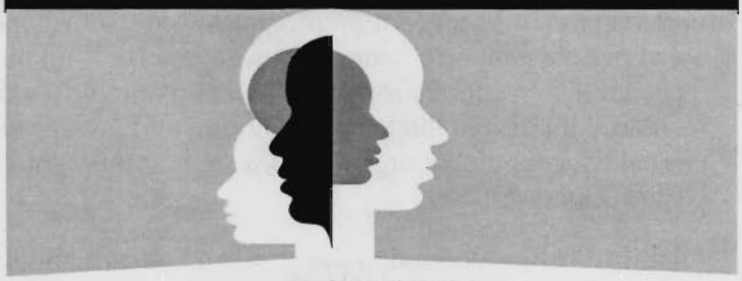
- Even small, community-based groups with little or no previous HIV/AIDS experience can be mobilized to support HIV/AIDS in their communities if funding and reporting mechanisms are kept simple.

Sustainability

- Capacity building and achieving program results should not be seen as conflicting or competing program objectives. Without appropriate attention to capacity building, sustainable results cannot be achieved.

- Sustainability requires effective partnerships between the public and private sectors. Donors should encourage collaboration among all community resources—NGOs, private sector companies, and governments—to capitalize on the comparative advantages and responsibilities of each sector.

Women's Initiative



AIDSCAP

Strategy Overview

A critical development in the epidemic over the life of the project has been the decisive shift of the HIV/AIDS pandemic from a predominantly male epidemic in the early 1980s to one in which HIV infections are rapidly rising among women and girls. Women comprise an increasing proportion of the HIV/AIDS-infected population. Worldwide, the proportion of new HIV infections that occur in women increased from 25 percent in 1990 to 45 percent by 1995.

Sixty percent of all new HIV infections now occur among women aged 15 to 24, with twice as many young women infected as young men in this age group. By the year 2000, it is estimated that the annual number of AIDS cases among women will equal or exceed the number of cases among men. The rising rates of HIV/AIDS in these populations reveal that all sexually active females, including those who are monogamous, are at increasing risk of HIV infection through heterosexual intercourse.

Women are more vulnerable than men to HIV infection for several reasons. First, the sexual transmission of the virus is estimated to be four times more efficient from men to women than from women to men. Second, because of their economic and social dependence on men, women have difficulty refusing unsafe sex or negotiating safer sex. Third, double standards that encourage men to have many sexual partners are common, a practice that places even monogamous women at risk. Women are targeted most often as commercial sex workers (CSWs), despite the increased evidence that where the epidemic has expanded to the general population, other women also are at high risk of HIV infection, primarily through sexual contact with HIV-positive husbands.

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This shift in the epidemic has been accompanied by recent developments in research, advocacy, and policy on reproductive health and sexually transmitted infection (STI) prevention that have emphasized the importance of integrating gender into STI/HIV/AIDS prevention programs. These developments include increased awareness of women's issues, renewed emphasis on the integration of HIV/AIDS into reproductive health, increased resources available for development of microbicides, increased interest in the female condom, and increased recognition of gender as a critical issue by global organizations such as the Joint United Nations Programme on HIV/AIDS (UNAIDS).

AIDSCAP/FHI responded to the growing concern about the impact of the epidemic on women by creating the AIDSCAP/FHI Women's Initiative (AWI) in 1994. AWI focused on integrating gender into all aspects of program design and implementation. Its original goal was to enable women to protect themselves against HIV/AIDS by incorporating women's issues and priorities into AIDSCAP/FHI activities. AWI's efforts were aimed at increasing the proportion of resources focused on women's susceptibility to HIV/AIDS; producing and supporting model AIDSCAP/FHI interventions and research targeting women's vulnerability; integrating women and HIV/AIDS issues into programs of collaborating organizations; and providing training related to women and HIV/AIDS issues. Over the course of the project, and as our understanding of the factors contributing to women's vulnerability expanded, AWI devoted increased resources to improving communication between men and women.

Accomplishments and Results

Because gender is considered a major crosscutting issue, successes related to gender are listed in nearly every section of this report. Only the major accomplishments and results specific to AWI objectives and activities are described in this section.

Institutionalizing Gender

AWI worked to change the way in which organizations and governments define and respond to the gender dimension of the HIV/AIDS epidemic. Its efforts focused on institutionalizing gender in STI/HIV/AIDS prevention by assisting in and monitoring the progress made toward incorporating gender throughout the AIDSCAP Project. To assist with integrating gender into HIV/AIDS prevention, the AWI Council was formed in 1994. The council, comprised of men and women from organizations working in areas of family planning, reproductive health, women's empowerment, and research, advised on the development and implementation of a gender strategy for STI/HIV/AIDS prevention.

As a result of these efforts, more attention has been focused on the gender component of the epidemic, both within AIDSCAP/FHI and in other organizations. More than half of the AIDSCAP/FHI country offices designated a staff person to monitor the gender component of the country program, and evaluation indicators were redefined. A number of governments and government-related groups devoted more resources to gender activities. In Haiti, for example, AIDSCAP/FHI-supported NGOs provided recommendations about women and HIV/AIDS for the National Plan of Action, and in Honduras, the women's governmental office is working with

AIDSCAP/Honduras on strategies to reach women with HIV/AIDS prevention messages and activities.

By introducing dialogue as a potential strategy for institutionalizing gender in STI/HIV/AIDS prevention, AWI expanded thinking on ways to approach the epidemic. AWI sponsored a satellite meeting, held July 6, 1996, at the Eleventh International Conference on AIDS in Vancouver, entitled Men, Women, and AIDS Prevention: A Dialogue Between the Sexes, where 97 participants, including researchers, donors, gay and lesbian groups, activists, and representatives of international organizations from five regions, met to debate issues of sexuality and power for the first time. In response to requests from participants and field offices, a resource guide has been developed to assist those interested in applying the dialogue strategy to their STI/HIV/AIDS prevention programs.

Since the introduction of the dialogue strategy in Vancouver, six countries have expressed an intent to replicate the activity. Follow-up reports and interviews with participants revealed a readiness for this strategy. Participants said such an initiative was "long overdue, a must!" and that dialogue is "the only way that women can approach men in my culture. We cannot 'negotiate' with our men." The dialogue has been formally applied in several countries, including Nigeria, where focus group discussions on the dialogue strategy were conducted among students, religious organizations, market women, and CSWs and their husbands. In addition, research on dialogue was conducted in India among truck drivers and their spouses.

Networking and Collaboration

Through networking and the creation of coalitions, AWI increased attention to mitigating the impact of HIV/AIDS on women in many health, development, and women's organizations, as the following examples illustrate:

- Women and AIDSA Coalition Educating for Empowerment and Prevention, a group of 10 organizations, was spearheaded by AWI to highlight HIV/AIDS at the United Nations Fourth World Conference on Women in Beijing in September 1995. The coalition organized 14 panel discussions and two film festivals; distributed more than 50,000 materials, including press kits; facilitated the publication of an op-ed article in *The Washington Post*; and held three press conferences. The three press conferences featured U.S. Ambassador Sally Shelton, UNAIDS Director Dr. Peter Piot, and Dr. Nkosazana Zuma, Minister of Health in South Africa. In addition, language about HIV/AIDS in women and girls was submitted to the Beijing Platform for Action.

  After the conference, AWI worked with colleagues from other organizations to help translate the Beijing Platform into action. Recommendations from a November 1995 USAID-sponsored meeting on integrated approaches to HIV/AIDS prevention in women were the result of continued collaboration between AWI and USAID to design policy in accordance with the recommendations outlined in the Beijing Platform for Action.

- In collaboration with the Asia Regional Office, AWI advised on the establishment of a women and AIDS network in the Asia region. Representatives from the Chiang Mai University Women's Studies Center, the Society of Women Against AIDS in Africa (SWAA) in Ethiopia and Senegal, and from Cambodia, Lao People's Democratic Republic, India, Burma (Myanmar), Sri Lanka, Thailand, and Vietnam attended a September 1995 workshop to identify objectives for and constraints to creating networks within and among the various countries in the region.

- In an effort to create a network focused on issues related to introducing the female condom more broadly into the STI/HIV/AIDS prevention arena, a conference entitled The Female Condom: From Research to the Marketplace was held in May 1997. More than 130 participants from 19 countries, including experts from service programs, research projects, governments, women's advocacy groups, manufacturers and product developers, marketing organizations, and the donor community, attended. The meeting resulted in a series of recommendations that will serve as the basis for networking and an agreement among the participants to consider and implement a strategy for introducing the female condom in STI/HIV/AIDS prevention programs.

Capacity Building

AWI enhanced the capacity of STI/HIV/AIDS prevention planners and implementers for technical gender approaches to STI/HIV/AIDS prevention programming through gender-training programs and the development of formal networks.

- In collaboration with Regional Development Services Office for East Africa and the AIDSCAP/FHI Africa Regional Office, AWI brought together 41 senior-level policymakers, planners, and implementers of STI/ HIV/AIDS prevention programs in five African countries (Ethiopia, Tanzania, South Africa, Kenya, and Zimbabwe) in 1995 for a series of gender-training and networking activities. These activities trained participants in designing policies and programs that explicitly recognize and address gender issues. The training module from the activity was modified and disseminated for use by other organizations that plan to redirect their programs to reflect gender. It is the first gender-training manual developed specifically for the integration of gender into HIV/ AIDS programs.

  Following the gender and AIDS training for eastern and southern Africa, projects for mainstreaming gender were launched in each of the participating AIDSCAP/FHI countries to reach schoolgirls and their parents, community leaders, women in the commercial sex trade, women advocates, and workplace managers. Participants in the gender training agreed that it had improved their understanding of how to recognize and analyze gender issues in STI/ HIV/AIDS prevention. The impact of the training also reached beyond the projects that participants

A Gender-Sensitive Resident Advisor

"Now I have understood gender for the very first time!" exclaimed AIDSCAP/FHI's resident advisor to Tanzania at the close of a 5-day workshop. She had been among 41 participants brought together for gender training specifically targeting senior-level management of HIV/AIDS prevention programs (USAID health, population, and nutrition specialists; heads of national AIDS control programs and of NGOs; and AIDSCAP/FHI resident advisors). Working as country teams to examine existing projects, participants discovered that addressing issues, policies, and programs from a gender perspective has a critical impact on the success or failure of HIV/AIDS prevention efforts.

Determined to ensure that gender would no longer "go missing" from her programs, the resident advisor organized the retraining of NGO leaders to enhance awareness and develop skills for incorporating gender perspectives in projects into two regional projects. She also conducted a series of workshops that resulted in gender training of NGO leaders in the nine regions of Tanzania targeted by AIDSCAP/FHI and assigned an officer to monitor and evaluate progress made in sustaining a gender focus.

initiated. For example, NGOs implementing the Tanzania AIDS Project in nine regions of the country convened to incorporate gender-specific activities into their programs. Based on its initial success, the gender and AIDS training was replicated in West Africa in July 1997.

- In August 1995, 30 representatives from eight Latin American and Caribbean countries (Bahamas, Bolivia, Brazil, Colombia, the Dominican Republic, Haiti, Jamaica, Nicaragua, and Peru) attended a workshop entitled Planning for the Future of the Epidemic Among Women in Latin America and the Caribbean to create networks, share information on effective models, and elicit commitment to gender-sensitive activities in the region. Through three follow-up meetings, AWI, the Latin America and Caribbean (LAC) resident advisors, and AIDSCAP/FHI's LAC Regional Office developed a formal mechanism for sharing lessons learned, implementing gender and STI training activities, and transferring these lessons to other countries in the region that are not directly linked to AIDSCAP/FHI. The resulting LAC Regional Gender and STI Strategy focused on creating a sustainable, field-driven response to the HIV/AIDS epidemic in women and men.

Enhancing Awareness for Action

Enhanced public awareness of gender and AIDS issues has been accomplished through dissemination of materials, media attention, and publications.

- AWI produced and disseminated approximately 20,000 documents that explain and address the gender dimensions of HIV/AIDS prevention.

They include *A Dialogue Between the Sexes: Men, Women, and AIDS Prevention;* a brochure on model interventions supported by AWI; *One Strong Voice: Writings on Women and HIV/AIDS; Cairo and Beijing: Defining the Women and AIDS Agenda;* and the report and manual set, *A Transformation Process: Gender Training for Top-Level Management of HIV/AIDS Prevention.* A fact sheet on women and HIV/AIDS was translated into three languages and disseminated at numerous conferences.

The dissemination of AWI materials resulted in increased public awareness of and continued demand for information about gender and HIV/AIDS. For example, more than 500 requests for *Cairo and Beijing: Defining the Women and AIDS Agenda* were received following its distribution at the Africa regional AIDS conference in Uganda. The Centers for Disease Control and Prevention selected *A Dialogue Between the Sexes: Men, Women, and AIDS Prevention* from among thousands of publications distributed at the Vancouver Conference for inclusion on its educational materials database website. Four thousand copies of *Cairo and Beijing: Defining the Women and AIDS Agenda* were distributed at more than 10 conferences worldwide.

- Recognizing the importance of the media in shaping public awareness, AWI developed a media strategy to support improved reporting on women and HIV/AIDS. Journalists, social scientists, and HIV-positive persons were brought together to review articles that had appeared in the print media in 50 countries from September 1995 to April 1996 and to identify a recipient of the Award for Excellence in Writing on Women and AIDS, as well as 10 finalists.

  The award, which was sponsored by AWI and UNAIDS, increased the number and the quality of articles published on the subject of women and HIV/AIDS, resulting in heightened public awareness of the vulnerability of women to the epidemic. Participants continued to report on the topic: one finalist wrote a series of radio programs about women and HIV/AIDS. The finalists were recognized in their respective countries, and their articles were compiled and distributed to over 800 persons.

- *Women's Experience with HIV/AIDS: An International Perspective,* edited by AWI Associate Director Dr. E. Maxine Ankrah and Lynellyn D. Long and published by Columbia University Press in November 1996, was the first book to discuss women and HIV/AIDS in both developing and developed countries. Women and women's organizations in the developing world will directly benefit from the sale of *Women's Experience with HIV/AIDS: An International Perspective.* AWI and the PANOS Institute of London agreed that royalties from publication sales would be directed back to the communities that are the focus of the book, women and women's groups.

Research

Research was conducted to understand how best to effectively intervene from a gender perspective.

- AWI, in collaboration with a technical working group, developed an innovative research design for introducing the female condom through women's organizations and groups. The research was conducted in Brazil and Kenya in 1996. These studies attracted women from all socioeconomic classes to try the device as a woman-initiated method of protection against HIV infection. Within the two countries, the research raised issues of cost, access, and government policies related to the female condom and generated media attention for the studies and the device. The research demonstrated the potential of women's organizations to introduce the female condom and provide support to women for its sustained use. Areas requiring further research were identified.

- In collaboration with AIDSCAP/FHI country offices, AWI developed research projects to understand HIV risk factors for both men and women and to assess communication among these groups. Research in Kenya looked at intergenerational communication between mothers and daughters, a study in Senegal examined risk factors and perceptions of risk among market women and their children, and focus groups among adolescents in the Dominican Republic explored their attitudes about sexual behavior. Based on research conducted among market women in Senegal, STI/HIV/AIDS prevention interventions have been designed to reach this population that address the multiple economic and social forces affecting their sexual behavior. In addition, findings on the risks facing the daughters of market women were used to design interventions for these girls.

Lessons Learned and Recommendations

Technical Approaches to Gender

The incorporation of gender into institutions, programs, and policies is hampered by the lack of available and sustainable technical approaches. These approaches must be measurable and based on a set of skills derived from a defined and known theoretical framework. Gender and HIV/AIDS approaches frequently require reformulating existing strategies to give programs a new orientation. Because these approaches evolve over time, they must be tested periodically and modified based on field applications.

Training

Training proved effective in making programs and projects more gender-sensitive. Gender training must be supported with appropriate time, resources, and materials. Gender integration necessitates gender training of staff at all levels to promote changes in attitudes and to develop skills. Where seminars and workshops were held

and staff participated by choice, country and regional programs were generated with a specific focus on women and girls. Examples include the following:

- a gender training in Tanzania modeled after the regional gender and AIDS workshop AWI organized for senior-level managers from eastern and southern African countries;
- LAC modules for research, service delivery, and interventions that were developed by AIDSCAP/FHI resident advisors following gender training;
- a gender-training manual that was produced and distributed for replication of training among senior-level managers in HIV/AIDS prevention.

Dialogue

Dialogue is a viable HIV/AIDS prevention strategy that can supplement efforts at sexual negotiation. It is defined here as a process through which individuals, couples, families, or communities begin to talk and exchange ideas in ways that result in mutually beneficial decisions and that create situations for change. It is also defined as a tool and strategy for encouraging men and women to share information, opinions, and beliefs directed toward changing practices and behaviors related to sexuality and HIV/AIDS.

The dialogue strategy provides a context where established beliefs and values can be challenged, potentially stimulating sustained behavior change. It was applied at the interpersonal, community, and policy levels. Examples include a national conference of decision makers in India, intervention research with truck drivers and their spouses in India, and focus group discussions on the use of dialogue among various target audiences in Nigeria.

Research

Research is a necessary but often neglected component of gender-sensitive strategies. Much of the clinical research on HIV/AIDS in the early period of the epidemic focused exclusively on male problems, with little attention to women. When women did become the focus of research, it was largely to answer questions about their roles as mothers and "core transmitters."

Gender-sensitive research, the aim set by AWI, not only focuses on women but also includes them in the design and execution of the research. It also includes the dissemination of results among women, since the research is conducted to help improve the quality of their lives. Because gender is about men and women, not just about women, AWI focused on a research agenda that included men's sexual behavior, their power relationships with female partners, and their roles as members of the community.

One of the most significant research projects undertaken by AWI was the intervention research on adoption of the female condom in Kenya and Brazil. Using an innovative approach, this exploratory study examined perceptions of, responses to, and sustained use of the female condom when it was introduced into a partner

A Dialogue Between Truck Drivers and Their Spouses

Dr. Goyal had a neatly crafted knowledge, attitudes, beliefs, and practices (KABP) study that had been pilot tested and was ready to be administered among truck drivers and their wives in Jaipur. He was sure that truck drivers would not be persuaded to change their behavior significantly as long as they were targeted as unattached individuals on the go, with only casual relationships with CSWs. He argued that while some of the men were single, most were married and belonged to associations and communities. This assumption provided the impetus for his KABP.

With technical assistance from AWI, the KABP was transformed into an intervention research project to test the introduction of the dialogue strategy with couples at risk of HIV. Dr. Goyal and his team recruited 170 couples to participate. In less than 2 months, more than 90 percent of the couples had engaged in dialogue about HIV/AIDS, and 53 percent of the truck drivers reported using condoms with their spouses for the first time. Dr. Goyal was selected to make an oral presentation of his results at the Third International Biopsychosocial Conference in Melbourne, Australia, and the MacArthur Foundation awarded him a two-year grant to continue the intervention. Colleagues from Calcutta who helped train his researchers to facilitate a dialogue between the truck drivers and their spouses have since introduced the dialogue as a strategy in their programs with truck drivers in that state.

relationship as a method of HIV/AIDS prevention and contraception. The intervention component of the research consisted of two sessions called peer support group discussions. During these discussions, the women shared experiences related to use of the female condom and its impact on their relationships with husbands and other partners. Focus groups discussions were also held with groups of male partners.

Data collected over 3 months showed that 100 Kenyan and 103 Brazilian women respondents accepted the female condom and continued to use it. Overall, the women were positive about the female condom: 75 percent liked the device and nearly a half of the women preferred it to the male condom. Of the male partners, almost 77 percent liked it. The women viewed the female condom as an option when a partner refused to use a male condom, for women who frequently change partners, and for persons in extramarital relationships. Many women from both countries reported being "empowered" by the female condom in their relationships with male partners. The peer support group sessions appeared to have had an important influence on women's acceptance of the female condom and its continued use.

Two other important research project sponsored by AWI were a study of women's lack of power to negotiate condom use in Haiti and a study of Senegalese market women to assess their perceptions of risk, factors contributing to their vulnerability, and their needs for HIV/AIDS prevention. Results from the Senegal study contributed

to the development of an integrated project that provides women with HIV/AIDS information and skills through a project linked with credit and literacy programs.

Evaluation Indicators

Gender-specific indicators must be developed to monitor and evaluate the impact of interventions on women's ability to negotiate safer sex, women's empowerment, and male involvement in HIV/AIDS prevention. Such indicators give program planners and evaluators a clear picture of the impact of interventions on women and men, document progress made in incorporating gender, and provide evidence of success that can be used to leverage resources for interventions. AIDSCAP/FHI was successful in educating its partners and staff of the importance of collecting and reporting data that are disaggregated by gender and in developing evaluation indicators to measure women's empowerment in HIV/AIDS prevention.

Involvement of Men

To ensure the success of HIV/AIDS prevention strategies, men must be drawn into the process of gaining mutual protection. Prevention programs need to move beyond viewing men primarily as sexual beings and recognize their multiple roles in production, reproduction, and participation in the community. Examples of AWI-supported projects that used this approach include intervention research on the dialogue strategy with Indian truck drivers and their wives; the use of clinical settings to counsel men and women on reproductive and sexual health in Brazil; and gender-sensitivity training for Kenyan drivers of *matatus* (vans that serve as informal public transport) that succeeded in encouraging them to treat their partners and female passengers as they would their mothers, sisters, wives, and daughters.

Coalition Building/Collaboration

Collaboration and coalition building should be encouraged as a technical strategy for resource mobilization. In particular, women's organizations and related groups should be targeted and trained in advocacy to influence policies and programs. In Asia and the Pacific, for example, a workshop of women and AIDS networks resulted in (1) a subregional seminar on HIV/AIDS at which representatives from five neighboring Indian states met to create multistate strategies and coordinate the allocation of scarce resources and (2) a project to strengthen an existing network of HIV-positive persons in northeast Thailand by increasing information sharing, income-generation activities, and outreach. The success of the coalition AWI organized to highlight HIV/AIDS at the Fourth United Nations World Conference on Women and of the international journalist's award co-sponsored by AWI and UNAIDS are other examples of the benefits of coalition building and collaboration.

Mechanisms for Institutionalizing Gender

Organizations need a specific mechanism to sharpen and sustain the focus on gender concerns, as AWI's success in institutionalizing gender in AIDSCAP/FHI programs illustrates. While explicit gender language is necessary for documenting activity, changing staff perceptions, and ensuring that gender is included in project design and implementation, it is not sufficient. Institutionalization of gender requires defined, concrete technical approaches and policy and resource support.

Women-Initiated Barrier Methods

Increased research is needed to develop new women-initiated STI/HIV/AIDS prevention methods and to improve women's access to these methods. Research and experience have shown that the male condom is not a feasible HIV prevention option for many women. In AWI's female condom study, for example, more than 70 percent of women from both Brazil and Kenya said they could not convince their partners to use male condoms; none of the women were able or willing to buy male condoms.

Participants at AIDSCAP/FHI's female condom conference in May 1997 agreed on the following recommendations for immediately increasing the availability of female condoms to the general population: (1) begin large-scale introduction in two to three countries; (2) promote the female condom for men as well as women; (3) market the female condom simultaneously through interpersonal and mass media strategies; (4) expedite research on whether the female condom can be used more than once; (5) provide incentives for alternative, less expensive product designs; and (6) disseminate information widely, including to the media.

Women in Development

Globally, women have solved problems, addressed concerns, and established priorities by organizing groups or by networking with other women and organizations that share their interests. Women's groups and indigenous organizations are found in most countries and should be considered as potential implementing agencies for HIV/AIDS prevention activities.

Partnerships with such organizations also facilitate the integration of HIV/AIDS prevention into programs that address broader development concerns. Among the AWI-supported activities that specifically incorporated broader development concerns were an intervention to educate Senegalese market women and their daughters about HIV/AIDS prevention within an integrated credit and literacy program; a project that addressed women's issues in the workplace in Kenya; and credit programs for CSWs in the Dominican Republic.

Challenges for the Future

Understanding Stable Relationships

Few studies have explored the dynamics of sexual communication and control between couples. More research is needed to understand how to help couples develop safe, respectful, mutually satisfactory sexual relationships.

Increasing Women's Options

The enthusiastic response to the female condom in studies and pilot projects throughout the developing world confirms the urgent need for HIV/STI methods that women can initiate and control. Female condoms are a promising option, but their cost has limited their availability to a few developing countries. Efforts to improve access to affordable female condoms and concurrent research to develop microbicides that protect women against HIV and other STIs must be top priorities for prevention programs.

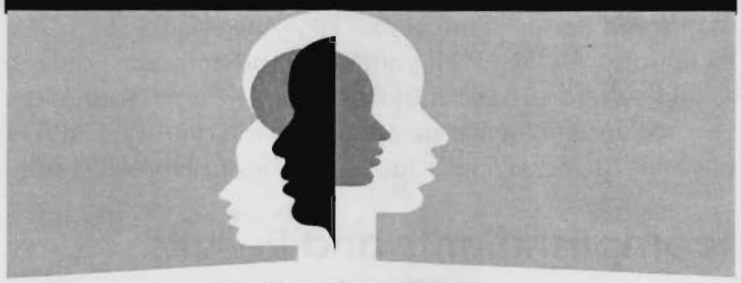
Integrating Reproductive Health

The promise of integrating family planning, HIV and STI prevention, and STI treatment services to reach millions of women through family planning, maternal-child health, and primary health care clinics has yet to be realized. One result is persistent denial, stigma, and lack of commitment to HIV/AIDS prevention. Obstacles include inadequate resources, providers' reluctance to address HIV/AIDS and STIs, a lack of clear technical guidance on how to provide integrated services in a range of settings, and an emphasis on treating and counseling women rather than couples. Operations research is needed to address these constraints before a truly integrated approach to reproductive health can be achieved.

Empowering Women

In many developing countries, women's vulnerability to HIV/AIDS will continue without fundamental changes in their social, economic, and legal status. Income-generating activities linked with HIV/AIDS prevention can empower women to protect themselves from infection, but to date the scope of such activities has been too limited to have a significant impact on the status of women in society or on the spread of the epidemic among women. Political commitment, human and financial resources, and true collaboration among health and development agencies and other organizations are required to empower women through legal reform, increased educational opportunity, and greater access to employment and credit.

Information Dissemination



AIDSCAP

Strategy Overview

One of the legacies of AIDSCAP/FHI will be the information that was collected, shared, and disseminated by the project in the course of the unprecedented experience of directing 540 subprojects in 44 developing countries. Over the 6 years of the project, AIDSCAP/FHI's information dissemination efforts grew substantially, fulfilling two responsibilities of global leadership: the worldwide sharing of information on the HIV/AIDS pandemic and the dissemination of AIDSCAP/FHI's strategies, best practices, and lessons learned for preventing the spread of HIV and other sexually transmitted infections (STIs) in developing countries.

AIDSCAP/FHI disseminated information to AIDSCAP/FHI field offices and implementing agency partners, USAID Bureaus and Missions, policymakers, USAID collaborating agencies, the international HIV/AIDS community, the military in developing countries, and the media. With this information dissemination, AIDSCAP/FHI provided program managers and field implementers in the international HIV/AIDS prevention and control community with the most effective prevention strategies and intervention models and influenced policymakers to devote more resources to HIV/AIDS by giving them with a better understanding of the pandemic.

Originally conceived of as a support mechanism for programmatic and technical activities, AIDSCAP/FHI's information dissemination component grew into a multipronged, proactive program that reported, published, and globally disseminated a wide range of HIV/AIDS-related information. This information included best practices and lessons learned in HIV/AIDS prevention; behavior change communication (BCC) strategies and methods; effective models for designing and

managing STI programs; behavioral research on HIV/AIDS; condom distribution and sales data; policy assessments; socioeconomic impact studies; models for the design, implementation, and evaluation of HIV/AIDS prevention programs; assessments of the status and trends of the global HIV/AIDS pandemic; AIDSCAP/FHI's magazine, AIDScaptions; AIDSCAP/FHI quarterly and annual reports; information on AIDSCAP/FHI's 584 subprojects; country-specific program information, including HIV prevalence and incidence data; information on AIDSCAP/FHI initiatives; and, finally, news about AIDSCAP/FHI's success stories in HIV/AIDS prevention.

Accomplishments and Results

Conferences/Symposia/Workshops

One of the most important information dissemination activities organized by AIDSCAP/FHI was the Third USAID HIV/AIDS Prevention Conference held in Washington, D.C., in August 1995. The 3-day conference was attended by approximately 750 HIV/AIDS prevention professionals from 52 countries. It included 17 plenary speeches, 8 roundtable sessions, and 90 oral presentations, and it received prominent media coverage by the U.S. and international media through WORLDNET TV and the Voice of America. Main topics at the conference ranged across the HIV/AIDS prevention and care continuum, and included communities and the context of interventions, specific strategies and components of behavior change, and the AIDSCAP/FHI plenary speech on a comprehensive approach to the prevention of the sexual transmission of HIV. A 300-page conference proceedings report was distributed to the conference participants and to several thousand other HIV/AIDS professionals around the world.

In October 1997, AIDSCAP/FHI held a special one-and-a-half day lessons learned forum in Washington, D.C., where AIDSCAP/FHI staff and implementing agency partners presented the lessons learned from the project's 540 subprojects in 44 countries. Some 250 people attended the forum, which consisted of 2 plenaries and 12 break-out sessions on such topics as lessons learned in peer education, implementation of behavioral surveillance surveys, advocacy for HIV/AIDS policy, STI syndromic management, HIV counseling and testing programs, and working with women as a primary target audience. Making Prevention Work, the AIDSCAP/FHI global special report on lessons learned, success stories, and accomplishments, was released at this forum. In addition, each major AIDSCAP/FHI country program held a lessons learned conference or series of workshops in 1996 or 1997. These activities were designed to share the lessons learned with implementing agencies, other HIV/AIDS-related programs, nongovernmental organizations (NGOs), donors, and governmental agencies.

Another AIDSCAP/FHI information dissemination activity was organizing the 2-day Status and Trends of the HIV/AIDS Epidemics in Africa Workshop with the François-Xavier Bagnoud Center of Health and Human Rights at the Harvard School of Public Health, which was held in Kampala, Uganda, in December 1995. The first meeting of this kind, the 2-day preconference workshop for 35 international HIV/AIDS experts was held prior to the IX International Conference on STI and AIDS in Africa. A provisional 20-page report was distributed to the conference participants in Kampala,

and the workshop's final report was disseminated worldwide a month later. The lessons learned, best practices, and HIV/AIDS-related information in the final report prompted USAID and the World Bank to reprogram their HIV/AIDS activities in Africa and provided the impetus for a front-page story in *The New York Times* on the epidemic in Uganda.

Based on the success of the Status and Trends Workshop in Kampala, AIDSCAP/FHI organized a similar 2-day symposium with Harvard's Bagnoud Center and the Joint United Nations Programme on HIV/AIDS (UNAIDS), titled the Status and Trends of the Global HIV/AIDS Pandemic. This symposium was a satellite to the XI International Conference on AIDS held in Vancouver in July 1996. The satellite symposium, attended by 50 internationally recognized HIV/AIDS experts, resulted in a 50-page provisional report that was released at a press conference during the Vancouver conference. This report received international media coverage, and 8,000 English copies and 1,000 French copies were distributed to conference participants. The final report was published a month later, and 4,000 copies were disseminated worldwide. Within a few months, the final report was translated into French, Spanish, Portuguese, Russian, and Japanese, and the translations were disseminated worldwide.

Building on the momentum of these two symposia, AIDSCAP/FHI organized the Monitoring the AIDS Pandemic (MAP) Network (December 1996) with the Bagnoud Center and UNAIDS. The goals of the network were to collect and analyze information on the status and trends of the global HIV/AIDS pandemic; to identify the information needs for improved monitoring and forecasting of the HIV/AIDS pandemic and fill those needs; and to monitor the impact of prevention, care, and social interventions on regional epidemics. AIDSCAP/FHI served as the HIV/AIDS interim secretariat for the MAP Network, whose members consist of approximately 100 international HIV/AIDS experts. MAP symposia were convened by AIDSCAP/FHI and its MAP partners in conjunction with the three biennial regional AIDS conferences held in October and December 1997.

Another AIDSCAP/FHI information dissemination activity was the sponsorship of individuals from developing countries to attend regional and global AIDS conferences. In addition to sponsoring AIDSCAP/FHI staff and its implementing agency partners, AIDSCAP/FHI worked closely with USAID Missions to sponsor representatives from governmental and nongovernmental organizations to attend international conferences. Overall, AIDSCAP/FHI supported the attendance of 550 individuals at 15 international conferences. These included: 55 individuals from 13 countries presenting 16 posters and one oral presentation at the global AIDS conference in Amsterdam in 1992; four individuals from two countries presenting one poster at the Asia AIDS conference in New Delhi in 1992; and 28 individuals from 12 countries presenting three oral presentations at the Africa AIDS conference in Yaoundé in December 1992 (AIDSCAP/FHI also held a one-day workshop on behavior change communication and another on sexually transmitted infection prevention at the conference in Yaoundé).

In 1993, 56 individuals from 10 countries presented 12 posters and four oral

presentations, including one plenary speech, at the global AIDS conference in Berlin in June; three individuals from two countries presented one oral presentation at the Latin America AIDS conference in Bogotá in November; and 49 individuals from 14 countries presented five posters and four oral presentations at the Africa AIDS conference in Marrakech in December (AIDSCAP/FHI also held a 2-day workshop on lessons learned in HIV/AIDS prevention). In August 1994, 34 individuals from 12 countries presented 22 posters and six oral presentations at the global AIDS conference in Yokohama.

In September 1995, 52 individuals from seven countries presented 17 posters and eight oral presentations at the Asia AIDS conference in Chiang Mai, Thailand; in November 1995, 19 individuals represented eight countries, and a plenary speech was delivered at the Latin America AIDS conference in Santiago (AIDSCAP/FHI also sponsored two meetings by the Civil-Military Project on HIV/AIDS in Santiago); and, in December 1995, 80 individuals from 12 countries presented nine posters and one oral presentation at the Africa AIDS conference in Kampala, Uganda, where AIDSCAP/FHI also held the first two-day status and trends workshop; a one-day workshop on behavior change communication; a one-day workshop on the control of STIs, including results from the Mwanza study; and two half-day workshops organized by the Civil-Military Project on HIV/AIDS.

At the XI International Conference on AIDS in Vancouver in July 1996, 55 AIDSCAP/FHI staff and implementing agency partners from 18 countries provided 65 poster presentations and 11 oral presentations. In addition, AIDSCAP/FHI conducted the Status and Trends Symposium; a one-day satellite workshop on gender issues; and a conference roundtable on HIV/AIDS and the military that was organized by the Civil-Military Project on HIV/AIDS. AIDSCAP/FHI reproduced and published the learned lessons that were presented in each of the 76 abstracts its representatives presented at the conference in an 80-page booklet and disseminated the booklet worldwide.

In 1997, AIDSCAP/FHI was represented by 22 staff and implementing agency partners at the Asia AIDS conference in Manila in October, by 9 staff and partner representatives at the Latin America AIDS conference in Lima in December, and by 25 staff and partners at the Africa AIDS conference in Abidjan in December. In addition to presenting a number of posters and oral presentations, AIDSCAP/FHI organized MAP symposia with Harvard and UNAIDS in Manila and Abidjan prior to the conferences and in Rio de Janeiro prior to the Lima conference. AIDSCAP/FHI also cosponsored a workshop with UNAIDS in Abidjan on behavioral surveillance surveys.

Throughout the life of the project, AIDSCAP/FHI sponsored hundreds of subproject planning, design, evaluation, and implementation workshops in the 44 countries in which the project was based. While the major objective of these workshops was to build the capacity of developing countries to prevent the spread of HIV/AIDS, they were also important for disseminating information on AIDSCAP/FHI's technical strategies, best practices, model programs, and lessons learned.

Publications

AIDSCAP/FHI staff wrote, produced, and disseminated hundreds of publications in English, French, Spanish, Portuguese, Swahili, Kindi Rwandan, Russian, Japanese, and Pidgin. Publications include 7 books, 60 reports, 3 special reports, 14 magazine issues, 14 newsletters, 10 book chapters, 6 brochures, 28 fact sheets, 7 flyers, and numerous press releases. Since 1991, more than 150 articles written by project staff and implementing agency partners have been published in medical, scientific, and other professional journals. Several representative AIDSCAP/FHI publications are summarized in the rest of this section, and a complete list is included in Appendix A.

- *AIDScaptions*, AIDSCAP/FHI's magazine, was the first magazine to address the prevention of HIV/AIDS and STIs globally. Ten issues were published in English, two in French, and two in Spanish, and readership totaled more than 350,000 people worldwide. Themes of *AIDScaptions* issues included: AIDS and Adolescents: Protecting the Next Generation; Communities and AIDS Prevention; AIDS in Asia; Women and AIDS: Empowerment and Prevention; HIV/AIDS Prevention: Mobilizing the Private Sector; Building Capacity in HIV/AIDS Prevention: Learning from Each Other; STI Prevention: New Challenges, New Approaches; New Paths in HIV/AIDS Prevention; HIV/AIDS Prevention: Perspectives from the Field; and Building on Success: The Next Generation of HIV/AIDS Programs.

AIDScaptions

In many developing countries, *AIDScaptions* has been the only readily accessible source of HIV/AIDS prevention information. The impact of the magazine can be seen in the following quote from a reader:

"I would like to thank you and all the staff who work for *AIDScaptions*. The journal is the main information resource for me since I came back to China. Based on the information I get from *AIDScaptions*, I developed a proposal, Integrating AIDS Prevention into Family Planning in Yunnan, China. We received $55,000 funds from the World AIDS Foundation. The program is going well." Zunyou Wu, Center for AIDS Surveillance and Control, Chinese Academy of Preventive Medicine, Beijing, China

- One of the most important AIDSCAP/FHI publications was the *Control of Sexually Transmitted Infections: A Handbook for the Design and Management of Programs*, which was written collaboratively by more than 40 internationally recognized STI experts. Launched at the Vancouver AIDS conference in 1996, the 325-page book outlines AIDSCAP/FHI's best practices for designing and implementing STI programs in developing countries. It has been well received, and is being used as a text for graduate students at the Harvard School of Public Health, the University of Washington, and the University of

Alabama and as supplementary text at the London School of Hygiene and Tropical Medicine and the Royal Tropical Institute in Amsterdam. UNAIDS, UNICEF, the United Nations Development Programme (UNDP), Médecins sans Frontières, among other international organizations, are also using the handbook in their field programs. AIDSCAP/FHI translated the book into French and Spanish, and some 4,000 copies of the translations were disseminated worldwide.

STD Handbook

AIDSCAP/FHI received more letters of appreciation after publishing its STD handbook than for any other single publication. The following is an excerpt from one letter:

"I received the STD handbook, which has a wealth of information useful to me in STI program management. I will try my best to disseminate knowledge which I gained from this handbook to anyone in the community, in order to enable our country to participate better in STI prevention." Dr. Truong Tan Minh, Khanh Hoa Provincial Health Service, Nha Trang City, Vietnam

- Other important handbooks and publications on best practices in behavior change communication, evaluation, and policy work with the private sector include the BCC handbooks: How to Create an Effective Communication Project: Using the AIDSCAP/FHI Strategy to Develop Successful Behavior Change; How to Create an Effective Peer Education Project: Guidelines for AIDS Prevention Projects; Behavior Change through Mass Communication: Using Mass Media for AIDS Prevention; How to Conduct an Effective Pretests: Ensuring Meaningful BCC Messages and Materials; Assessment and Monitoring of BCC Interventions: Reviewing the Effectiveness of BCC Interventions; and HIV/AIDS Care and Support Projects: Using Behavior Change Communication Techniques to Design and Implement Care and Support Projects.

- AIDSCAP/FHI's Evaluation Tools Modules series includes the following publications: Module 1: Introduction to AIDSCAP/FHI Evaluation; Module 2: Conducting Effective Focus Group Discussions; Module 3: A Framework for Incorporating Evaluation into Project Design; Module 4: Application of a Behavioral Surveillance Survey Tool; and Module 5: Qualitative Methods for Evaluation Research in HIV/AIDS Prevention Programming.

- AIDSCAP/FHI's Private Sector AIDS Policy: Businesses Managing HIV/AIDS kit includes the following publications: Module 1: Introduction; Module 2: Representation, Leadership and Support from Top Management; Module 3: Determining the Impact of HIV/AIDS and the Cost of a Prevention Program to a Workplace; Module 4: Developing

Workplace HIV/AIDS Policies; Module 5: Developing an HIV/AIDS Prevention Program; Module 6: Conducting a Workplace HIV/AIDS Needs Assessment: A User's Guide; Case Studies on Businesses Managing HIV/AIDS; Facilitator's Guide for Conducting Business Manager Presentations and Workshops; and African Workplace Profiles.

- A series of AIDSCAP/FHI special reports was published in the final year of the project to highlight AIDSCAP/FHI's accomplishments, success stories, lessons learned, and best practices. One global special report was a compilation of this information from all AIDSCAP/FHI projects, and two others focused on AIDSCAP/FHI country and programs in Tanzania and the Dominican Republic that could be used as models for other countries or regions. As part of AIDSCAP's information dissemination activities, the special reports were distributed both in their respective countries and regions, and globally.

- By the end of AIDSCAP/FHI, more than 150 peer-reviewed articles about HIV/AIDS or STI issues written by AIDSCAP/FHI staff or implementing agency staff had been published in professional journals around the world. Among the journals in which articles appeared were The Lancet, the New England Journal of Medicine, the Journal of the American Medical Association, AIDS, and approximately 40 others (for a complete list, see Appendix A).

One of the most important dissemination activities of AIDSCAP/FHI, which was lauded by some of the most prominent individuals in the field of international HIV/AIDS prevention, was its dissemination of key journal articles on HIV/AIDS and STI issues. These articles were chosen for their significance and currency in the field. The dissemination of journal articles service was provided four times a year in English and twice a year in French, and each information packet included more than 15 key articles. Special publications and reports, in addition to the articles themselves, were also included. The packets were distributed to approximately 1,000 individuals and institutions in developing countries, where, in many cases, they were the only form of readily accessible, current information on HIV/AIDS-related issues. Thirty packets of articles (for which AIDSCAP/FHI negotiated special rights for dissemination to developing country audiences) were sent, bringing the total number of distributed articles to approximately 450, which included many of the most important articles on HIV/AIDS and STI prevention and care published worldwide from 1991 to 1997.

AIDSCAP's Article Dissemination Service

AIDSCAP/FHI's packets mailings were well received. The following is an excerpt of one example of the positive feedback received:

"I cannot begin to tell you how beneficial and informative the AIDSCAP/FHI mailings have been to me in my three years in Ghana." Joanne M. Hetrick, Ph.D., MPA, CLDir, Family Planning and Health Project, c/o USAID, Accra, Ghana

- AIDSCAP/FHI project reports were published on a semiannual basis from 1991 through 1993. In 1993, AIDSCAP/FHI changed from a cooperative agreement to a contractual agreement. At this time, AIDSCAP began to publish quarterly reports and, from 1994 through 1996, annual reports. This AIDSCAP/FHI final report replaces the AIDSCAP/FHI annual report for 1997, and AIDSCAP/FHI is publishing individual final reports on each of AIDSCAP/FHI's 18 major country programs.

- On behalf of USAID's HIV/AIDS Division, AIDSCAP/FHI produced and published the agency's annual HIV/AIDS reports to Congress and a special biennial version that was disseminated worldwide by mail and at international conferences. Because USAID is the largest donor of funding for international HIV/AIDS activities, this report has been a critically important document to the agency, its implementing partners, other donors, governments, and NGOs worldwide. As it comprised approximately 70 percent of the agency's HIV/AIDS portfolio over the life of the project, AIDSCAP/FHI was in the best position to document overall activities and work closely with other USAID partners and the bureaus and Missions to accurately describe the agency's strategies and project activities.

AIDSCAP publications that document the status and trends of HIV/AIDS worldwide proved to be a valuable source to highlight USAID's work and to track past and future directions of international HIV/AIDS prevention strategies and initiatives.

Films and Video

In 1992, with its precursor project AIDSTECH, AIDSCAP/FHI coproduced a 20-minute, 16mm film, titled *The Faces of AIDS*, in collaboration with local counterparts in Zimbabwe and Cameroon. The film was made in English and French and distributed worldwide. It won two awards, a first place in health category in the 1993 International Black Independent Film, Video, and Screenplay Competition, and a certificate of educational merit in the British Medical Association Film and Video Competition. AIDSCAP/FHI produced a 13-minute projectwide video, *AIDSCAP/FHI:Global Partners in Prevention*, that was shown at the XI International Conference on AIDS in Vancouver in 1996. It was also showcased at three events in Washington, D.C., and on Kenyan, Nepali, and Tanzanian television, and it was translated into Portuguese for TV broadcast in Brazil. The video was disseminated to all AIDSCAP/FHI offices to promote the need for policymakers worldwide to increase support for HIV/AIDS prevention efforts.

Electronic and CD-ROM Dissemination

- In 1996 AIDSCAP/FHI began its electronic dissemination worldwide via the Internet through the AIDSCAP/FHI site on the World Wide Web. More than 30 AIDSCAP/FHI publications, with an emphasis on technical best practices, model projects, lessons learned, and status and trends of the HIV/AIDS pandemic reports, are available electronically

on the website. AIDSCAP/FHI publications are available in English, and some are also available in French, Spanish, and Russian. The website receives more than 17,000 hits per week and is accessed by NGOs, universities, government agencies, donors, and health and development professionals from around the world.

- In the fall of 1997, AIDSCAP/FHI produced and disseminated 1,000 copies of a CD-ROM of more than 300 AIDSCAP/FHI publications, including how-to handbooks, manuals, journal articles, annual reports, project modules, and conference abstracts. The compact disc provides a single mechanism by which a large amount of AIDSCAP/FHI information can be easily distributed to those who have access to this technology. It was launched at AIDSCAP/FHI's Lessons Learned Forum held in Washington, D.C., in October 1997.

Media Outreach

News and information about AIDSCAP/FHI project activities and research results were also disseminated through press conferences, press releases, and other types of media outreach. Broadcast outlets that covered AIDSCAP/FHI include CNN, NBC News, BBC World Service, National Public Radio, C-Span, Radio Germany, Voice of America, WORLDNET TV, JBC Radio West (Jamaica), Kenya Broadcasting Corporation, and Nepal TV, among others. Among the wire services that covered AIDSCAP/FHI were Reuters World Service, Associated Press, United Press International, Kyodo New Service, Cox News Service, Scripps Howard News Service, Deutsche Presse Agentur, Inter Press Service, U.S. Information Agency, Medical News Network, and Earth Times News Service.

Newspapers that covered AIDSCAP/FHI over the 6 years of the project included *The New York Times, The Los Angeles Times,* the *International Herald Tribune, The Christian Science Monitor, The Independent, Financial Post, The Chicago Tribune, Newsday, San Francisco Chronicle, Toronto Globe and Mail, Journal de Genève et Gazette de Lausanne, Folha de São Paulo, Jornal do Brasil, Indian Express, Hindu Times, The Kathmandu Post, The Rising Nepal, Daily Nation* (Kenya), *East African Standard* (Kenya), *Daily Times* (Nigeria), *The Guardian* (Tanzania), *Sunday News* (Tanzania), *The Herald* (Zimbabwe), *Sistin* (Haiti), and many others. AIDSCAP/FHI also received coverage in the journal *Science,* the Brazilian magazines *Claudia, Playboy,* and *Istoé* and in *Africa Health.*

Other Dissemination Activities

Civil-Military Project on HIV/AIDS

From 1994 through June 1997, AIDSCAP/FHI funded the African-Caribbean Institute, which, in collaboration with the Civil-Military Alliance to Combat HIV and AIDS, implemented the Civil-Military Project on HIV/AIDS. The project's goal was to inform military and civilian populations about the need for and methods of STI/HIV/AIDS prevention. Because military populations are mobile, they have played a key role in the transmission of HIV to civilians in developing countries. Their sexual contact with

local populations, including their spouses, girlfriends, and sex workers, puts civilians at risk of HIV and STI infection.

The Civil-Military Project's activities consisted of organizing training workshops and conferences, publishing a newsletter and training documents, and operating a resource center. Training workshops on HIV/AIDS prevention were held in Harare, Zimbabwe; Zomba, Malawi; Kampala, Uganda; Windhoek, Namibia; Santiago, Chile; and Vancouver, British Columbia. More than 660 participants (and an additional 1,000 observers) from some 40 countries attended these workshops. Among the participants were surgeons general, government ministers, army generals, medical commanders, and significant military representation.

More than 26,000 copies of 12 quarterly newsletters (including three in French for Francophone Africa) were published and disseminated, reaching more than 105,000 readers. Proceedings from each workshop, briefing books, other training documents, and five occasional papers were also published and disseminated worldwide. In addition, materials from the resource center were exchanged with individual researchers, planners, trainers, and policymakers in the United States, Africa, Asia, Latin America, and the Caribbean.

The Civil-Military Project was extremely successful in its outreach efforts and information dissemination activities. Based on its achievements and effectiveness, the Civil-Military Alliance has received funding from the European Community, UNAIDS, and the Ford Foundation to continue its initiatives and replicate them in other regions. Also, a branch of the Civil-Military Alliance in South Africa has been funded by the South African military.

AIDSCAP/FHI Library

The AIDSCAP/FHI library has been referred to as the third-best library in the United States for international and domestic information on HIV/AIDS and STI issues. It contains thousands of articles, reports, and books on all issues of relevance in the field. The library filled information requests and performed online searches for AIDSCAP/FHI staff and partners, USAID staff, and collaborating agencies. It also produced AIDS Awareness, a monthly compilation of 75 or more citations of articles and publications on HIV/AIDS and STI issues, for dissemination to AIDSCAP/FHI's 20 field offices and USAID's HIV/AIDS Division.

AIDSCAP/FHI's library housed the AIDSCAP/FHI slide database, which contains descriptions of the more than a thousand 35mm slides and overhead transparencies on HIV/AIDS and STI topics and data that have been used in hundreds of AIDSCAP/FHI's presentations. AIDSCAP/FHI used this database to create an AIDSCAP/FHI slide show documenting the project's strategies and activities that was shown at a variety of venues in the United States and internationally. Both of these audiovisual databases were used frequently by AIDSCAP/FHI and USAID staff to present data at meetings with officials from foreign governments and international agencies, project partners, and target audiences.

Information Requests

In the final year of the project, AIDSCAP/FHI received and responded to, on average, 15 requests for information or materials each day. These included requests for funding information, HIV/AIDS- and health-related information, printed publications, videotapes, posters, and training materials. As funding for international development declined and the HIV/AIDS epidemic expanded in many developing countries, an increasing number of NGOs and government ministries looked to AIDSCAP/FHI for HIV/AIDS resources. Requests came from persons living with HIV or AIDS, U.S. ambassadors, foundations, universities, community groups, physicians, graduate students, village schools, refugee groups, the media, and others. The range and quantity of information requested is, to an extent, a recognition of AIDSCAP/FHI's as a global leader in international HIV/AIDS prevention.

To respond efficiently and comprehensively to information requests, AIDSCAP/FHI used a wide range of resources, including its own materials and publications, reports from the U.S. Bureau of the Census, the Centers for Disease Control and Prevention (CDC) daily news summary, online sources from AIDSCAP/FHI's library, the AIDSCAP/FHI behavior change communication database, and the AIDSCAP/FHI subproject database, and the AIDSCAP/FHI process indicator form database. Other sources of information included governmental agencies, relevant organizations, and universities. All funding requests were referred to at least one potential funding source in the country or region of the request's origin.

Mailing List

Starting with FHI's HIV/AIDS mailing list initially developed for the AIDSTECH Project, AIDSCAP/FHI created an active working list of approximately 10,000 individuals and institutions around the world with interest in HIV/AIDS and STI issues. Most of AIDSCAP/FHI's target audiences for dissemination were in developing countries. During the last two years of the project, however, many U.S.- and European-based organizations and institutions asked to be added to the list as AIDSCAP/FHI became widely recognized not only as an excellent source for HIV/AIDS and STI prevention information for use in developing countries but also in more developed countries.

Lessons Learned and Recommendations

Expansion of Effort

While the value of HIV/AIDS-related information is increasingly recognized, there has not been a commensurate commitment to worldwide information dissemination. In countries where the epidemic is in its early stages, the timely dissemination of up-to-date HIV/AIDS prevention information to policymakers can help thwart an expansion of the epidemic. Any individual or organization involved in HIV/AIDS prevention can also benefit from the dissemination of prevention-related best practices and lessons learned. To this end, information dissemination should be a high priority when staffing and budgeting decisions are made at the beginning of a project, rather than near the end, when it will be too late to have an impact on the epidemic or when project funds have diminished.

Policy Advocacy

One major obstacle to mobilizing resources for HIV/AIDS prevention and care has been the lack of understanding by policymakers of the political impact the epidemic could have on their countries and lack of political will to change the policymaking dynamic. To ensure more effective policy advocacy, more effort needs to be put into packaging HIV/AIDS-related information for policymakers in a language and format that they can readily understand and use. In addition, advocacy activities, such as personal visits, briefings, community organizing, and media outreach, need to be organized to highlight the importance of the information policymakers are given and foster the political will to use it quickly and effectively.

Lack of Staffing

Because AIDSCAP/FHI's information dissemination staff was based at the headquarters in the United States, the project experienced difficulties disseminating lessons learned and best practices in the field of HIV/AIDS prevention and control to AIDSCAP/FHI staff, its partners, and other organizations in the international HIV/AIDS community. Specific individual in prevention and care field projects should be tasked with disseminating information about a project while it is taking place. This will facilitate better cooperation, collaboration, and support during the life of the project; widen the potential for sustainability; and provide a base for sharing lessons learned and best practices with a wider audience.

Donor Collaboration

During the project, AIDSCAP/FHI had difficulty funding the much needed worldwide dissemination of how-to manuals for the field of HIV/AIDS prevention and control. One way to ameliorate this problem would be to pool international donor funds to meet the need to produce up-to-date training manuals, translate them into more languages, and disseminate them more widely and quickly.

Need for Training

AIDSCAP/FHI found that levels of knowledge and technical skill vary greatly among audiences who need HIV/AIDS information. Consequently, some audiences need specific training through workshops or other forums to be able to effectively use the disseminated information. Projects with an information dissemination component should consider including regional training-of-trainers workshops in their planning and budgeting to ensure that materials are understood and used efficiently.

International Exchange

In developing countries, there is interest in up-to-date best practices for STI/HIV/AIDS prevention and control, especially best practices for areas where resources are limited. To this end, efforts to share information among developing country professionals through international workshops, study tours, and conference facilitation need to be expanded. Workshops, tours, and conferences will enable those working in prevention and control to learn from the experiences of their colleagues in other countries without the delay involved in publication and dissemination of best practices and lessons learned.

The Civil-Military Project on HIV/AIDS: Lessons Learned and Recommendations

Confidentiality

Military institutions around the world tend to be insular, protected by confidentiality, disinclined to cooperate with civilian organizations, and committed to secrecy, especially about their own troops and troop deployments. The separation between the military and civil society does not encourage civil-military cooperation, including the reporting of activities about the health and well-being of personnel and commercial sex workers. Nonetheless, militaries in countries with high rates of HIV prevalence have been encouraged to cooperate with civil institutions to prevent and control the spread of HIV. To further encourage civilian-military openness and cooperation, more NGO projects that focus on the military, prevention workshops for military at the garrison town level, and mobile teams visiting military institutions in remote locations should be developed.

Western Military Involvement

At times, the U.S. Department of Defense and the military leadership of NATO do not regard HIV as a high priority, and do not see its spread as a direct threat to their military readiness and combat capability. This lack of support may have a negative impact on the success of international prevention initiatives, as the absence U.S. military leadership in HIV/AIDS prevention and control has lead to other Western militaries drifting away from a serious overseas commitment to assist Asian, African, and Latin American nations. Western militaries tend to position the issue of HIV within the foreign aid agencies of their countries, but by structure and design these agencies do not have easy access to the military in developing countries nor the cooperation common to military-to-military projects. Until HIV is recognized as destabilizing political and military issue in regions of potential crisis, American leadership will be needed to encourage the involvement of other Western nations, including members of NATO, in HIV prevention.

Policy Advocacy

Few surgeons general are experts in HIV or know much of its potential impact. For these leaders, HIV is a new threat that plunges them into the uncertain world of sexuality, sex-based politics, condom issues, church issues, gay issues, and other potential career-curtailing pitfalls. The usual reaction is not to deal with these issues, or to delegate them to a lower echelon and avoid or deny their importance. Efforts must be made to recruit high-level advocates in national governments who will support HIV prevention and be willing to speak out on behalf of prevention programs.

Gender Bias

In developing countries, women in military service, including officers and enlisted women, wives of soldiers, and civilian women working for military institutions, are often subject to discrimination. In garrison towns and neighborhoods surrounding military bases, women live in conditions that lead to bias, harassment, and

occasionally violence, particularly in bars and brothels. Commercial sex workers near military bases often live in unsanitary conditions and have limited access to condoms, health advice, or health care services. NGOs need to address gender-related and women's health issues in these situations as part of a comprehensive HIV/AIDS prevention and control program.

"Safe Zone" Forums

One way that AIDSCAP has effectively dealt with civilian-military prevention and control coordination has been the "safe zone" forum. First developed at the Civil-Military Workshop in Namibia in 1997, a safe zone forum is a setting where representatives of military bases (particularly in garrison towns) and representatives of commercial sex workers meet to coordinate and develop joint HIV prevention policies. Issues such as condom use, alcohol control, behavior in brothels, control of violence against women, codes of sexual conduct, and education for commercial sex

Appendixes

AIDSCAP

Presentations and Publications

AIDSCAP

AIDSCAP Presentations and Posters (Summary) 1992

Lamptey P. AIDS in Developing Countries. Great Decisions Seminar. University of North Carolina at Chapel Hill, North Carolina, March 10, 1992.

Hollerbach. P. Presentation on heterosexual and perinatal transmission of HIV. World Affairs Council of Washington, D.C. Washington, D.C. March 18, 1992.

Lamptey P. Presentation on accomplishments and lessons learned from AIDSTECH: An update on the AIDSCAP program. World Health Organization/Global Programme on AIDS. Geneva, Switzerland. May 1 - 5, 1992.

Lamptey P. Presentation on general information concerning AIDS in developing countries. North Carolina Central University, Durham, North Carolina. May 11, 1992.

Lamptey P. Presentation concerning general information about AIDSTECH, AIDSCAP. Meeting on effective approaches to AIDS prevention. World Health Organization. May 24 - 29, 1992.

Hollerbach P. Participant at roundtable discussion on *The AIDS Pandemic: Global Scourge, U.S. Challenge.* Fifth Annual Great Decisions Book Review Program. Washington, D.C. June 6, 1992.

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Lamptey P. Presentation on AIDSTECH and AIDSCAP. Congressional forum on the HIV/AIDS pandemic. Washington, D.C. June 25, 1992.

Hollerbach P. Presentation on heterosexual and perinatal transmission of HIV. World Affairs Council of Washington, D.C. Washington, D.C. June 1992.

Dubow J. IEC technical working group. World Bank. Washington, D.C. June 1992.

Lamptey P. Participant at II International Congress of Behavioral Medicine. Hamburg, Germany. July 15 - 16, 1992.

VIII International Conference on AIDS/II STD World Conference. Amsterdam, the Netherlands. July 19 - 24, 1992.

Poster Presentations:

Apeagyei. Combat Readiness: Condom Readiness.

Bailey. Heterogeneity Among Commercial Sex Workers and Commonalities of Condom Use.

Barth. Reducing the Risk of HIV Infection: An Operations Research Project on Educational Strategies to Prevent AIDS in Costa Rican Young People.

Calica. We're Safe, We're Happy, We Use Condoms: Promotion of Condom Use Among Workers in Pleasure-Oriented Establishments in the Philippines through Health Education Interventions.

Fraser-Mackenzie. Promotion of AIDS Prevention Among Farm Workers and Their Families in Zimbabwe. 1986 - 1992.

Handwerker. Sexuality and De Fas Life in Barbados.

Havanon. Male Sexual Networking in a Provincial Thai Setting.

Hernandez. Solidarity and Life: AIDS Prevention and Education for Women with HIV/ AIDS in Netzahualcoyotl City, Mexico.

Herrasme. Commercial Sex Workers in AIDS Prevention Activities in the Dominican Republic.

Lopez. Upgrading of Social Hygiene Clinics in the Philippines.

de Moya. The Costs and Benefits of HIV Blood Donor Screening Systems in Trinidad and Tobago, the Dominican Republic, and the Philippines.

Namanja. Lessons Learned from Modeling of the AIDS Epidemic in Malawi.

Nyathia. Replicating Interventions Targeting Vulnerable Groups in Zimbabwe: Analysis of a Multi-Site Replication.

Palet. Rocio, the Story of a Woman from Our Time.

Welsh. Peer Education and AIDS Prevention: Accessing and Influencing a Targeted Population.

Yoda. Social Marketing of Condoms to Persons at Risk of HIV Infection in Burkina Faso: PROMACO at Your Service.

Oral Presentations:

Van Landingham M. Prostitute Patronage in a High-HIV Prevalence Environment: Male Sexual Risk Taking in Thailand.

Dubow J. Prevention Programs for Commercial Sex Workers. International workshop on STDs. Sponsored by the World Health Organization and the Alfred Fournier Institute. Dakar, Senegal. September 1992.

Mugrditchian D. Update on STD Diagnostics/Introduction to Syndromic Approach. Lecture at the Diploma Course on STDs. Prince Songkla University and Thai Medical Society. Bangkok, Thailand. September 1992.

Bennett T. AIDS Interventions for High-Risk Groups: Thailand Case Studies. Paper presented at the International Planned Parenthood Congress. New Delhi, India. October 1992.

Lamptey P. The Impact of AIDS on Reproductive Health. Paper presented at the Society for the Advancement of Contraception, VIII Annual Meeting. Barcelona, Spain. October 1992.

Mugrditchian D. STDs in the AIDS Epidemic. Paper presented at the International Planned Parenthood Congress. New Delhi, India. October 1992.

Mugrditchian D. Strategies for Prevention of Perinatal Transmission of HIV Infection. Paper presented at the VII Congress of the Federation of the Asia-Oceania Perinatal Societies. Bangkok, Thailand. October 1992.

Lamptey P. Presentation on general description of epidemiology of AIDS. Rockefeller Foundation. Sponsored consultation on funding needs for AIDS programs in developing countries. November 5, 1992.

The II International Congress on AIDS in Asia and the Pacific. New Delhi, India. November 8 - 12, 1992.

Poster Presentation:

Wienrawee P. Evaluation of an AIDS-Prevention Video for Thai Urban Adolescents.

Kendall C. Presentation on the use of 'risk' in AIDS prevention programs at the annual meeting of the American Anthropological Association. San Francisco, California. November 30, 1992.

VII International Conference on AIDS in Africa. Yaoundé, Cameroon. December 8 - 11, 1992.

Plenary Speech:

Lamptey P. Interventions in the Sexual Transmission of HIV...Success Stories in Africa.

Oral Presentations:

Dallabetta G. and Kendall C. Local Perceptions, Knowledge, Experience and Vocabulary of Sexually Transmitted Illness (STI) in Malawi.

Mitchell S. Monitoring the Blood Safety Supply in Cameroon through a National Quality Assurance Programme (NQAP).

Workshop:

Roberts M. AIDS and Policy Reform: Developing Options.

Kendall C. Presentation on the AIDSCAP project including the Africa Thematic Grants Program and working with USAID. Harvard School of Medicine, Department of Social Medicine, Cambridge, Massachusetts. December 22, 1992.

Dubow J. Local Perceptions, Knowledge, Experience, and Vocabulary of Sexually Transmitted Illness in Malawi. VII International Conference on AIDS in Africa. Yaoundé, Cameroon. December 1992.

1993

Lamptey P. Presentation on HIV Center for Clinical and Behavioral Studies. New York City. January 14, 1993.

Hollerbach P. Presentation on interventions for prevention and reduction of perinatal HIV transmission: the impact of counseling and therapy on decision-making and behavior change. Department of Demography Seminar Series, Georgetown University, Washington, D.C. March 19, 1993.

Hughes P. Condom Social Marketing Success in Africa. Nepal Government and NGOs. Kathmandu, Nepal. April 19, 1993.

Kendall C. Presentation on the construction of risk and AIDS control programs: Theoretical Bases and Popular Responses Conference on International Perspectives in Sex Research. AIDS and Reproductive Health (ARHN) Working Group on Sexual Behavior Research. Rio de Janeiro, Brazil. April 22 - May 2, 1993.

Mitchell S. Presentation on AIDSCAP Overview. U.S. Information Agency. Washington, D.C. April 28, 1993.

The IX International AIDS Conference and IV STD World Congress. Berlin, Germany. June 6 - 11, 1993.

Plenary Presentation:

Lamptey P. Prevention: Is It Working?

Oral Presentations:

Hanenberg R. The Use of Sexually Transmitted Disease (STD) Statistics to Evaluate Thailand's HIV Prevention Program.

Forsythe S. Projecting the Socio-Economic Impact of HIV/AIDS in Malawi.

Manci M. Organizing South African Traditional Healers to Mount Sexually Explicit AIDS Prevention Initiatives.

Nunez M. AIDS in Honduras: Modeling the Epidemic.

Workshop:

Ankrah E.M. Panel moderator of workshop on individual and institutional response: risk perception.

Poster Presentations:

Cordova. Pharmacy Worker AIDS/STD Prevention and Condom Sales Education in Guayquil, Ecuador.

Dallabetta G. Determining Effective and Affordable Antibiotic Therapy for STD Patients with Urethritis in Malawi.

Dallabetta G. Sexually Transmitted Infections (STI) in Malawi: Local Perceptions, Knowledge, and Behavior.

Dallabetta G. Specificity of Dysuria and Discharge Complaints and Presence of Urethritis in Male Patients Attending an STD Clinic in Malawi.

Dallabetta G. STD Control in a Large, Slum-Based Haitian Health Institution: Confronting the Obstacles and Designing a Strategy.

Flores. Projecting the Economic Impact of HIV/AIDS in the Two Largest Cities in Honduras.

Génécé E. NGO Condom Social Marketing in Haiti.

King. Modeling the Efficacy of Vaginal Virucides.

Koenig. Quality Assurance in Dominican Laboratories Detecting HIV Antibodies.

Koloko. Ethnomedical Practices of Significance to the Spread and Prevention of HIV in Southern Africa.

Lule. Determining Effective and Affordable Antibiotic Therapy for STD Patients with Genital Ulcer Disease (GUD) in Malawi.

Mofokeng. Organizing Community-Based Prevention and Support for HIV-Positive Mothers and Their Families in South Africa.

Mugrditchian D. Management of STD Cases in Madras: Are Opportunities for Reducing Future Risk of HIV Infection Being Taken?

de Weiss P. The Impact of Pharmacist AIDS/STD Prevention Training on Condom Sales and Information Dissemination in Mexico City.

Githens W. AIDS: The Global Crisis, Center for Development and Population Activities (CEDPA). For 50 female participants from Central America, Africa, Asia, Eastern Europe, and the Middle East taking part in a management training program. June 8, 1993.

Githens W. Capacity Building of NGOs in AIDS Prevention. National Council for International Health Annual Conference. Arlington, Virginia. June 1993.

Kotellos K. Building of NGOs Working in HIV Prevention. National Council for International Health Annual Conference. Arlington, Virginia. June 1993.

Mitchell S. Project Process Course for USAID. CEDPA. June 1993.

Lamptey P. Presentation for Berlin conference debriefing. U.S. Department of State. July 20, 1993.

Ankrah E.M. Organized and moderated a panel on AIDS: mothers and daughters. VII International Meeting on Women's Health. September 13 - 18, 1993. Kampala, Uganda.

Hughes P. Condom Social Marketing and HIV/AIDS. London School of Tropical Medicine and Hygiene. September 22, 1993.

Ryland S. Evaluation of Prevention Programs Lecture in International Course in Surveillance and Applied Epidemiology for HIV and AIDS. Centers for Disease Control and Prevention. Atlanta, Georgia. September 23, 1993.

de Zoysa I. Counseling and Testing for HIV Prevention in Developing Countries. Centers for Disease Control and Prevention. International HIV/AIDS course. Atlanta, Georgia. September 27 - 28, 1993.

Kotellos K. Presented the AIDSCAP evaluation strategy to the Ministry of Health/ Epidemiology Unit. Jamaica. September 1993.

Schwarzwalder T. Presentation on AIDSCAP and the opportunities/constraints in integrating HIV/AIDS and family planning programs. Office of Health, USAID. September 1993.

Lamptey P. Participant at STDs: Epidemiologic Realities and Rational Public Health Policy Meeting. University of North Carolina at Chapel Hill, Chapel Hill, North Carolina. October 8, 1993.

Ankrah E.M. Organized and moderated panel with AIDSCAP colleagues Wendy Githens, Kari Hartwig, and Jessica Price: Designing AIDS Presentation Projects with an Impact on Women. Association for Women in Development's Sixth International Forum. Washington, D.C. October 22, 1993.

Kotellos K. Presented the AIDSCAP evaluation strategy to USAID/Brazil and the Ministry of Health. Brazil. October 1993.

Mugrditchian D. Sexually Transmitted Disease (STD) Trends in Bangkok: A Case for Cautious Optimism in the Fight Against AIDS. Paper presented at the VIII IUVDT Regional Conference. Chiang Mai, Thailand. October 1993.

IX Biannual Congress on STDs and III Pan American Conference on AIDS. Cartagena de India, Colombia. November 3 - 7, 1993.

Oral Presentation:

Calderón R. Development of HIV/AIDS Prevention and Control Programs: National, Technical Strategies, and Lessons Learned.

Lamptey P. Presentation on AIDS prevention in Africa. Baylor College of Medicine. Houston, Texas. November 13, 1993.

Roberts M. Discussant on AIDS on Africa panel. Annual Conference of the African Studies Association. Boston, Massachusetts. November 1993.

VIII International Conference on AIDS and STDs in Africa. Marrakech, Morocco. December 6 - 13, 1993.

Preconference training for AIDSCAP-funded participants:

Roberts M. The Private Sector AIDS Policy Presentation Package.

Field M. Community-Based, Institution-Based, and General Population-Based: General Approaches to Prevention Lessons Learned.

Oral Presentations:

Madando. Implementing Community-Based Prevention and Support for HIV-Positive Mothers and Their Families in South Africa.

Tchupo. Evaluation of Social Marketing Program for the Treatment of Urethritis in Men in Cameroon.

Roundtable Sessions:

Ella. Self-Financing of AIDS Prevention Activities by CSWs—Is It Possible?

Mbuya. Defining a Risk Score for STD Treatment for Women in Seven Truck Stops in Tanzania.

Poster Presentations:

Boupda. Contribution du Projet-Prevention du SIDA Auprés des Prostituées et Leurs Clients: Dans la Lutte Contre le SIDA au Cameroun de Janvier 1993. Cameroon.

Boupda. Formation des Prostituées à l'Education par les Pairs Comme Strategie de Lutte Contre les MST/SIDA à Yaoundé, Cameroon.

Nkya. The Pattern of Sexually Transmitted Diseases in a Group of Commercial Sex Workers in Morogoro, Tanzania.

Outwater. A Workplace-Based Response to AIDS Intervention by NGOs.

Riley. Implementing Community-Based Prevention and Support for HIV-Positive Mothers and Their Families.

Schwarzwalder T. Presentation on World AIDS Day on the global HIV/AIDS situation. Smithsonian Institution. Washington, D.C. December 1, 1993.

Githens W. PVO/NGO program overview. USAID ATSP for 10 ATSP members. December 1993.

1994

Sweat M. Presentation on the current status of the international AIDS epidemic to a meeting of the South-Eastern AIDS Training Network. Charleston, South Carolina. February 3 - 6, 1994.

Lamptey P. Presentation on AIDS in Africa. Opening of FHI Africa Regional Office. Nairobi, Kenya. February 10, 1994.

de Zoysa I. Presentation on the design of a prospective study of a multisite counseling and testing efficacy study. World Health Organization/Global Programme on AIDS meeting on the context of counseling interventions. Geneva, Switzerland. February 12 - 13, 1994.

Dubow J. Behavioral Issues and Communication. Professional Development Day. Office of Population, USAID. Washington, D.C. February 1994.

Lamptey P. Appeared on telecast. WORLDNET. March 17, 1994.

Hughes P. The Principles and Success of Condom Social Marketing. Asian Journalist Workshop. Bangkok, Thailand. March 24, 1994.

Dubow J. Peer Education and AIDS Prevention: An African Experience. George Washington University School of Public Health. Washington, D.C. March 1994.

Lamptey P. Appeared on telecast. WORLDNET. April 5, 1994.

Ankrah E.M. Presented a paper on AIDS: strengthening the family. All Africa Church consultation on AIDS. Monitoring the AIDS Pandemic (MAP) International. Nairobi, Kenya. April 24 - 30, 1994.

Lamptey P. Panel on AIDS: steps toward Howard University containing the AIDS crisis. April 7, 1994

Lamptey P. Panel member on data and research priorities for arresting AIDS in sub-Saharan Africa. National Academy of Sciences Committee on Population. Washington, D.C. April 12 - 13, 1994.

Hollerbach P. Chairperson at International Health Session. Annual meeting of the Population Association of America. Miami, Florida. May 6, 1994.

Ankrah E.M. Address to the Africa Regional Resident Advisors. The Women's Initiative in the AIDSCAP Project. Nairobi, Kenya. May 11, 1994.

Denison J. Presentation on HIV and AIDS. American Red Cross/Charles County Public Health Department. Waldorf, Maryland. June 2; July 12, 26, 28; and August 1, 1994.

Lamptey P. Participant at White House meeting on Africa. June 26 - 27, 1994.

Sweat M. Presentation on current and planned AIDSCAP behavioral research unit projects. Centers for Disease Control and Prevention. Atlanta, Georgia. July 13 - 14, 1994.

X International Conference on AIDS.
Yokohama, Japan. August 7 - 12, 1994.

Oral Presentations:

Desormeaux J. Introduction of Partner Referral and Treatment for Control of Sexually Transmitted Diseases in a Poor Haitian Community.

Ella M. Mobilization of Students for STDs/AIDS Prevention in Universities in Cameroon.

Forsythe S. Measuring the Impact of HIV/AIDS on Africa's Commercial Sector.

Gomez E. Projections of the AIDS Epidemic in the Dominican Republic.

Terto V. The AIDS Prevention for Men Who Have Sex with Men in Rio de Janeiro and São Paulo, Brazil.

Poster Presentations:

Arabaje. Lessons Learned from an AIDS Policy Program in the Dominican Republic.

Behets. High Prevalence of Reproductive Tract Infections (RTIs) Among Pregnant Women of Low Socioeconomic Status (SES) in Haiti.

Boulos. HIV and Other Sexually Transmitted Diseases (STDs) Among Women Attending Two Antenatal (AN) Clinics in Cité Soleil, Haiti.

Boupda. Sensitization of Prostitutes and Their Clients Using a Commercial Sex Workers' Drama Troupe in Cameroon.

Garba. Rural HIV Transmission in Northern Nigeria.

Godfrey. HIV Infection among Patients with Urethritis (U) and Genital Ulcer Disease (GUD) in Blantyre, Malawi.

Hoffman. Etiology of Genital Ulcer Disease (GUD) in Male STD Patients in Blantyre, Malawi.

Koenig. Quality Assurance (QA) in Dominican Laboratories Doing HIV Testing.

Mougntou. Summary of Activities of the National Information and Documentation Center on AIDS in Yaoundé.

Roberts and Forsythe. Private Sector Practices and Perspectives on AIDS and the Workplace.

Saidel. HIV Incidence in a Cohort of Burundian Male Workers.

Sweat. Identifying Goals for Behavior Change Programs in Urban African Settings: High Effectiveness and Moderate Coverage Maximize Impact and Cost-Effectiveness.

Yokohama: Additional Poster Presentations from Brazil:

Alemida. Expressionist Theater and HIV/AIDS Prevention for Men Who Have Sex with Men in Brazil.

Fini. AIDS Control and Prevention in Brazil.

Gravato. Census of Commercial Sex Workers in Santos City-SP-Brazil.

Lacerda. Prevalence of HIV Infection and AIDS Behavioral Risk Among Port Workers in Santos, Brazil.

Lima. Study of Urethritis Management in Pharmacies in São Paulo, Brazil.

Linhares. AIDS, Sexuality, Sexually Transmitted Diseases: Everything You Have Always Wanted to Know and Had the Courage to Ask.

Mota. Men Who Have Sex with Men in Rio de Janeiro: An Analysis of Research Methodology for a Hard-to-Reach Population.

Perez. Analysis of Condom Social Marketing in Brazil.

Quemmel. Safer Sex Workshops for Men Who Have Sex with Men in Rio de Janeiro, Brazil.

Wasek. Brazil Logistics Management.

Oral Presentations:

Terto V. The AIDS Prevention for Men Who Have Sex with Men in Rio de Janeiro and São Paulo, Brazil.

Bennett T. Behavioral Sentinel Surveillance for HIV Prevention Programs. Paper presented at the Thailand National Epidemiological Conference. Bangkok, Thailand. August 1994.

Ankrah E.M. Presented a paper on AIDS: culture and the status of women. Panos Institute International Media Seminar to Journalists. Cairo, Egypt. September 4, 1994.

Ankrah E.M. Organized and moderated a panel and a caucus on women and AIDS as a component of the FHI reproductive health symposium. International Conference on Population and Development. Cairo, Egypt. September 5 - 13, 1994.

Goodridge G. Developing Rationale for AIDS Care. World Health Organzation consultation on rationale for care in resource constraint settings. Geneva, Switzerland. September 20 - 22, 1994.

Lamptey P. Presentation on Current AIDSCAP Activities. World Health Organization/ Global Programme on AIDS. Geneva, Switzerland. September 22, 1994.

Ryland S. Surveillance of Sentinel STD Syndromes to Monitor HIV/AIDS Prevention. International course on surveillance and applied epidemiology for HIV and AIDS. Centers for Disease Control and Prevention. Atlanta, Georgia. September 26, 1994.

Ryland S. Evaluation of Prevention: International course on surveillance and applied epidemiology for HIV and AIDS. Centers for Disease Control and Prevention. Atlanta, Georgia. September 26, 1994.

Schwarzwalder T. Facilitated a discussion at the annual meeting of the International Association of African Scientists. September 1994.

Dubow J. Regional AIDS Control and Prevention Plan. The World Bank. Ougadougou, Burkina Faso. September 1994.

Roberts M. Presentation on Emergence of Gay Identity and Gay Social Movements in Developing Countries: The AIDS Crisis as Catalyst. Annual meeting of the American Political Science Association. New York, New York. September 1994.

Kotellos K. Presented the AIDSCAP global evaluation strategy to USAID, Mission, and State Departments of Health. Rio de Janiero and São Paulo, Brazil. September 1994.

Asia Regional Office staff. Current Prevention and Treatment of STDs in the Context of Maternal and Child Health. Paper presented at the International Symposium on Prevention and Therapy of Perinatal Infections of Mother and Child Health. Lombok, Indonesia. September 1994.

Asia Regional Office staff. Special Challenges in the Detection, Diagnosis, and Treatment of STDs in Women. Paper presented at the International Symposium on Prevention and Therapy of Perinatal Infections of Mother and Child Health. Lombok, Indonesia. September 1994.

Asia Regional Office staff. Designing and Implementing STD Control Activities in the Filipino Context. Paper presented at the first postgraduate course on sexually transmitted diseases and AIDS. Philippines Society of Venereologists. Manila, the Philippines. September 1994.

Ankrah E.M. Presentation on AIDS among Asian and Africa women: some common dimensions. AIDSCAP Forum. Asia Regional Office. Bangkok, Thailand. October 18, 1994.

Ankrah E.M. Presentation on the impact of AIDS on women and families. The Women's Studies Center, Chiang Mai University. Chiang Mai, Thailand. October 21, 1994.

Calderón R. Presentation on trends, policies, and recent developments in HIV/AIDS prevention and control in Latin America and the Caribbean. Society for International Development. George Washington University. Washington, D.C. October 1994.

Brenden N. Presented an overview of AIDSCAP's HIV/AIDS prevention programs in the Asia region. The American Red Cross. Washington, D.C. December 1, 1994

Calderón R. Presentation on the regional profile of the HIV/AIDS pandemic: current activities and future directions for HIV/AIDS prevention. The American Red Cross. Washington, D.C. December 1, 1994.

Sikipa G. Presented an overview of AIDSCAP's HIV/AIDS prevention programs in the Africa region. The American Red Cross. Washington, D.C. December 1, 1994.

Roberts M. Panel chair and presenter on business responses to HIV/AIDS in the African formal sector workplace: findings of a Kenya needs assessment. Annual conference of the African Studies Association. Toronto, Canada. November 1994.

Lamptey P. Presentation on epidemiology. USAID briefing on AIDSCAP Project. Washington, D.C. December 5, 1994.

Roberts M. Presentation on business responses to HIV/AIDS in the African formal sector workplace: findings of a Kenya needs assessment. Business Exchange on AIDS and Development (BEAD). London, England. December 1994.

1995

Kamenga C. Interviewed about AIDS and Women in Africa (in French). Voice of America. Washington, D.C. January 11, 1995.

Kamenga C. Interviewed about AIDS in Africa (in French). Voice of America. Washington, D.C. January 11, 1995.

Lamptey P. Presentation on mathematical modules of HIV transmission. University of North Carolina at Chapel Hill. January 30, 1995.

Mitchell S. Presentation on quality assessment program for HIV testing. World Health Organization. Geneva, Switzerland. January 30, 1995.

Lamptey P. Presentation on AIDSCAP update. Family Health International. Research Triangle Park, North Carolina. February 21, 1995.

Forsythe S. Presentation on methods for measuring the socioeconomic impact of HIV/AIDS in Central America. Workshop on the social and economic impact of HIV/AIDS in Central America. Guatemala City, Guatemala. February 1995.

Hartwig K. Keynote address on women's health in an age of globalization. International Conference on Women's Health in the Age of Globalization. Chiang Mai, Thailand. February 1995.

Mugrditchian D. Presentation on update on RTI diagnostics and antibiotic resistance. Regional meeting on reproductive tract infections. Population Council. Bangkok, Thailand. February 1995.

Wienrawee P. Presentation on safe marital sexual behavior. International workshop on pediatrics and AIDS. Bangkok, Thailand. February 1995.

Lamptey P. Overview of AIDSCAP. Behavior Change Communication Technical Working Group Meeting. Arlington, Virginia. March 16, 1995.

Ankrah E.M. Moderator of panel on women and AIDS: action agendas. New York Preparatory Conference for the United Nations Fourth World Conference on Women.

New York, New York. March 24, 1995.

Calderón R. HIV/AIDS in the Policy Context. USAID/AIDSCAP workshop assessing the socioeconomic impacts of HIV/AIDS in El Salvador, Guatemala, and Nicaragua. Guatemala City, Guatemala. March 1995.

Calderón R. Global View of the Epidemiology, Trends, and Impact of HIV/AIDS. USAID/AIDSCAP workshop assessing the socioeconomic impacts of HIV/AIDS in El Salvador, Guatemala, and Nicaragua. Guatemala City, Guatemala. March 1995.

Calderón R. Clinical and Epidemiological Aspects of AIDS and Its Mortality. USAID/AIDSCAP workshop assessing the socioeconomic impacts of HIV/AIDS in El Salvador, Guatemala, and Nicaragua. Guatemala City, Guatemala. March 1995.

Calderón R. The Socioeconomic and Development Impacts of HIV/AIDS. USAID/AIDSCAP workshop assessing the socioeconomic impacts of HIV/AIDS in El Salvador, Guatemala, and Nicaragua. Guatemala City, Guatemala. March 1995.

Mugrditchian D. Presentation on managing sexually transmitted diseases with limited resources. IUVDT World STD/AIDS Congress. Singapore. March 1995.

Wi T. Risk Assessment and Syndromic Approach to Management of Gonoccocal and Chlamydia Infection in Female Sex Workers in the Philippines. Paper presented at the World Health Organization/AIDSCAP syndromic case management meeting. IUVDT World STD/AIDS Congress. Singapore. March 1995.

Wi T. Presentation on fluoroquinolone resistance in *Neisseria gonorrhoea* in the Republic of the Philippines. IUVDT World STD/AIDS Congress. Singapore. March 1995.

Joshi B. Presentation on sexually transmitted diseases in Nepal. IUVDT World STD/AIDS Congress. Singapore. March 1995.

Helitzer-Allen D., Allen H., Dallabetta G., Lurie M., and Rodieck M. Presentation on developing targeting intervention research (TIR): case studies on programmatic research for sexually transmitted illnesses and tuberculosis. Society for Applied Anthropology Annual Meeting. Albuquerque, New Mexico. March 29 - April 2, 1995.

Moktan P. A Qualitative Study of Chemists Shops on the Land Transportation Routes from Naubise to Janakpur and Birgunj. National Center for AIDS and STD Control. Kathmandu, Nepal. April 13, 1995.

Regmi S. Presentation on a baseline study of commercial sex workers and sex clients on the land transportation routes from Naubise to Janakpur. National Center for AIDS and STD Control. Kathmandu, Nepal. April 13, 1995.

Shresta B. Presentation on an assessment of traffic patterns and the HIV/AIDS

situation on the trucking routes between India, Nepal, and Bangladesh. National Center for AIDS and STD Control. Kathmandu, Nepal. April 13, 1995.

Lamptey P. Overview of AIDSCAP. Women's Council. Arlington, Virginia. April 24, 1995.

Brathwaite A. Oral presentation on the rise in prevalence of genital ulcers among STD clinic attendees in Jamaica: significance for HIV transmission. 40th Annual Commonwealth Caribbean Medical Research Council (CCMRC). Barbados. April 25 - 30, 1995.

Calderón R. Presentation on the worldwide epidemiology of HIV/AIDS and the response of USAID/AIDSCAP in Latin America and the Caribbean. II National Meeting of USAID/AIDSCAP Implementing Agencies in Brazil. Caxambu, Brazil. May 1995.

Wi T. Syndromic Approach to the Diagnosis and Management of Sexually Transmitted Diseases. The Philippines Medical Association 88th Annual Convention. Manila, the Philippines. May 1995.

Lamptey P. Presentation on AIDSCAP update. Program committee, FHI Board of Directors. Research Triangle Park, North Carolina. May 6, 1995.

Dallabetta G. Presentation on the fundamentals of STDs. USAID/John Snow, Inc. Arlington, Virginia. May 8, 1995.

Ankrah E.M. Presentation on women and AIDS: a global perspective. Women's Day of Reflection. Haiti Country Office. Port-au-Prince, Haiti. May 26, 1995.

Fernades M.E. Overview of AIDSCAP projects in Brazil. II National AIDSCAP Meeting. Caxambu, Brazil. May 1995.

Lamptey P. Presentation on AIDS prevention in developing countries: an update. State of the art meeting. Arlington, Virginia. June 14, 1995.

Lamptey P. Presentation on AIDS prevention and care in developing countries. Meeting of general practitioners in the Reston - Herndon area. Reston, Virginia. June 15, 1995.

Ankrah E.M. Keynote presentation on women, family, and AIDS prevention. Area of Affinity workshop on women, family, and AIDS prevention. Chiang Mai, Thailand. July 4, 1995.

Ankrah E.M. Presentation on the Society for Women and AIDS in Africa (SWAA): sharing the vision with women of Asia. Area of Affinity workshop on women, family, and AIDS prevention. The Women's Studies Center Faculty of Social Sciences, Chiang Mai University. Chiang Mai, Thailand. July 6, 1995.

Forsythe S. Presentation on the economic impact of HIV/AIDS on Thailand's private sector and the cost effectiveness of prevention. AIDSCAP/FHI meeting of private sector leaders. Bangkok, Thailand. July 6, 1995.

Forsythe S. Presentation on opportunities for the sustainability of services at Bangkok's public and private STD clinics. Meeting of STD service providers. Bangkok, Thailand. July 7, 1995.

Brathwaite A. Oral presentation on syndromic approach to STD control in Jamaica. Medical Association of Jamaica's VI STD/HIV practitioner workshop. Kingston, Jamaica. July 30, 1995.

Lamptey P. Oral presentation on trends in AIDS prevention and treatment. Medical Association of Jamaica's VI STD/HIV practitioner's workshop. Kingston, Jamaica. July 30, 1995

Leone P. Oral presentation on STD clinical research update. Medical Association of Jamaica VI STD/HIV practitioner's workshop. Kingston, Jamaica. July 30, 1995.

Lamptey P. Keynote speech on update on AIDS prevention and treatment. Final workshop on STD treatment and diagnosis. Medical Association of Jamaica. July 30, 1995.

Calderón R. Presentation on the USAID/AIDSCAP HIV/AIDS prevention program and strategies. HIV/AIDS Honduras program workshop for implementing agencies. Tegucigalpa, Honduras. July 1995.

III USAID HIV/AIDS Prevention Conference. Washington, D.C. August 7 - 9, 1995.

Plenary Session:

Lamptey P. Comprehensive HIV/STD Prevention Programs.

Chairs:

Holmes K. Oral Session: Case Management of Sexually Transmitted Diseases.

Makinwa B. Oral Session: HIV Education: Working with the Media.

Preble E. Oral Session: Impact of Culture, Socioeconomic Status, and Gender on HIV.

Schellstede W. Oral Session: The Private Sector Response to HIV/AIDS.

Schwarzwalder A. Oral Session: Policy Dialogue: What It Is and How to Use It.

Panelist:

Hassig S. Roundtable Session: Benchmarks.

Respondents:

Génécé E. Roundtable Session: Prevention and Care.

Weinrawee P. Roundtable Session: Behavior Change Communication.

Presentations:

de Almeida V. Cabaret Prevenÿão: Expressionist Theater and HIV/AIDS Prevention for Men Who Have Sex with Men in Brazil.

Ankrah E. Building Alliances Across Borders: Women Networking on HIV/AIDS Prevention in Southeast Asia.

Benjamin J. AIDS Prevention in a Society in Crisis: The Case of Rwanda Refugees in Tanzania.

Brenden N. From Denial to Response: Factors Influencing the Evolution of HIV/AIDS Prevention Policies of the Royal Thai Government (RTG).

Brenden N. Developing a Center of Excellence in HIV/AIDS Training.

Butler de Lister M. AIDS Policy Program in the Dominican Republic: Keeping AIDS on the Agenda.

Cato M. Haiti Condom Social Marketing Program: Safety Net Private Sector Condom Distribution Versus Free Condom Distribution in Time of Crisis.

Dallabetta G. Comparison of Data on Quality of Provider Performance on STD Case Management: Direct Observations, Provider Interviews, and Simulated Patients.

Dallabetta G. Male STD Health-Care-Seeking Behavior in Bangkok, Thailand.

Denison J. Targeting Interventions for the Prevention of HIV Infection in Developing Countries: When to Begin Targeting non-Core Groups.

Fernandes M.E. Study of Urethritis Management in Pharmacies in São Paulo, Brazil.

Ferreros C. Condom Social Marketing Experience in Brazil.

Génécé E. NGO Condom Social Marketing in Haiti: A Motivating Model for Condom Promotion and Distribution.

Ghee A. Communications for Sexually Transmitted Disease Programs: An Opportunity for Innovation.

Ghee A. Comparison of STD Prevalence and the Behavioral Correlates of STD Among Registered and Unregistered Female Sex Workers (FSWs) in Manila and Cebu City, the Philippines.

Githens W. Rapid Response Funds: Supporting Community-Based Initiatives in HIV Prevention.

Grimard B. Haiti Condom Social Marketing Program, Rara Celebration: Integrating Cultural Activities with Condom Promotion and Sales.

Gunawan S. The Impact of Policy Study Programs: The Case of Indonesia.

Hogle J. The Bangkok Behavioral Surveillance Survey (BSS): Methodology and Use in HIV Prevention Programming.

Hughes V. AIDS, Sexuality, Sexually Transmitted Diseases...Everything You Always Wanted to Know and Had the Courage to Ask: A Book for Commercial Sex Workers (CSWs).

Hylton-Kong T. Tutorial Training for Syndromic STD Case Management in a Kingston, Jamaica, STD Clinic.

Kamenga M. Premarital Screening for Human Immunodeficiency Virus Infection: Issues to Consider.

Kornfield R. Perspectives on AIDS Education in Primary Schools: Evaluation of the HIV/AIDS Education Orientation for Primary School Teachers in Malawi.

MacNeil J. Closing the Gap: Care is a Form of Prevention.

Mahler H. Fear-Based and Content-Free Information, Education, and Communication (IEC) Messages: The Academic Perspective Versus the Field Reality.

Manyathi S. Community HIV/AIDS Pilot Project (CHAMPS) Phase I.

Mugrditchian D. Promotion of Standard STD Case Management Guidelines in Nepal.

Niang C. A Targeted Intervention Research Study for STD Program Design in Senegal.

Nyamete A. Mobilizing the Business Sector to Respond to the HIV/AIDS Crisis in Africa: Findings and Experiences of the Private Sector AIDS Policy Presentation (PSAPP) Activity.

Nyamuryekung'e K. STD Services for Women in Truck Stops in Tanzania: An Evaluation of Acceptable Approach.

Ochola P. Does the 'Fleet of Hope' Hold Water? An Evaluation of a Controversial Campaign to Provide a Personal Assessment of Risk.

Parker R. Sexual Behavior and Behavior Change Among Men Who Have Sex with Men in Brazil, 1989 - 1994.

Paterson P. Brazil Logistics Management of Essential Commodities for AIDS Prevention.

Sangiwa G. A Study of the Impact of HIV Counseling and Testing on Behavior Change in Tanzania: Justification and Methods.

Steen R. Partner Referral as a Component of Integrated STD Services in Two Rwandan Towns.

Tchupo J.P. The MSTOP Experience in Cameroon: Conclusions.

Umozurike J. An Innovative Initiative for Targeting Commuters in Traffic Jams in Lagos, Nigeria, through the AIDSCAP Rapid Response Fund.

Umozurike J. Effectiveness of Mass Media Campaigns as Catalyst for Behavior Change Communication.

Wasek G. National AIDS Control Policy and Planning for Condom Requirements Forecasting.

Wienrawee P. Behavioral Effects of HIV Outreach Communication and Peer Education to Male Laborers in Factories in Bangkok, Thailand.

Wienrawee P. Promoting a Sense of Ownership as a Critical Aspect of Capacity Building

Lamptey P. Presentation on AIDSCAP. TAG meeting. Arlington, Virginia. August 10, 1995.

Ankrah E.M. Moderator of press conference on women and AIDS in collaboration with Women and AIDS: A Coalition Educating for Empowerment and Prevention. National Press Club. Washington, D.C. August 16, 1995.

XI Meeting of the International Society for STD Research. New Orleans, Louisiana. August 27 - 30, 1995.

Oral Presentation:

Anyangwe S., Wiseman J., Jackson R., Dallabetta G. STD Management in Zambia: Making a Case for the Syndromic Approach.

Poster Presentations:

Sangare O.F., Ryan, C.A., Diarra A.S., Kouliabail A., Dallabetta G., Holmes K.K. Clinical Algorithms for the Screening of Women for STD. Evaluation in a High-Risk Population in Mali.

Ghee A.E., Field M., Dubow J., Flanagan D., Dallabetta G. Communications for Sexually Transmitted Disease Programs: An Opportunity for Innovation.

Desormeaux J., Behets F., Adrien M., Dallabetta G., Boulos R. Knowledge, Perception and Attitudes regarding STDs among Pregnant Women and Their Partners Living in a Poor Urban Community in Haiti.

Génécé E., Behets F., Dallabetta G. Approaches to the Development of STD Control Programs in Haiti (1992 - 1995).

Brathwaite A., Behets F., Bennett L., Douglas K., Williams Y., Whitbourne F., Bryce J., Dallabetta G., Cohen M., Figueroa P. Decentralization of Syphilis Screening for Prompt Treatment and Improved Contact Tracing in Jamaican Public Health Clinics.

Crabbé F., van Dyck E., Dallabetta G., Laga M. Gonococcus Antimicrobial Susceptibility Surveillance in Africa: Perspectives.

Fehler H., Ye H., Dangor Y., Radebe F., Ntsekhe P., Plier P., Lee H., Ballard R. Sexually Transmitted Diseases among Women Attending STD, Family Planning, and Antenatal Clinics in Maseru, Lesotho.

Kendall K., Ghee A., Helitzer-Allen D., Allen H., Hogle J., Dubow J., Lurie M., Field M., Dallabetta G. Research for Sexually Transmitted Disease Programming: A Rapid Ethnographic Approach.

Green M., Brathwaite A., Hoffman I., Figueroa P., Wedderburn M., Dallabetta G., Behets F., Cohen M. Improving STD Case Management in the Private Sector: The Jamaican Experience.

Tempongko S., Tigalo T., Ghee A., Wi T., Mugrditchian D. Targeted Intervention Research on Sexually Transmitted Diseases in the Setting of Commercial Sex. Manila and Cebu City, the Philippines.

Douglas K. Improving a Contract Investigator Program as Part of Effort to Control Syphilis in Jamaica.

Verley J. Detection of C. Trachomatis (CT) in a Jamaican STD Clinic Population.

Figueroa P. Prevalence of Human Papilloma Virus (HPV) among STD Clinic Attenders in Jamaica: Association of Younger Age and Sexual Activities.

Ankrah E.M. Panels on women and AIDS organized by the AIDSCAP women's initiative in collaboration with Women and AIDS: A Coalition Educating for Empowerment and Prevention. NGO Forum on women schedule of activities. Beijing, China. August 1995.

Ankrah E.M. Moderator of World Health Organization panel on women and AIDS. The United Nations IV World Conference on Women. Beijing, China. September 5, 1995.

Preble E. Child and Youth Centered Strategies for HIV/AIDS Prevention. VI Millennium PAHO/INMED Conference. Washington, D.C. September 11, 1995.

Forsythe S. Presentation on Methods of Performing Cost Analyses. Asia Regional STD Workshop. Bangkok, Thailand. September 14, 1995.

III International Conference on AIDS in Asia and the Pacific. Chiang Mai, Thailand. September 17 - 21, 1995.

Symposium:

Lamptey P. Co-Chair: Symposium V on women and AIDS.

Workshop:

Hartwig K. Moderator of AIDSCAP preconference workshop. Creating an Asian Network on Women and AIDS.

Panels:

Bennett A. Moderator of panel on innovative strategies for difficult-to-reach populations.

Burian C. Presenter of panel on women and AIDS, results of a satellite symposium to create an Asian network on women and AIDS.

Hartwig K. Moderator of panel on reporting on the Beijing Conference and NGO Forum: implications for the HIV epidemic in women.

Oral Presentations:

Benjarattanaporn P. Male Health Care-Seeking Behavior Related to STDs and AIDS in Bangkok, Thailand.

Lamptey P. Reaching Bisexual Men and Clients of CSWs.

Mills S. The Bangkok Behavioral Surveillance Survey (BSS): Methodology and Use in HIV Prevention Programming.

Mugrditchian D. STD and STD Control Efforts in Asia.

Regmi S.C. STD and STD Health Seeking Behavior among CSWs and their Clients, and the Role of Chemist Shops as Source of STD Treatment in Central Nepal.

Shrestha B. Areas of Infinity: Risk along the Truck Routes of Northern India.

Shrestha B. Promoting Standard STD Case Management Guidelines in Nepal.

Wiebel W. Strategic Planning for AIDS Prevention in Five Indonesian Cities.

Poster Presentations:

Abellanosa I. Comparison of STD Prevalence and Behavioral Correlates of STDs among Registered and Unregistered Female Sex Workers in Manila and Cebu City, Philippines.

Apaiwong O. Bangkok Fights AIDS: A Community Mobilization Approach.

Burian C. Developing a Center of Excellence in HIV/AIDS Training.

Burian C. Journalist Workshop as a Means to Promote Accurate Information to the Public and Policymakers.

Chinworasopak W. Values Training for NGOs in Preparation for Behavioral Change Communication Interventions in the Workplace.

Cox T. Sexual Networking in Five Urban Areas in the Nepal Terai: An Assessment.

Neupane S. Sexual Networking in Five Urban Areas in the Nepal Terai: An Assessment.

Parmualratana A. Areas of Affinity: Assessing the Potential for HIV Transmission across the Thai-Cambodian Border.

Pattalung R. Differences in Sexual Behavior and Condom Use among Lower-Income Single Women Employed in Factories and Offices in Bangkok, Thailand: Results from the Bangkok Behavioral Surveillance Surveys.

Pekanan M. Helping Low-Income Housewives Reduce Risk of STD and HIV.

Pollock J. The Use of Local Technical Working Groups (TWGs) and Technical Advisory Groups (TAGs) for Policy Advocacy and Capacity Building: Case Studies from Nepal, Thailand, and the Philippines.

Porapakkham Y. Behavior Change Intervention among Factory Employees in Bangkok through Outreach Communication by Graduate Volunteers.

Pyakuryal N. Enhancing NGO Capacities in HIV/AIDS Materials Development: Experiences from Nepal's NGO IEC Coordination Committee.

Regmi S. High-Risk Behaviors Among Female Commercial Sex Workers (CSWs) and Male Clients on Transportation Routes in Nepal and India.

Shrestha B. Areas of Affinity: Risk along the Truck Routes of Northern India.

Singhanetra-Renard A. Building Alliances across Borders: Women Networking on HIV/AIDS Prevention in Southeast Asia.

Sundhagul D. Condom Use Trends and Behavioral Differences between Direct and Indirect Commercial Sex Workers (CSWs) in Bangkok, Thailand: Results from the Bangkok Behavioral Surveillance Surveys.

Dallabetta G. Presentation on STD Control Reduces HIV Transmissions. ICAAC. San Francisco. September 18, 1995.

Lamptey P. Presentation on future prospects for AIDSCAP and the future of USAID and international foreign assistance. AIDSCAP Asia Resident Advisors Meeting. Chiang Mai, Thailand. September 22, 1995.

Calderón R. Presentation on the shift of the HIV/AIDS pandemic to women. V Sexuality Congress. Santo Domingo, Dominican Republic. September, 1995.

Field M. Presentation on integrating family planning and STD/HIV/AIDS programs. Population Council. INOPAL Meeting. September 1995.

1995

Oral Presentations:

Field M. Development of an Information Tool for UNICEF Country Offices: The HEALTH 95 Promotion and Services Compact Disk. UNICEF Programming Meeting. New Paltz, New York. October 10, 1995.

Field M. Family Health International Technical Support to UNICEF Technical Support Group Countries: Highlights of Lessons Learned. UNICEF Programming Meeting. New Paltz, New York. October 10, 1995.

Field M. AIDS Prevention from Different Perspectives: The Need for Interorganizational and Interdisciplinary Collaboration. Yale School of Public Health. New Haven, Connecticut. November 2, 1995.

IV Latin American Congress on Sexually Transmitted Diseases and the IV Pan American Conference on AIDS.
Santiago, Chile. November 10 - 13, 1995.

Plenary Session:

Lamptey P. Prevention of the Sexual Transmission of HIV: A Comprehensive Approach.

Oral Presentation:

Calderón R. Reality of HIV/AIDS. Media Seminar for Latin American Journalists. Panos Institute. Santiago, Chile. November 14, 1995.

Calderón R. Press conferences and television interview.

Calderón R. HIV/AIDS towards the Future. Jamaica Close-Out Forum. Kingston, Jamaica. November 25, 1996.

Lamptey, P. AIDS in Developing Countries: An Update. Woodrow Wilson School of Public and International Affairs. Princeton, New Jersey. November 28, 1995.

Field M. STDs in Adolescents. Advocates for Youth X Anniversary Meeting. Washington, D.C. December 1995.

Calderón R. One-hour WORLDNET TV satellite Latin America/Caribbean Conference for World AIDS Day. WORLDNET TV. U.S. Information Agency. Washington, D.C. December 1, 1995.

Lamptey P. WORLDNET TV interview on HIV/AIDS in Africa for World AIDS Day. WORLDNET TV. U.S. Information Agency. Washington, D.C. December 1, 1995.

Saidel T. Uses of HIV/AIDS Epidemiologic Data, Estimates, and Projections in Policy Development. International Conference on AIDS—Law and Humanity. New Delhi, India. December 7, 1995.

Lamptey P. Prevention of the Sexual Transmission of HIV: A Comprehensive Approach. Professor K.S. Sanjivi Endowment Lecture. Voluntary Health Services. Madras, India. December 18, 1995.

IX International Conference on AIDS and STD in Africa. Kampala, Uganda. December 10 - 13, 1995.

Workshops:

Lamptey P. Co-Chair of AIDSCAP preconference workshop: The Status and Trends of the HIV/AIDS Epidemics in Africa.

Asiedu K. and Hayman J. Chairs of AIDSCAP behavior change communication preconference workshop on peer education.

Makinwa B. Presented the study findings of peer education projects in Africa.

Steen R. Chair of AIDSCAP preconference workshop on sexually transmitted disease.

Mtasiwa D. Presentation on baseline assessment of STD case management in Tanzania.

Plenary Session:

Eka-Williams E. Women, Are They Still a Vulnerable Group?

Special Session:

Lamptey P. Chair of panel, Determinants of Stable and Declining HIV Prevalence and Incidence Rates. Behavior Change or Natural Incidence Dynamics.

Poster Presentations:

Benjamin J. AIDS Prevention in a Society in Crisis: One Year Experience of Rwanda Refugees in Tanzania.

Costello D. Sexually Transmitted Diseases: A Survey of Case Management in Malawi.

Crabbé F. Antimicrobial Treatment and Susceptibility Surveillance of NG in Africa: Perspectives.

Eitel M. An STD Prevention Program Among Men Attending STD Clinics in Yaoundé, Cameroon.

Mahler H. The Power of Fear-Based Messages: Do They Promote Behavior Change?

Nakyanjo N. Qualitative Evidence for Sexual Behavior Change in Muslim Ugandan Communities.

Outwater A. Evidence of Behavior Change in a Prostitute Population in Morogoro, Tanzania.

Steen R. STD Case Management in Nongovernmental Health Care Facilities in Dar es Salaam, Tanzania.

Steen R. Syndromic Management of STDs: Notes from the Field.

Widmeyer G. Social Marketing and Free Condom Distribution in the Context of an Emergency Situation: Constraints and Lessons Learned.

1996

Lamptey P. Interview on HIV/AIDS education in Africa. BBC World Service. January 1996.

Schellstede W. The Advantages of Mass Media Communications. Experts Meeting National Academy of Sciences. Washington, D.C. January 1996.

Rau B. The Private Sector AIDS Policy Presentation (PSAPP) Materials. USAID/Africa Bureau. Washington, D.C. March 11, 1996.

Preble E. Women and AIDS in Developing Countries. Columbia University International Women's Health Seminar Series. New York, New York. March 19, 1996.

Rau B. AIDSCAP's Policy Development and Advocacy Processes in the Context of Kenya HIV/AIDS Prevention Efforts. USAID/Kenya and collaborating agencies. Nairobi, Kenya. April 2, 1996.

Calderón R. AIDS in the World: The Growing Gap. Leadership Training Program. The Margaret Sanger Center International. New York, New York. May 1996.

Calderón R. Overview of the Epidemiology, Trends, and Impact of HIV/AIDS. Leadership Training Program. The Margaret Sanger Center International. New York, New York. May 1996.

Calderón R. Diagnosis and Treatment of HIV/AIDS. Leadership Training Program. The Margaret Sanger Center International. New York, New York. May 1996.

XI International Conference on AIDS. Vancouver, Canada. July 7 - 12, 1996.

Lamptey P. Press conference on the status and trends of the global HIV/AIDS pandemic.

Symposium:

Lamptey P. Co-Chair: The Status and Trends of the Global HIV/AIDS Pandemic Satellite Symposium.

Calderón R. Presentation on the status and trends of the HIV/AIDS pandemic in South America.

Rehle T. Presentation on the status and trends of the HIV/AIDS epidemic in West and Central Africa.

Oral Presentations:

Brathwaite A.R. Survey of STDs Seen among Private Physicians in Jamaica.

Crespo J. Lessons Learned: What Makes HIV/AIDS Prevention Sustainable?

Daly C. Validation of the World Health Organization Diagnostic Algorithm and Development of an Alternative Scoring System for the Management of Vaginal Discharge in Malawi.

Hancock J. The Macroeconomic Impact of HIV/AIDS in Kenya.

Hayman J. Comparative Experience with Worksite Prevention Programs in Africa: Zimbabwe, Tanzania, and Kenya.

Hoffman I. Effects of Urethritis Therapy on the Concentration of HIV-1 in Seminal Plasma.

Pradhan Mahesh P. STD/HIV/AIDS: Chemists and the Community.

Sanchez L. Broadening the Social Base of AIDS Prevention among Men Who Have Sex with Men in the Dominican Republic.

Siegel G. The Epidemiologic, Social, and Economic Impact of HIV/AIDS in Three Central American Countries: A Country Specific and Regional Analysis.

Wi T.E. Communications Patterns Related to STDs—Findings from a Qualitative Research Activity among Female Sex Workers in Manila and Cebu City, Philippines.

Wienrawee P. The Socioeconomic Impact of HIV/AIDS in Thailand's Workplace.

Poster Presentations:

Alves A. Training and Capacity Building on Forms of STD/AIDS Infection for Information Multiplying Agency among Marginalized Populations in Rio de Janeiro.

Ankrah E.M. The Female Condom as a Woman-Controlled Protective Method.

Asiedu K. Gender and AIDS: Training the Top Policymaker.

Basnyat A. Dhaaley Dai Speaks HIV/AIDS Messages in Nepal.

Benjamin J. AIDS Prevention in Chaos: The Case of Rwandan Refugees in Tanzania.

Bhattarai Mahesh D. Involving Women in HIV/AIDS Outreach in a Conservative Hindu Society.

Brito C. "VIEJO SI TE DA NO LLEGAS": Tapping in on Private Sector Collaboration for a BCC Adolescent AIDS Campaign in the Dominican Republic.

Burian C. Creating an Asian Network on Women and AIDS.

Butler de Lister M. Prevalence of STDs among Women on the Sugar Cane Plantations (Batayes) of the Dominican Republic.

Carvalho R.C. STD Control: Building Bridges for HIV/AIDS Prevention in Rio de Janeiro, Brazil.

Castillo J. Provocative Theater: An Invitation to Life, an Innovative Strategy for HIV/AIDS Prevention in the Commercial Sex Industry.

Chicrala M. To Evaluate HIV/AIDS Knowledge, Attitude and Practices among Low-Income Teenagers, including Street Dwellers in Rio de Janeiro, Brazil.

Clemente M. The Brazilian Condom Market: Positive Effects of Social Marketing.

Coleman J. Women and AIDS: A Coalition Educating for Empowerment and Prevention.

Cromack L. Should We Distribute Condoms to Adolescents? The Experience in Rio de Janeiro, Brazil.

Dallabetta G. Validation of the World Health Organization Diagnostic Algorithm and Development of an Alternative Scoring System for the Management of Vaginal Discharge in Malawi.

Delgrande J. AIDS Prevention for Low-Income CSWs in Two Urban Areas in the Northeast of Brazil.

de Zalduondo B. Insider Images of Sexual Relations in Cité Soleil: A Resource for BCC Interventions in Urban Haiti.

Douglas K. Risk Factors Associated with STD/HIV Seropositivity among Female Commercial Sex Workers: Implications for an Integrated Intervention Strategy.

Ella A. Strategy for HIV/AIDS Prevention Activities in the Armed Forces and Police in Cameroon.

Fernandes M.E. Capacity Building: A Critical Component in the Implementation of HIV/AIDS Prevention in Brazil.

Flanagan D. *Emma Says* and the Fleet of Hope: The Appeal of Global Messages and Icons.

Ford K. What Makes an Intervention Effective? A Multilevel Analysis of Data from Female Sex Workers, Pimps, and Clients in Bali, Indonesia.

Forsythe S. The Evolution and Role of Socioeconomic Impact Assessments in the Policy Process.

Gebre A. Health-Seeking Behaviors for STDs in Four Ethiopian Communities: Their Relevance for Designing Treatment and Prevention Programs.

Ghee A. Experience in the Philippines Using a Predesigned Qualitative Research Protocol to Investigate STD Health-Seeking Behavior.

Gravato N. Refinement of Census for Commercial Sex Worker in the City of Santos.

Hartwig K. The Role of Women Living with HIV in Community Education, Prevention, and Care.

Kalckmann A.S. Female Condom and the Media in Brazil.

Lacerda R. A Cohort Study of Risk and Serology among Male Port Workers in Santos, Brazil.

Lacerda R. Intervention for HIV/AIDS Prevention among Harbor Workers in the City of Santos, São Paulo, Brazil.

Lima Ivanilda S. Commercial Sex Workers Experience as Health Agents in Rio de Janeiro, Brazil.

MacNeil J. Weighing the Evidence: Linking Prevention with Care.

Mahlalela X. Experience of Capacity Building in HIV/AIDS Education and Prevention with South African Traditional Healers: The Nompumelelo Phambili Traditional Healers' Project.

Mahler H. Afraid to Use Fear? Observations and Recommendations from Africa, Asia, and Latin America.

Makinwa B. Misinformation among AIDS Educators: A Survey of Key Persons in Rwanda, Senegal, South Africa, and Tanzania.

Mangkalopakorn C. Opportunities for Sustainability in Bangkok's STD Clinics.

Manhart L. Sexually Transmitted Disease (STD) in Three Types of Health Clinics in Morocco: Prevalence, Risk Factors, and Syndromic Management.

Maradizika J. Knowledge of Preventive Practices, Awareness of Chances of Being

Infected, Reported Sexual Behavior, and Condom Use Prevalence among Youth.

Martins D. Qualitative Assessment of a Commercial Sex Workers Intervention Program in Santos, Brazil.

Marufu T. An HIV/AIDS KABP Survey Carried Out in a Military Community in Zimbabwe.

Moreno L. Empowerment among Commercial Sex Workers in STD/AIDS Prevention.

Naamara W. The Experience of Building Capacity with Local Evaluation Research Institutions in Africa: Zimbabwe, Tanzania, and Kenya.

Nhova A. An STD/HIV/AIDS KABP Survey Conducted in the Zimbabwe National Army.

Niang C. Health-Seeking Behavior for STDs in Senegal: Findings of a Targeted Intervention Research Study.

N'tcha J. A Targeted Intervention Research Study to Improve the Prevention and Treatment of STDs in Youth in Benin.

Odhiambo Ochola P. NGO Clustering for HIV/AIDS/STD Prevention and Control: The Tanzania AIDS Project (AIDSCAP) Experience.

Odindo R. The Use of Mass Media for Public Education on AIDS through Training of Journalists as AIDS Educators in Rwanda, Senegal, and Zimbabwe.

Paterson P. Brazil Logistics Management of Essential Commodities for AIDS Prevention.

Perez C. Sharing a Successful Experience in HIV/AIDS Prevention among Young Adults and Adolescents in São Paulo, Brazil.

Plucieni K. Logistics Management: AIDS Drugs and Condoms Procurement in the State of São Paulo, Brazil.

Preble E. MCH/FP Services and HIV/AIDS Prevention: The Case for Connection.

Pupo L. Speak Girl and Boy: Prevention of STD/AIDS, Safe Sex, Reproduction, and Sexuality.

Roets L. Health-Seeking Behaviors for STDs and the Social Context of Commercial Sex in a Gold Mining Community: A Case Study of Welkom, South Africa.

Rusakaniko S. Knowledge of Preventive Practices, Awareness of Chances of Being Infected, and Reported Condom Use Prevalence among Commercial Sex Workers.

Ryan C. Validation of Algorithms for the Syndromic Management of Sexually Transmitted Diseases in the Dominican Republic.

Siziya S. AIDS-Related Knowledge and Practices among Adult Commercial Farm

Workers in Zimbabwe.

Suazo M. STD Syndromic Management Program Implementation.

Szterenfeld C. Focus Group Discussions with Female Commercial Sex Workers in Rio de Janeiro, Brazil: Diversity in the Perception of Sexuality and Sex Workers.

Tellini R. Control and Prevention of Sexually Transmitted Disease in the Municipality of Santos, Brazil.

Tempongko S. Health-Seeking Behavior Related to STDs in a Commercial Sex Setting.

Tiglac T. Explanatory Models of STD Illnesses—Findings from a Qualitative Research Activity among Female Sex Workers in Manila and Cebu City, Philippines.

Velyvis Kristen A. Market Women in Senegal: Realities, Risks, and Appropriate Interventions.

Ward E. Contact Tracing: The Opportunity of Breaking the Chain of HIV Transmission.

Wasek G. National AIDS Control Policy Planning for Condom Requirements Forecasting.

Wasek G. The Pantera Condom: Meeting the Needs and Increasing the Availability of Condoms in the Dominican Republic.

Wendo D. Syndromic STD Surveillance and Monitoring of STD Case Management at MCH/FP Clinics in Kenya.

Calderón R. HIV/AIDS: Walking Towards the Future. USAID/AIDSCAP Dominican Republic HIV/AIDS prevention conference and preconference workshops. Santo Domingo, Dominican Republic. July 1996.

Calderón R. HIV/AIDS: A Challenge to Development. USAID/AIDSCAP Dominican Republic HIV/AIDS prevention conference and preconference workshops. Santo Domingo, Dominican Republic. July 1996.

Calderón R. HIV/AIDS and the Private Sector. USAID/AIDSCAP Dominican Republic HIV/AIDS prevention conference and preconference workshops. Santo Domingo, Dominican Republic. July 1996.

Calderón R. HIV/AIDS: A Priority Military Mission. USAID/AIDSCAP Dominican Republic HIV/AIDS prevention conference and preconference workshops. Santo Domingo, Dominican Republic. July 1996.

Calderón R. Press Conferences, TV Interviews, Radio Interviews. Santo Domingo, Dominican Republic. July 1996.

Calderón R. HIV/AIDS: A Challenge to Development. Chimaltenango State Medical Association and Regional Hospital. Guatemala City, Guatemala. August 1996.

Calderón R. HIV/AIDS and the Private Sector. Chimaltenango State Medical Association and Regional Hospital. Guatemala City, Guatemala. August 1996.

Calderón R. Diagnosis and Treatment of HIV/AIDS. Chimaltenango State Medical Association and Regional Hospital. Guatemala City, Guatemala. August 1996.

Calderón R. HIV/AIDS: A Challenge to the Private Sector and to Development. Asociación de Empresarios de Atlántida. La Ceiba, Honduras. August 1996.

Calderón R. USAID/AIDSCAP Cooperation in Central America. PAHO/WORLD HEALTH ORGANIZATION's IX Meeting of NACP Directors in the Central American Isthmus. Guatemala City, Guatemala. October 1996.

I Portuguese Congress of Epidemiology.
Porto, Portugal. October 20 - 22, 1996.

Oral Presentations:

Alves A. Training and Capacity/Building on Forms of STD/AIDS Infection for Information Multiplying Agents among Marginalized Populations in Rio de Janeiro.

Carvalho R.C. STD Control: Building Bridges for HIV/AIDS Prevention in Rio de Janeiro, Brazil.

Chricrala M. To Evaluate HIV/AIDS Knowledge, Attitude, and Practices among Low-Income Teenagers, including Street Dwellers in Rio de Janeiro, Brazil.

Clemente M. The Brazilian Condom Market: Positive Effects of Social Marketing.

Cromack L. Should We Distribute Condoms to Adolescents? The Experience in Rio de Janeiro, Brazil.

Delgrande J.P. AIDS Prevention for Low-Income CSWs in Two Urban Areas in the Northeast of Brazil.

Fernandes M.E. Capacity Building: A Critical Component in the Implementation of HIV/AIDS Prevention in Brazil.

Fernandes M.E. Process Indicator Information System: A Tool for Monitoring and Evaluating HIV/AIDS Prevention Programs.

Gravato N. Refinement of Census for Commercial Sex Workers in the City of Santos.

Henriques C. Educational Intervention for CSWs and Their Clients in the Municipality of Santos, Brazil.

Kalckmann A. Female Condom and the Media in Brazil.

Lacerda R. Intervention for HIV/AIDS Prevention among Harbor Workers in the City

of Santos, São Paulo, Brazil.

Lima I. Commercial Sex Workers (CSWs) Experience as Health Agents in Rio de Janeiro, Brazil.

Martins D. Qualitative Assessment of a Commercial Sex Workers Intervention Program in Santos, Brazil.

Perez A. Women and AIDS Prevention: The Private Sector Response through *Claudia* Magazine.

Perez C. Sharing a Successful Experience on HIV/AIDS Prevention among Adults and Adolescents in São Paulo, Brazil.

Pinto V. HIV Infection and STD Prevalence among Women Monitored through a Prenatal Program in Brazil.

Pupo L. Speak Girl and Speak Boy—Prevention of STD/AIDS, Safe Sex, Reproduction and Sexuality.

Szterenfeld C. Focus Group Discussions with Female Commercial Sex Workers in Rio de Janeiro, Brazil: Diversity in the Perception of Sexuality and Sex Work.

Tellini R. Control and Prevention of Sexually Transmitted Diseases (STDs) in the Municipality of Santos, Brazil.

Tellini R. STD Survey among Female Inmates in the City of Santos, Brazil.

Wasek G. Brazil Logistics Management of Essential Commodities for AIDS Prevention.

Calderón R. HIV/AIDS: Walking Towards the Future. USAID/AIDSCAP HIV/AIDS program close-out forum. Kingston, Jamaica. November 1996.

Lamptey P. AIDS in Africa. BBC World Service. November 15, 1996.

Lamptey P. Sexual Transmission of HIV. Harvard University School of Public Health. Boston, Massachusetts. November 25, 1996.

Calderón R. CNN International's "Insight" program on HIV/AIDS around the world. Washington, D.C. December 2, 1996.

Calderón R. USIA WORLDNET TV interview on AIDS, drugs, and the workplace. Washington, D.C. December 2, 1996.

1997

Calderón R. Future Challenges in HIV/AIDS Prevention and Control. FHI/AIDSCAP/

CEDPA Gender and STD Training Workshop. Arlington, Virginia. January 1997.

Lamptey P. Global HIV/AIDS Situation. U.S. Department of State. January 16, 1997.

Steen R. Periodic Presumptive Treatment of Women at High Risk: An Intervention to Reduce the Prevalence of STDs in a South African Mining Community. World Health Organization collaborative center meeting. Nairobi, Kenya. January 1997.

Ankrah E.M. AIDS Prevention Among Women: A Synergistic Framework. The Role and Responsibility of Women for the Prevention of RTI/STD/HIV/AIDS Seminar. Chennai, Tamil Nadu, India. February 21 - 22, 1997.

Calderón R. A Challenge to Development and the Role of the Parliamentarians in the Fight against HIV/AIDS. Interamerican Parliamentarians Workshop. Nicaragua. March 1997.

Calderón R. A Challenge to Development and the Multidimensional Model for the Prevention and Control of HIV/AIDS. VII National Congress on Research and Public Health Symposium. Mexico. March 1997.

Hogle J. Assessing Behavior Change Communication in Ethiopia: Lessons for HIV/AIDS/STD Prevention Programming. Society for Applied Anthropology. Seattle, Washington. March 1997.

Vivanco L. Gathering Data and Web Sources for Research. Washington, D.C. March 26, 1997.

Ankrah E.M. Opening and closing remarks. Gender and STDs: Challenges to Partners in the Latin American/Caribbean Region. Arlington, Virginia. April 29 - 30, 1997.

Calderón R. The Multidimensional Model for the Prevention and Control of HIV/AIDS. The Margaret Sanger Center for International Leadership Training Program. New York, New York. May 1997.

The Female Condom: From Research to the Marketplace. Arlington, Virginia. May 1 - 2, 1997.

Oral Presentations:

Ankrah E.M. Opening and Closing Remarks.

Lamptey P. Opening Remarks.

Asiedu K. Chair: Report Back to Plenary.

Schwarzwalder T. Closing Remarks.

Butler de Lister M. Closing Remarks.

Facilitators:

O'Grady M. The Science of the Female Condom.

Vigano O. Price as a Pivotal Factor: How Can the Female Condom Be Made More Affordable?

Hogle J. Evaluating the Impact of this New Prevention Option.

Saidel T. Evaluating the Impact of this New Prevention Option.

Moderators:

Schellstede W. Social Marketing.

Meloni Vieira E. FHI/AWI Kenya and Brazil.

Dallabetta G. Partner Management. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Dallabetta G. STD Drugs. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Dallabetta G. STD Program Management. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Dallabetta G. STDs as a Public Health Priority. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Dallabetta G. The Challenge of STDs. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Dallabetta G. and Field M.L. Launch of *Control of Sexually Transmitted Diseases: A Handbook for the Design and Management of Programs* in Portuguese. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Fernandes M. STD Work Proposal. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Field M.L. Behavior Change in the Clinical Setting. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Field M.L. Information, Education, and Communication Strategies. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Field M.L. Innovative Approaches. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Vuylsteke B. Syndrome Management. Control of Sexually Transmitted Diseases: International Workshop. Salvador, Bahia, Brazil. May 15 - 17,1997.

Ankrah E.M. Opening and Closing Remarks. All India Women's Conference. New Delhi, India. May 29 - 30, 1997.

Douglas D. Strangers in a Strange Land: Foreign Fishermen in Indonesia and the Risk of HIV Transmission to Indigenous Communities. Chiang Rai, Thailand. May 30 - 31, 1997.

Calderón R. HIV, AIDS, and STDs. Christian Youth Week Conference. Washington, D.C. June 1997.

Ankrah E.M. Opening Address. REDSO/WCA Family Health and AIDS Project. Ouagadougou, Burkina Faso. July 7 - 11, 1997.

Ankrah E.M. HIV/AIDS: The AIDSCAP Experience through its Women's Initiative. Congressional Task Force. U.S. State Department. Washington, D.C. July 22, 1997.

Calderón R. USAID/AIDSCAP's Technical Cooperation, Strategies, and Lessons Learned in HIV/AIDS. Regional Civil Military Conference. Honduras. July 1997.

Lamptey P. Status and Trends of the HIV/AIDS Epidemic in Africa. African-American African Summit. Harare, Zimbabwe. July 22, 1997.

Calderón R. A Challenge to Development and the Multidimensional Model for the Prevention and Control of HIV/AIDS. USAID/AIDSCAP program close-out workshop. Honduras. August 1997.

Calderón R. Program Close-Out Remarks. USAID/AIDSCAP program close-out ceremony. Dominican Republic. August 1997.

Hogle J. and Mills S. Validity and Reliability of BSS: Methods and Examples. HIV Risk Behavioral Surveillance Workshop. Bangkok, Thailand. August 11 - 14, 1997.

Lamptey P. The Status of the HIV/AIDS Epidemics in Africa. CNN. Washington, D.C. August 8, 1997.

Rehle T. The Role of BSS in Evaluation: Attribution of Observed Behavior Changes to Prevention Programs. HIV Risk Behavioral Surveillance Workshop. Bangkok, Thailand. August 11 - 14, 1997.

Rehle T. and Saidel T. Modeling HIV Infections Averted Using BSS Data: The AVERT Program. HIV Risk Behavioral Surveillance Workshop. Bangkok, Thailand. August 11 - 14, 1997.

Saidel T. Trend Analysis and Other Analysis Issues. HIV Risk Behavioral Surveillance Workshop. Bangkok, Thailand. August 11 - 14, 1997.

Saidel T. and Hogle J. Questionnaire Design and Indicators. HIV Risk Behavioral Surveillance Workshop. Bangkok, Thailand. August 11-14, 1997.

Steen R. Syndromic Management of STDs. JHPIEGO workshop for nurse-trainers. Nairobi, Kenya. August 1997.

Ankrah E.M. The Female Condom: Is It Acceptable to Both Men and Women? Maxwell Women's Caucus of Syracuse University. Washington, D.C. September 24, 1997.

Lamptey P. Cultural Issues Affecting Mother-Infant Transmission. Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants. Arlington, Virginia. September 3, 1997.

Lamptey P. Prevention of HIV Transmission: Global Success Stories. Annual meeting of the Infectious Diseases Society of America. San Francisco, California. September 14, 1997.

O'Grady M. Presentation on the History and Objectives of the Monitoring the AIDS Pandemic (MAP) Network. Pan American Health Organization. Washington, D.C. September 1997.

Odindo R. Women Audiences Response to HIV/AIDS Education and the Prevention of Vertical HIV Transmission. Poster Presentation at the Global Conference on Mother-to-Child Transmission of HIV. Arlington, Virginia. September 2 - 6, 1997.

Steen R. Periodic Presumptive Treatment of Women at High Risk: An Intervention to Reduce the Prevalence of STDs in a South African Mining Community. South African STD and ID Congress. Cape Town, South Africa. September 1997.

Steen R. Cost-Benefit Analysis of an Intervention to Reduce the Prevalence of Curable STDs in a South African Mining Community. Poster presentation at the South African STD and ID Congress. Cape Town, South Africa. September 1997.

Steen R. Asymptomatic Gonococcal and Chlamydial Infections in a Population-Based Sample of South African Gold Miners. Poster presentation at the South African STD and ID Congress. Cape Town, South Africa. September 1997.

Steen R. STD Services for Women at High Risk: Outreach and Service Delivery. Poster presentation at the South African STD and ID Congress. Cape Town, South Africa. September 1997.

Steen R. Training in STD Management. Forum for the Establishment of Appropriate STD Services. Johannesburg, South Africa. September 1997.

AIDSCAP Lessons Learned Forum.
Washington, D.C. October 7 - 8, 1997.

Oral Presentations:

Lamptey P. Introduction.

Mtasiwa D. Integration with Family Planning.

Flanagan D. Overview of AIDSCAP's Peer Education.

Basnyat A. Nepal: General Welfare Pratisthan Outreach.

Rau B. Private Sector AIDS Policy Program.

Fernandes M. Brazil: Private Sector Leveraging.

Tennah A. Kenya: Workplace Collaborating.

Rehle T. Evaluation in AIDSCAP, AVERT, and Future Challenges.

Saidel T. HIV Risk Behavioral Surveillance Surveys: Rationale, Examples, and Lessons Learned.

Rosengren J. Gender: An Emerging Technical Strategy.

Meloni Vieira E. Coalition Building among Women's Groups.

Ochola P. Lessons in Gender Training.

MacNeil J. AIDSCAP's Behavioral Research.

Kamenga C. Counseling and Testing for HIV/AIDS Prevention.

Schellstede W. Condom Social Marketing through AIDSCAP.

Forsythe S. AIDSCAP's Experience with Economic Assessments.

Rau B. AIDSCAP's Experience in Kenya.

Mitchell S. Capacity Building.

chola P. Nongovernmental Organization Clusters and Jump Start Process.

Goodridge G. Community Involvement.

Dallabetta G. Cameroon: *MSTOP* (Stop Sexually Transmitted Disease).

Steen R. Periodic Presumptive Treatment of Women at High Risk.

Butler de Lister M. Dominican Republic: Mass Media Campaigns for Adolescents and Their Parents.

Nguma J. Tanzania: Radio and Newspapers.

Fernandes M. Brazil: *Claudia* Magazine.

Lamptey P. Summary of Lessons Learned during the AIDSCAP Project.

Dallabetta G. Current Issues in HIV/AIDS Prevention and Mitigation. State of the Art Course. Chiang Mai, Thailand. October 3, 1997.

Lamptey P. Interview for video documentary on Global HIV/AIDS situation, an independent production by Levi Strauss. Arlington, Virginia. October 1997.

Lamptey P. Co-chair of the Monitoring the AIDS Pandemic (MAP) Network Symposium on the Status and Trends of the HIV/AIDS/STD Epidemics in Asia and the Pacific. Manila, Philippines. October 1997.

IV International Congress on AIDS in Asia and the Pacific. Manila, Philippines. October 25 - 29, 1997.

Oral Presentations:

Basnyat A. Keys to Improved Intra-Project Partner Collaboration.

Benjarattanaporn P. Patients with Higher Risk Behavior Seek Treatment at Informal STD Health Treatment Sources.

Bun Leng H. Current Situation and Future Projection of HIV/AIDS Epidemic in Cambodia.

Mitchell S. Co-chair for quality assurance in HIV testing panel.

Mitchell S. HIV Testing: Ensuring a Safe Blood Supply.

Mitchell S. Reducing the Costs of HIV Testing.

Neupane B. The STD Case Management Approach Suits Client Needs in Nepal.

Shrestha K. Human Resource Development in the Field Strengthens Outreach Interventions in a Nepal-India Cross-Border Community.

Tuladhar S. Evaluating Chemists' Dispensing Practices to Treat Sexually Transmitted Diseases in Central Nepal.

Poster Presentations:

Bennett T. HIV Differentials in Asia.

Gorbach P. The Risk of Sex in Cambodia: Individual Risk Factors for STD/HIV.

Leng H. Fueling the HIV Fire—Sexually Transmitted Infections (STIs) in Cambodia: Prevalence, Antibiotic Susceptibilities, and World Health Organization Algorithm Performance.

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Shrestha A. Cross-Border HIV/AIDS Prevention Experiences from Nepal.

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Financial Summary

Project Funding

FHI AIDSCAP PROJECT

Funded by United States Agency for International Aid (USAID)

Cooperative Agreement	DPE-5972-A-00-1031-00
Core Contract	HRN-C-00-94-00001-17
Requirements Contract	HRN-5972-Q-00-4002-00

Life of Project Funding:

Cooperative Agreement	77,135,212
Core Contract	74,1355,010
Requirements Contract	51,730,567
Total Funding	$203,141,789

Sources of Funding

USAID Regional Bureaus

Africa	5,799,500
Asia	6,641,000
LAC	1,125,881
Subtotal USAID Regional Bureaus	**13,566,381**

USAID Missions

Africa

Burundi	490,894
Cameroon	1,550,000
Côte d' Ivoire	79,776
Ethiopia	3,413,771
Guinea	97,000
Kenya	5,937,182
Lesotho	624,000
Malawi	400,000
Mali	475,000
Morocco	829,585
Mozambique	500,000
Niger	350,000
Nigeria	5,630,000
REDSO/ESA	263,000

REDSO/WCA	770,000
Rwanda	4,660,000
Senegal	8,405,614
South Africa	6,591,584
Tanzania	13,766,818
Uganda	200,000
Zimbabwe	4,940,000
Subtotal Africa	**59,974,224**

Asia

India	920,500
Indonesia	6,848,897
Nepal	1,799,232
Philippines	450,000
Subtotal Asia	**10,018,629**

LAC

Bolivia	49,804
Brazil	7,934,293
Colombia	75,000
Costa Rica	150,000
Dominican Republic	6,623,463
Ecuador	298,000
El Salvador	150,000

Haiti	7,792,820
Honduras	3,153,291
Jamaica	5,509,252
Mexico	100,000
Nicaragua	608,190
Peru	14,055
Subtotal LAC	**32,458,168**
Subtotal USAID Missions	**102,451,021**

Other

CDC	100,000
NIAID	400,000
R&D UNICEF Collaborative Effort	500,000
R&D/Women in Development	582,000
Subtotal Other	**1,582,000**
Global Bureau/HIV/AIDS Division	**85,542,387**
Total	**$203,141,789**

Family Health International/AIDSCAP
Projected Life of Project Expenditures
By Award/Program Category

Total Expenditures
Core Contract HRN-C-00-94-00001-17

Fiscal Year 91	-
Fiscal Year 92	-
Fiscal Year 93	-
Fiscal Year 94	6,785,880
Fiscal Year 95	20,967,948
Fiscal Year 96	20,405,430
Preliminary Fiscal Year 97	18,357,327
Projected Fiscal Year 98	5,000,000
	71,516,585

Requirements Contract
HRN-Q-00-94-00002-04

Fiscal Year 91	-
Fiscal Year 92	-
Fiscal Year 93	-
Fiscal Year 94	1,402,364
Fiscal Year 95	13,927,528
Fiscal Year 96	16,002,785
Preliminary Fiscal Year 97	18,311,009
Projected Fiscal Year 98	240,000
	49,883,686

Cooperative Agreement
DPE-5972-A-00-1031-00

Fiscal Year 91	32,500
Fiscal Year 92	9,276,618
Fiscal Year 93	25,162,666
Fiscal Year 94	25,765,115
Fiscal Year 95	10,567,551
Fiscal Year 96	6,234,193
Preliminary Fiscal Year 97	1,060
Projected Fiscal Year 98	-
	77,039,703

Total

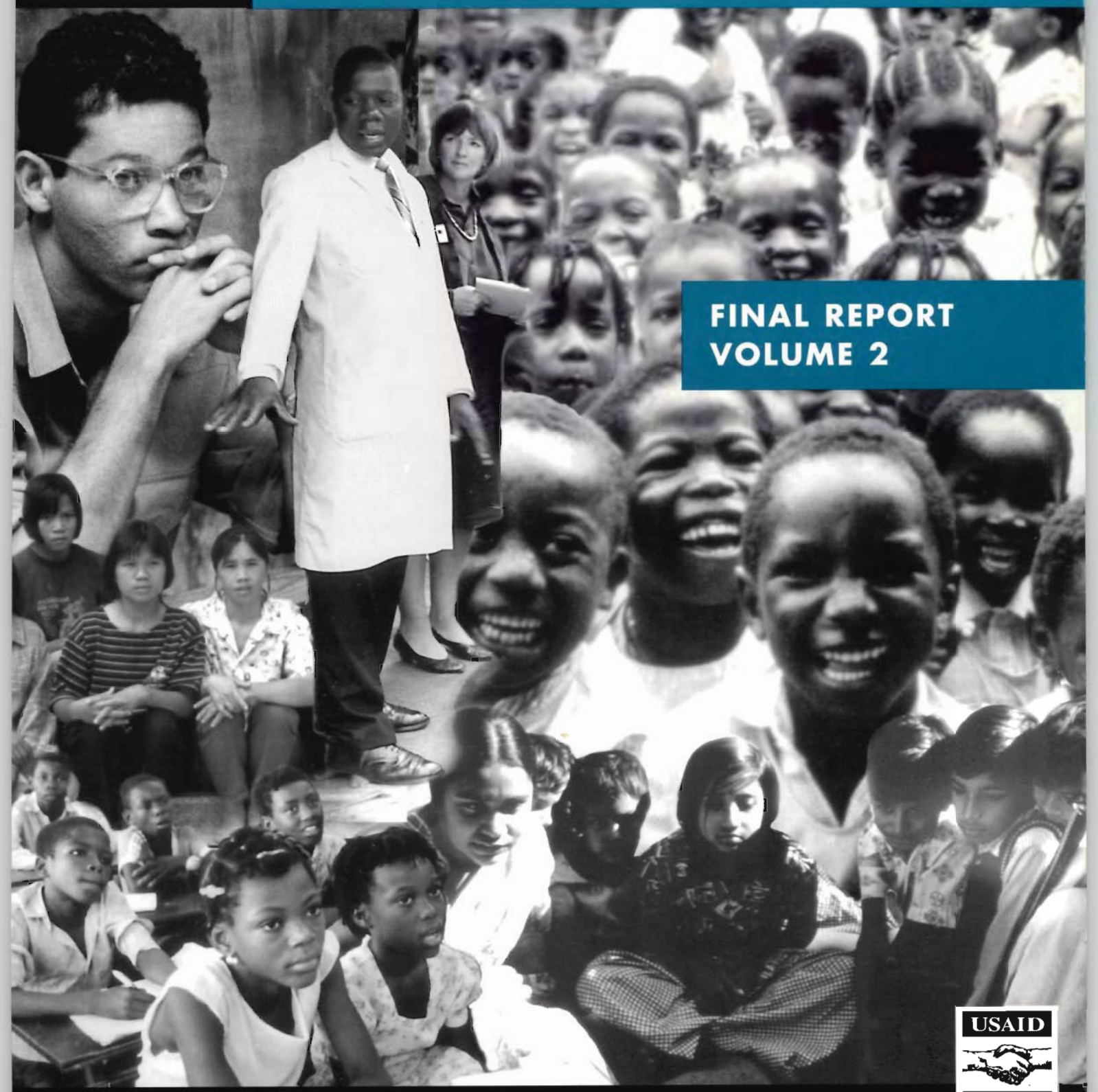
Fiscal Year 91	32,500
Fiscal Year 92	9,276,618
Fiscal Year 93	25,162,666
Fiscal Year 94	33,953,359
Fiscal Year 95	45,463,027
Fiscal Year 96	42,642,408
Preliminary Fiscal Year 97	36,669,396
Projected Fiscal Year 98	5,240,000
	198,439,974

AIDSCAP

FAMILY HEALTH INTERNATIONAL

AIDS CONTROL AND PREVENTION PROJECT

AUGUST 27, 1991 - DECEMBER 31, 1997



FINAL REPORT
VOLUME 2

USAID

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Final Report

AIDSCAP

Family Health International

AIDS Control and Prevention Project

August 21, 1991-December 31, 1997

Final Report Volume 2

December 31, 1997

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Project 936-5972.31-4962046

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Introduction

From August 27, 1991, to December 31, 1997, the AIDS Control and Prevention (AIDSCAP) Project implemented by Family Health International (FHI) assisted in the design, implementation, monitoring, and evaluation of 584 subprojects and more than 250 rapid-response activities. This volume contains brief summaries of each AIDSCAP/FHI country program or activity. It is divided by region (Africa, Asia/Near East, Latin America/Caribbean), and within each region countries are grouped alphabetically under two categories: major and associate countries.

Countries designated as "major" had large-scale, comprehensive programs that encompassed AIDSCAP/FHI's major program strategies (behavior change communication, condom programming, and control of sexually transmitted infection) and efforts to create more supportive policy environments for HIV/AIDS prevention. Activities in "associate" countries ranged from design and implementation of large-scale country programs to smaller but long-term subproject activities and short-term technical assistance in program design and evaluation. Each summary presents an overview of a country program or activity, including the context, program objectives, accomplishments, and outcomes. This information was drawn from the final reports submitted for each country. For more detailed information on regional programs, please refer to Volume 1 of the AIDSCAP Final Report.

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Africa

Major Countries

Cameroon

Ethiopia

Kenya

Nigeria

Rwanda

Senegal

South Africa

Tanzania

Zimbabwe

Associate Countries

Côte d'Ivoire

Lesotho

Mali

Mozambique

Niger

West Africa

Zambia

Asia

Major Countries

India

Indonesia

Nepal

Thailand

Associate Countries

Bangladesh

Egypt

Mongolia

Morocco

Philippines

Sri Lanka

Areas of Affinity:

Indian Subcontinent

Indonesia/Philippines

South Pacific Island Nations

Thai/Cambodia/ Vietnam

Thai/Lao PDR/Burma

Latin America/ Caribbean

Major Countries

Brazil

Dominican Republic

Haiti

Honduras

Jamaica

Associate Countries

Bolivia

Colombia

Costa Rica

Ecuador

El Salvador

Guatemala

Nicaragua

Peru

Regional Activities

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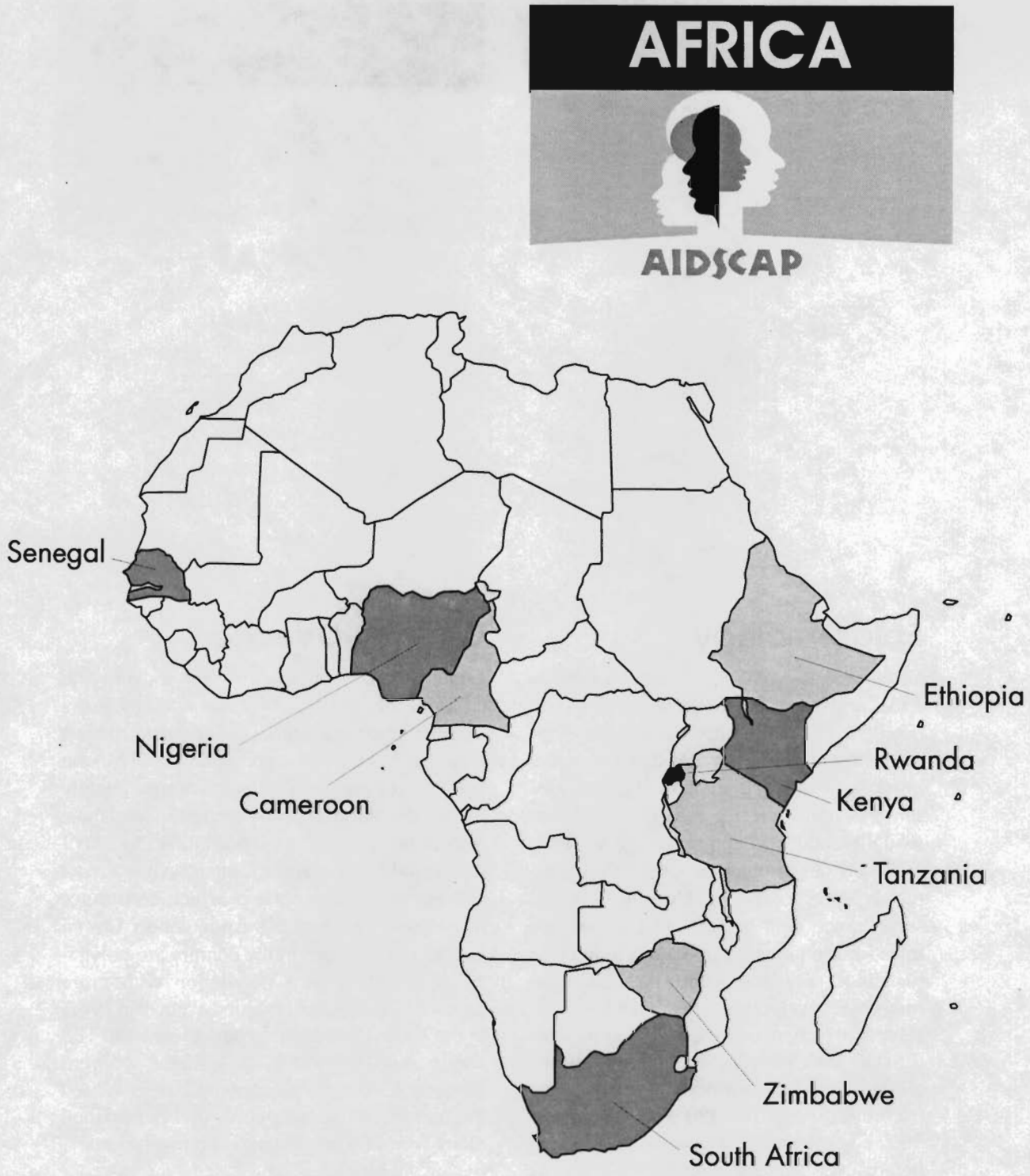

Major Countries

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Cameroon

Epidemiology

Cameroon's first AIDS case was reported in 1985, and by 1995 the number of cases had risen to 8,141. The United Nations Development Programme estimates that the actual number of cases is at least 24,000. HIV seroprevalence among the general, urban, sexually active population has grown from less than 0.5 percent in 1987 to approximately 5 percent in 1996. However, sentinel surveillance data indicate that prevalence rates for the general population may be as high as 10 percent in some cities. Dramatic increases in seroprevalence have been observed in urban commercial sex workers (CSWs). For example, among Yaoundé sex workers, the HIV seroprevalence rate rose from 8.6 percent in 1990 to 25 percent in 1992. The primary transmission mode is heterosexual, and the epidemic primarily affects the young, sexually active population: 70 percent of Cameroon's AIDS cases are among the population aged 20 to 39. HIV prevalence is higher in urban areas than in rural settings, and the proportion of male to female cases is nearly equal.

Country Overview

Cameroon, one of Africa's most socially and culturally diverse countries, has a rapidly growing population, currently estimated at 13 million inhabitants. Half of the population is within the sexually active age range group. Approximately 35 percent of the population is urban, and most of these persons live in the port city of Douala or the capital city Yaoundé. Cameroon has almost 200 ethnic groups, none of which constitutes more than 20 percent of the population. Over a quarter of marriages in the country are polygamous, resulting in a population with more unmarried men than unmarried women: in 1987, in the 15 to 39 year age group, there were 183 single men for every 100 single women. Cameroon's stagnant economy has increased the number of single people and has pushed many women and girls into commercial sex.

In 1992, AIDSCAP/Cameroon, with financial and political support from USAID/Cameroon, initiated a 4-year program to assist the National AIDS Control Service in strengthening its capacity to design, implement, evaluate, and sustain

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programs to prevent the sexual transmission of HIV. In collaboration with governmental agencies, international donors, and both indigenous and international nongovernmental organizations (NGOs), AIDSCAP/Cameroon conducted activities on a national level and in geographically focused areas. The program targeted subpopulations increasingly affected by the epidemic: young people, CSWs and their clients, sexually transmitted infection patients, and the military personnel. Sentinel surveillance, policy development, capacity building, and behavioral research supplemented behavior change activities.

Accomplishments

AIDSCAP/Cameroon mobilized communities, organizations, and individuals against HIV/AIDS and fulfilled most of the objectives of the country's second medium-term plan for HIV/AIDS control. Interventions conducted on a national scale included condom social marketing, HIV sentinel surveillance, and the development of national STI treatment guidelines. Geographically focused activities were conducted at university campuses, military bases, hotels, bars, brothels, and STI clinics located in urban and commercial sites throughout Cameroon's French-speaking provinces. Postintervention data indicated that significant knowledge and behavior change occurred among targeted populations. Moreover, through AIDSCAP's efforts, the staff of government agencies and local NGOs improved their HIV/AIDS knowledge base and their technical and managerial skills.

Behavior Change Communication

The heart of AIDSCAP/Cameroon's program was its pioneering behavior change interventions, which have inspired peer education models currently used worldwide. All targeted interventions focused on treating STIs and reducing sexual risk taking, including promotion of abstinence for young adults, fidelity for couples, partner reduction, and condom use. Interventions used multiple, reinforcing communication channels and activities. Specific approaches consisted of formal educational sessions, informal chats, one-on-one counseling, and use of mass and traditional media. Through its behavior change communication (BCC) activities, AIDSCAP/Cameroon trained over 2,000 peer educators and leaders, who in turn educated more than 620,000 women, men, and youth about STI/HIV/AIDS prevention. Production and distribution of over 300,000 educational materials reinforced interpersonal and mass communication activities. Results of pre- and postintervention studies (see Table 12) indicated notable knowledge and behavior change.

Condom Promotion and Distribution

Condom social marketing, implemented by AIDSCAP subcontractor Population Services International (PSI), complemented and reinforced BCC activities. Under AIDSCAP, the program expanded nationwide through officially recognized and supervised distributors in all major urban centers. Peer educators, especially CSWs, served as sales agents in nontraditional venues, while social marketing staff supplied more traditional commercial outlets. Over the life of AIDSCAP, the social marketing program sold over 24 million condoms.

Strengthening STI Services

At the initiation of the AIDSCAP/Cameroon program, no national STI control program existed, and many existing health care structures managed STI cases ineffectively. As a result of AIDSCAP activities, a national STI control plan and standard diagnosis and treatment guidelines were developed and adopted by the Ministry of Public Health (MOPH). Moreover, a core group of 10 physicians at the central level, as well as 40 military health care staff, received the necessary training and are currently disseminating the treatment guidelines to providers throughout the country. As part of the development of the

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AIDSCAP/Cameroon Pre- and Postintervention Knowledge, Attitudes, Beliefs, and Practices (KABP) Results

	1993/4	1996
Knowledge of two correct methods of HIV/AIDS prevention	**Percent**	
Male university students	79	95
Female university students	84	95.6
Clients of sex workers	50	86
CSWs	40	87
Male university students reporting > one sexual partner in the last 3 months	53	36
Male military personnel reporting > two sexual partners in the last 3 months	47	37
Proportion who report having ever used a condom		
CSWs	68	88
CSW clients	55.5	81
Proportion of CSW clients reporting condom use during last sexual encounter with nonregular partner	54 (1992)	97
Proportion reporting consistent condom use		
Sex workers with nonregular clients	52	75
Military personnel with CSWs	48	59

guidelines, AIDSCAP also supported critical research to determine the sensitivity of *Neisseria gonorrhoeae* to 10 antibiotics commonly used in Cameroon. In addition, AIDSCAP, in collaboration with the MOPH and PSI, conducted an innovative pilot project to distribute prepackaged urethritis treatment kits using social marketing techniques. Although the MOPH discontinued this project after the pilot phase, it provided invaluable information for other countries considering such an approach.

Capacity Building

AIDSCAP assisted in building the capacity of governmental agencies as well as international and local NGOs. Capacity building focused on improving the skills of local experts to help them become more effective in HIV/AIDS prevention. Through AIDSCAP's efforts, approximately 20 master trainers now improve the skills of local staff in technical areas, including BCC materials development and STI case management. AIDSCAP-sup-

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ported development of training manuals, adapted locally with the assistance of local health care, social science, and communication experts, were greeted enthusiastically by organizations conducting HIV/AIDS prevention activities.

Special Features

AIDSCAP/Cameroon's integration of CSW peer educators into condom social marketing efforts proved highly successful: CSW educators/salespersons sold over 3 million condoms in Yaoundé alone. The Cameroon program also capitalized on the effectiveness of drama as an HIV/AIDS prevention medium, particularly in noisy, crowded bars and clubs not conducive to educational activities. For example, with AIDSCAP support, three theatrical CSW troupes toured the country, giving highly popular performances in venues from small beer houses to small urban theaters. Troupes even performed for international audiences at HIV/AIDS and STI conferences. Video recordings of these troupes' performances were broadcast on national television and are currently used in a variety of educational programs.

Development of a close collaborative relationship with the Ministry of Defense and National Security provided an unusual opportunity to bring HIV/AIDS prevention activities to men and women in uniform, culminating in a military decree that made STI/HIV/AIDS prevention an obligatory component of military training and part of the examination for promotion in Cameroon's armed forces. Finally, as part of AIDSCAP's Care and Management Program, the Cameroon program provided technical assistance and financial support to the Association of United Brothers and Sisters, an indigenous NGO providing counseling and care to persons living with HIV/AIDS and their families.

Implementing Partners

Ministry of Public Health

Ministry of Defense and National Security

Ministry of Higher Education

Cameroon Health Program

Institute of Tropical Medicine

Population Services International

Institut Pasteur

Institut de Recherche et des Études de Comportement

CARE Cameroon

Save the Children

The Association of United Brothers and Sisters

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Ethiopia

Epidemiology

Ethiopia's first HIV-positive individuals were reported in 1986. In 1988, HIV prevalence rates among commercial sex workers (CSWs) were already 15 percent in Awassa and 20 percent in Bahirdar. Rates increased in Bahirdar to 70 percent by 1991. Rates among pregnant women aged 15 to 24 in Addis Ababa were 2 percent in 1989 and 13 percent in 1993. By 1996, estimates of HIV prevalence in four antenatal clinics in Addis Ababa were 26.5 percent, 21.4 percent, 15.7 percent, and 9.0 percent, and among CSWs, prevalence ranged from 40 to 60 percent. The HIV/AIDS epidemic is still in an expansion stage, and studies conducted in 1994 and 1996 indicate that HIV incidence rates remain high.

Factors contributing to the rapid spread of HIV/AIDS include the seasonal migration of workers in search of employment and better economic conditions, which leads to increased multiple partner sexual networking; dislocation of populations due to the 17-year civil war, which created social situations conducive to increased sexual networking; high rates of sexually transmitted infections (STIs) in high-risk and general populations; increased sexual activity among youth; and high unemployment rates, exacerbated by the return of 400,000 demobilized soldiers to rural areas, towns, and cities after 1991.

Country Overview

Northeast Africa's most populous country, Ethiopia has a 2,000-year history and over 70 ethnic groups speaking nearly 100 languages. The population, which is 90 percent rural, is predominantly Orthodox Christian, although there is a substantial Muslim population. For the past 3 decades, severe political, economic, and ecological crises—a long civil war, unstable government, recurrent drought, massive environmental degradation, and an unfavorable international economic environment—have created a context conducive to the rapid spread of HIV. The government of Ethiopia took an early aggressive stance toward coping with the epidemic and has continued its commitment in

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spite of these crises. From January 1993 to March 1997, AIDSCAP implemented a comprehensive set of HIV/AIDS prevention activities, under two USAID/Ethiopia bilateral projects, through the Ministry of Health (MOH), the Ministry of Education, and 15 nongovernmental organizations (NGOs).

Accomplishments

AIDSCAP/Ethiopia helped fill gaps left by the government's decentralization of HIV/AIDS control activities, which occurred at the beginning of the program. Twenty sites participated in interventions to improve STI services. Of the participating sites, four focus sites developed a model of integrated, comprehensive interventions that coordinated public and private resources at the regional level and featured improved STI care and outreach to high-risk individuals. National condom social marketing supported all activities.

The four focus sites targeted female sex workers (referred to locally as MPSCs, or multiple partner sexual contacts), factory and government workers, in- and out-of-school youth, and the general population with behavior change communication (BCC) messages. AIDSCAP/Ethiopia supported key players and organizations in the four targeted regions by implementating intervention activities that included creating innovative focus site intervention teams (FSITs); training health care providers, peer educators, and other stakeholders; supplying drugs and equipment for STI clinics; and supplying educational equipment to support BCC programming.

Behavior Change Communication

The foundation of AIDSCAP/Ethiopia's program was behavior change intervention which focused on promoting ways of reducing sexual risk taking. NGOs supported by the program developed innovative strategies to reach target groups and creative materials, including a pocket risk assessment calendar, traditional street theater with prevention messages, and an adaptation of the Fleet of Hope imagery originally developed in Tanzania. Messages promoted delayed sexual initiation for young adults, fidelity for couples, partner reduction, condom use, and prompt and effective treatment for STIs. Interventions used multiple, reinforcing communication channels and BCC activities, emphasizing drama, puppetry, sports events, and materials shared widely among implementing agencies.

During the life of the $3-million program, AIDSCAP/Ethiopia provided training to nearly 6,000 people, reached about 750,000 people with HIV/AIDS prevention messages, distributed nearly 900,000 educational materials, and distributed or sold close to 42 million condoms.

Results of evaluation research indicate that knowledge increased and risk behavior changed among the target audiences. For example, the proportion of MPSCs who could cite two or more prevention methods increased from 78 to 99 percent, and the proportion who had recently received appropriate STI treatment rose from 55 to 73 percent. Although a higher percentage of out-of-school youth reported that they were sexually active and had multiple partners at the end of the program, their use of condoms also increased. Qualitative research suggests that AIDSCAP/Ethiopia's intensive interventions made substantial progress in changing knowledge, attitudes, behaviors, and practices (KABP) related to HIV/AIDS.

Condom Promotion and Distribution

The Ethiopia Social Marketing Project (ESMP), implemented by DKT International and Population Services International (DKT/PSI), has emerged as one of the most successful social marketing efforts in Africa since its inception in 1990. During the 33 months of collaboration with AIDSCAP, the ESMP sold approximately 42 million condoms through more than 10,000 outlets in 533 different

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AIDSCAP/Ethiopia Pre- and Postintervention KABP Results

Percentage	1994–5	1996
Knowledge of 2 or more prevention methods		
out-of-school youth	78	32
MPSCs	98	99
Reported AIDS can be prevented by not touching AIDS patient		
MPSCs	91	21
Know HIV-positive person can look healthy		
out-of-school youth	85	69
MPSCs	99	55
Are sexually active youth	39–69	males- 83 females -63
Have access to condoms		
out-of-school youth	78	95
MPSCs	91	95
Were examined at appropriate health facility during past 3-6 months		
MPSCs	55	73
Had >1 partner in past 12 months		
out-of-school youth	12–30	males- 50 females -33
Ever used condoms		
out-of-school youth	31–57	males 72/females 57
MPSCs	48–97	97
Used condom during last sex with nonregular partner		
out-of-school youth	21–40	males 58, females 48
MPSCs	45	80

cities, towns, and villages. In the last full year of program activities, the ESMP sold over 15 million condoms, averaging 1.25 million per month—25 percent more than the target of one million per month. These impressive sales figures were achieved despite serious constraints to implementation, including the lack of a developed commercial marketing and distribution system, the expansion of civil war, and target populations' unfamiliarity with condoms. Sales through bars and hotels—marketing and distribution outlets easily accessible to high-risk populations—accounted for nearly 25 percent of all ESMP sales. AIDSCAP support enabled DKT/PSI to secure longer-term funding from USAID and the Dutch Government for the continued operation and expansion of social marketing in Ethiopia through 1999.

Strengthening STI Services

Improving STI services was a significant component of the program. AIDSCAP refurbished the 20 clinical sites by providing STI drugs and laboratory equipment, improving infrastructure, training providers in syndromic management, developing case management guidelines and counseling protocols, and increasing the availability of condoms.

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The program also sponsored a rapid ethnographic study (targeted intervention research, or TIR) of KABP related to STI/HIV/AIDS among targeted populations, which yielded results that were used to develop educational materials, and conducted a gonococcal chemosensitivity study in two locations.

A comprehensive assessment of the 20 clinical sites at the end of the program found that 97 percent of health care providers had the skills and knowledge required for appropriate STI case management and had accepted syndromic management as essential for managing STI cases. In all focus sites and in 80 percent of the STI clinical sites, STI services are integrated into maternal child health and family planning (MCH/FP) services as a result of onsite training conducted for MCH/FP workers that emphasized STI screening of FP attendants and syphilis screening of pregnant women.

Capacity Building

Through its collaboration with local public and private partners, AIDSCAP/Ethiopia made a substantial contribution to developing local capacity to design, implement, and evaluate HIV/AIDS prevention programs, despite the massive decentralization of government activities that occurred during the first year of the program. Capacity building took a variety of forms in Ethiopia, including training workshops, a study tour, attendance at regional and international conferences, collaboration with local researchers to collect and analyze data, and providing resources for implementing agencies that were not contractual partners with AIDSCAP. A rapid organizational assessment performed at the end of the project revealed that implementing partners believed there had been significant improvement in technical, organizational, and management skills building; organizational systems development; and enhancement of networks and global learning.

Special Features

In collaboration with the Ethiopian government's regional health bureaus, AIDSCAP/Ethiopia developed the concept of FSITs so that HIV/AIDS prevention interventions could be effectively implemented at the regional level. FSIT members were drawn from regional health care and education sectors, NGOs, municipal government offices, regional agricultural offices, factories, religious organizations, and regional DKT/PSI staff. Their activities involved convening monthly meetings to discuss achievements and challenges and to plan complementary activities among members. They also shared a wide range of educational materials and training resources. The FSITs enabled implementing agencies in each region to maximize the types of interventions implemented and the types of populations reached. They continued to operate after the end of the AIDSCAP program.

Implementing Partners

Ministry of Health

Ministry of Education

DKT/Population Services International

Christian Children's Fund

Family Guidance Association of Ethiopia

GOAL

Nazareth Children's Center for Integrated Development

Marie Stopes International Ethiopia

Tigray Development Association

Integrated Holistic Approach Urban Development Project

Society for Women and AIDS/Ethiopia

Development Aid for Youth

Ethiopian Aid

Organization for Social Services for AIDS

Save Your Generation Association

Beza Lewegen

Love to Human Beings Ethiopia AIDS Prevention Society

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Kenya

Epidemiology

Kenya has one of the best established HIV/AIDS surveillance systems in sub-Saharan Africa. Since 1990, the National AIDS/STD Control Programme (NASCOP) has been monitoring HIV prevalence among antenatal clinic attendees in 13 urban sites around the country. Eleven additional periurban and rural sites were added in 1994 and 1995. Results are widely disseminated through a regular report published by NASCOP.

Trends between 1990 and 1995 indicate that the epidemic is still growing and is spreading from urban to periurban areas. HIV prevalence in the adult population in Kenya, estimated to be 3.1 percent in 1990, rose an average of 1 percent per year to 7.5 percent in 1995. While prevalence may have reached a plateau in some areas such as Mombasa (12.5 percent in 1995), the epidemic is still growing in areas of central and western Kenya, particularly periurban sites. In the western areas, prevalence increased between 1990 and 1995 from 17 to 22 percent in Busia and from 19 to 27 percent in Kisumu. There have also been dramatic increases in Nakuru, from 9.9 to 27.2 percent, and in Nairobi, from 5.8 to 24.6 percent. Prevalence has remained lower in areas to the north and east of Nairobi, with two rural sites in central and eastern Kenya having 2 percent prevalence rates in 1994.

Changes in the patterns of infection and the impact of past infections are evident. The peak ages for AIDS cases are 25 to 29 for females and 30 to 34 for males, with young women aged 15 to 24 twice as likely to be infected as males of that age. The number of reported AIDS cases was 65,647 as of June 1996, and it is estimated that by the year 2000, about half of all hospital beds will be used for AIDS patients. The effect on families is increasingly severe. For example, the number of AIDS orphans is projected to be to 580,000 by the year 2000.

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Country Overview

Kenya, a country with an estimated population of 27.6 million, is rapidly urbanizing. However, approximately 80 percent of the population still live in the rural areas. Eighty percent of the population is Christian, with a significant minority of Muslims, particularly along the coast. The national languages are Kiswahili and English, and numerous local languages are also spoken. Diverse local languages and cultures play an important role in shaping the social norms that govern sexual behavior, particularly in the rural areas.

The Government of Kenya, working through NASCOP, developed two medium-term plans to address the epidemic. Numerous donors, including United Nations agencies, governments, and international private voluntary organizations, also support HIV/AIDS prevention and care activities. In addition, a growing number of Kenyan nongovernmental organizations (NGOs) are involved in HIV/AIDS interventions.

In September 1992, Kenya became an AIDSCAP priority country. Activities began in 1993 with four projects to bridge the transition from the earlier AIDSTECH program in Kenya to AIDSCAP. These activities were followed in early 1994 with the start of major subproject activities. The target populations were men and women in the formal workplace; men and women seeking sexually transmitted infection (STI) services at clinics, including maternal and child health/family planning clinics; and students in institutions of higher education. The populations were targeted in periurban and urban areas in Nairobi, Mombasa, and Eldoret, which are high-prevalence areas along the Trans-Africa Highway. The program sought to reduce high-risk sexual behavior in the target populations in order to reduce the incidence of sexually transmitted HIV/AIDS.

Accomplishments

AIDSCAP/Kenya implemented 32 subprojects and three additional initiatives addressing policy, sustainability, and gender issues. The Kenya program worked with 21 organizations on major subprojects, as well as providing technical assistance to NASCOP.

Behavior Change Communication

The behavior change communication (BCC) component of the Kenya program combined reaching specific target audiences, primarily through a peer education approach, with broader mass media interventions and capacity building in BCC skills.

Peer education projects were set up at 17 worksites in Mombasa, Eldoret, and Nairobi and at nine institutions of higher education. The higher education intervention trained 240 peer educators, reached 19,000 students, and distributed 10,600 materials and over 300,000 condoms. The worksite projects trained 375 peer educators and reached over 24,000 workers. Other workers were reached through incorporating HIV/AIDS education into training for five security guard companies.

Media projects included a theater group, Miujiza Players, which combined plays on HIV/AIDS with interactive communication with audiences; a weekly radio soap opera, *Maajabu*, produced in five local languages; and a weekly newspaper column, *AIDS Watch*, in the national press. Mechanisms for learning about and responding to the audiences were built into all the media interventions. For *Maajabu*, this resulted in an astonishing average of 2,000 letters per month from listeners.

The Kenya program also contributed to building long-term BCC capacity among NGOs. First, the program supported the Kenya AIDS NGOs Consortium (KANCO) to set up a

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resource center for HIV/AIDS and reproductive health materials. Within 3 years, the center's collection grew to over 800 materials, serving as a resource for an average of 230 visitors a month. In addition, AIDSCAP funded the Program for Appropriate Technology in Health to train participants from 19 NGOs in materials development, resulting in seven new materials and a core group of trained staff who continue to apply their new skills.

Finally, the Kenya program worked with Medical Assistance Programs (MAP) International to train church pastors in HIV/AIDS prevention and counseling and to develop church-based education, training, and counseling materials. The training resulted in at least 576 activities carried out by trained pastors for their communities. In addition, a manual was developed for pastoral training institutes, which will facilitate the institutionalization of HIV/AIDS counseling, prevention, and support skills. MAP also developed *Growing Together: A Guide for Parents and Youth,* which helps parents discuss sexuality with their children. In response to demand, 11,000 copies of this guide were distributed.

Strengthening STI Services

AIDSCAP supported training and supervision of health workers in STI case management through two subprojects. Family Planning Private Sector (FPPS) trained 402 health workers, mainly from FPPS-supported clinics. Moi University Department of Reproductive Health provided training and an innovative approach to supervision for 95 nurses, clinical officers, and doctors in private practice. Results showed that syndromic management of STIs is acceptable in the private sector, but post-training supervision is necessary. Notifying and treating sexual partners was perceived to be problematic. AIDSCAP also participated on NASCOP's committee that reviewed and revised the national STI guidelines.

Policy Dialogue

Work in the policy area was one of the most important aspects of the Kenya program. An initial AIDSCAP policy assessment found a sense of frustration that HIV/AIDS policy issues were not being addressed. As a result, three organizations were funded to facilitate debate and policy development. The first was KANCO, which conducted eight workshops with nearly 300 district, provincial, and national leaders. The workshops identified and prioritized HIV/AIDS policy issues, which were later presented as recommendations to policymakers, including those drafting the national sessional paper on HIV/AIDS. All of these issues were addressed in the paper, which is the government's first comprehensive policy statement on HIV/AIDS. The second organization, MAP International, was supported to facilitate policy development with churches in Kenya. MAP's baseline research on sexual activity among church-going youth helped motivate senior church leaders to publish a statement of commitment to developing HIV/AIDS policies and strategies for their denominations. AIDSCAP also worked with NASCOP to train senior government officials in making policy-related presentations using the AIDS Impact Model. These presentations to government and community leaders are credited with raising awareness about the extent of the epidemic in Kenya and its impact on all sectors.

Working with over 20 Kenyan and North American authors, AIDSCAP developed new data on the impact of HIV/AIDS on the national economy, businesses, and households. The book, published in 1996 and titled *AIDS in Kenya: Socio-economic Impact and Policy Implications,* was launched by the vice president of Kenya and received wide media coverage.

Research and Surveillance

Four AIDSCAP-supported research projects studied different aspects of interpersonal relationships and how they affect decision making about sexual behavior. The Kenya

Association of Professional Counselors (KAPC) took part in the AIDSCAP/UNAIDS multicenter randomized study of the efficacy of counseling and testing. Over 1,500 people were recruited for the study. Another multisite study on the female condom looked at ways in which use of the device affected women's ability to negotiate safer sex and at the role of women's groups in sustaining its use. The acceptability of the device was good, with over 70 percent of participants wishing to continue using it. KAPC also studied strategies for renegotiating sexual relationships among stable couples. Results showed the need for an education program focusing on dialogue, equality, condoms, and knowledge. A small study of 20 mother and daughter pairs implemented by the Centre for the Study of Adolescence found poor communication patterns and a lack of effective information and skills for HIV/AIDS prevention.

AIDSCAP financial and technical support made it possible for NASCOP to expand sentinel surveillance to 11 new rural and periurban sites. The program also helped NASCOP upgrade its hardware and training for site surveillance officers.

Capacity Building

Capacity building was provided through technical assistance, support for attendance at conferences, training workshops, and through the focus of many projects on skills building in both technical and management skills. The main approach, which was to assign an individual or group of consultants to work with a partner organization over time, facilitated a sense of mutual trust and led to supportive and enabling interactions. In addition, AIDSCAP developed a methodology to review, in collaboration with selected partner NGOs, their organizational status and the cost of their interventions. These data were condensed into brief reports recommending ways to improve the sustainability of each project and the institution.

Special Features

AIDSCAP/ Kenya had a strong emphasis on policy interventions, with the objective of creating a more supportive and positive environment for HIV/AIDS programming. Interventions to facilitate debate and policy development were directed at government officials, religious leaders, and provincial and national leaders. AIDSCAP/Kenya also emphasized working with the private sector through workplace peer education programs and by upgrading the skills of health care personnel in private clinics. Finally, there was a strong interest in integrating HIV/AIDS prevention into family planning activities, building on USAID/Kenya's leading role in supporting family planning in Kenya since the 1970s. These priorities were reflected in the choice of target populations and in the design of subprojects.

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Implementing Partners

Ace Communications Limited

Appropriate Health Resources and Technologies Advisory Group (AHRTAG)

Association of Medical Students of the University of Nairobi AIDS Awareness Campaign (AMSUNAAC)

Artistic Network Productions (APNET)

Artnet Waves Communications

Braeburn Limited

Centre for the Study of Adolescence

Collaborative Centre on Gender and Development

Family Planning Private Sector (FPPS)

Health Economics and Development Research Associates (HEDRA)

John Snow Incorporated: Family Planning Private Sector (FPPS)

Kenya AIDS NGOs Consortium (KANCO)

Kenya Association of Professional Counsellors

Kenya One World Linking Forum (K-OWL)

Medical Assistance Program (MAP) International

Miujiza Players Limited

Moi University Department of Reproductive Health

Nairobi AIDS Task Force

National AIDS/STD Control Programme (NASCOP)

Owen House

Program for Appropriate Technology in Health (PATH)

Rotoract Club, University of Nairobi

University Students AIDS Control Association (USACA)

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Nigeria

Epidemiology

In 1992, at the time of initial AIDSCAP planning, available serologic and clinical data indicated that Nigeria was in the early epidemic phase. HIV seroprevalence in the adult population was low (estimated at 530,000 persons or 1 percent of the general population), but seroprevalence rates were higher among groups engaging in high-risk sexual behavior. Infection rates had surpassed 20 percent in patients with sexually transmitted infections (STIs) and commercial sex workers (CSWs) in a few urban areas. Since then, however, the epidemic has entered the intermediate stage, where between 1 and 10 percent of the sexually active age group (aged 15 to 44) are infected. In 1994, the national HIV prevalence rate was estimated to be 3.8 percent among sexually active adults.

HIV is rapidly increasing in the general population, especially among young females, and prevalence rates in rural areas are approaching those of urban areas. The documented number of persons with AIDS more than doubled from 1993 to 1994, and persons infected with HIV are becoming more visible in the general population. Approximately 2 to 3 percent of inpatients in urban hospitals have AIDS. Nigeria's high rate of population growth is also a critical factor in the progress of the epidemic, both in terms of the HIV sexual transmission rate and the absolute number of individuals who could become infected.

Country Overview

Nigeria, with an estimated population of more than 100 million, is the most populous country in Africa and continues to grow by approximately 3.1 percent annually. The sexually active age group comprises over 60 percent of the total population. Approximately 84 percent of the population live in rural areas, but recent economic development has led to explosive growth of cities such as Lagos, Ibadan, Kaduna, and Port Harcourt. Over 250 ethnic groups live in Nigeria. The 3 largest groups—the Hausa in the north, Yoruba in the southwest, and the Ibo in the southeast—make up approximately 65 percent of the population.

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In 1991, the Government of Nigeria, in recognition of the potential for a rapid increase of HIV infection in Nigeria, launched the War Against AIDS campaign. As part of its campaign, the Government of Nigeria pledged increased funds toward HIV/AIDS prevention, urged local governmental institutions and nongovernmental organizations (NGOs) to develop appropriate programs, and appealed to international organizations for assistance in meeting this public health challenge. The following year, USAID/Lagos asked AIDSCAP to develop and manage a 5-year, $4,598-million program to reduce the rate the sexual transmission of HIV in Nigeria. Despite considerable economic and political instability, including periodic U.S. congressional action prohibiting collaboration with the Nigerian government, AIDSCAP directed 20 subprojects, distributed 64 small grants to more than 100 NGOs, and functioned as the largest single HIV/AIDS control program in the country.

To maximize its impact on the epidemic, AIDSCAP concentrated on specific urban and periurban at-risk populations. Primary target populations were CSWs and their clients and transportation workers. Secondary target populations included university and other postsecondary students, market women, and urban, employed men. Given social and cultural norms that reinforce male control over sexual behavior, AIDSCAP emphasized the development of prevention activities sensitive to the problems of women and girls. To complement activities with target populations, AIDSCAP worked with education officials and corporate managers to develop public education and workplace policies supportive of effective HIV/AIDS prevention activities. Throughout the life of the program, AIDSCAP supported program activities in 11 of Nigeria's 36 states, with activity concentrated in 3 states: Lagos, Cross River, and Jigawa.

Accomplishments

AIDSCAP's primary contribution to HIV/AIDS prevention activities in Nigeria was the development of a network of 13 NGOs with the managerial and technical capacity to design and implement community-based HIV/AIDS prevention activities. In turn, these NGOs have implemented targeted behavior change communication (BCC) and condom distribution interventions. AIDSCAP/Nigeria also supported training activities to improve STI case management; develop appropriate HIV/AIDS workplace policies; incorporate prevention components into university and secondary school curricula; and promote accurate, sensitive mass media coverage of the HIV/AIDS epidemic.

Behavior Change Communication

Behavior change communication activities have provided individuals with the information, skills, and social support necessary to protect themselves from STI/HIV/AIDS. Three key behaviors—partner reduction, condom use, and seeking treatment for STIs—were promoted through the use of a range of innovative communication strategies. AIDSCAP and collaborating NGOs developed a network of over 6,300 peer educators and resource persons who provide needed information and support to target group members who were trying to reduce sexual risk taking in their lives. BCC activities implemented on the community level, such as information booths at trade shows and mass media interventions, reinforced HIV/AIDS prevention messages and skills transferred through one-on-one and small-group counseling. BCC activities conducted through the AIDSCAP Women's Initiative not only improved the ability of women's organizations, especially grassroots organizations, to address HIV/AIDS, but also helped all participating NGOs understand the importance of integrating gender and sexual information into prevention programs. Through these various

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approaches, AIDSCAP/Nigeria educated over 800,000 persons about HIV/AIDS prevention. Results of pre- and postintervention surveys conducted among target populations indicated improved knowledge about HIV/AIDS transmission and increased use of condoms.

AIDSCAP/Nigeria Pre- and Postintervention

Knowledge, Attitudes, Beliefs, and Practices (KABP) Results

Percentage citing 2 effective ways to prevent HIV/AIDS transmission

	1994-95	1997
Lagos dock workers	60	88
Cross River and Jigawa truck drivers	48.2	92.4

Percentage reporting condom use in last sexual encounter with nonregular partner

	1994-95	1997
Lagos dock workers	13.9	45
Cross River and Jigawa truck drivers	21.2	44.8

Percentage reporting consistent condom use with nonregular partners

	1994-95	1997
Lagos university students	18	39
Cross River CSWs	—	84.5

Condom Promotion and Distribution

AIDSCAP collaborated with a large, ongoing national condom social marketing project to create sales outlets convenient to target populations and to incorporate condom distribution into NGO activities. AIDSCAP-supported NGOs sold over 820,000 condoms and distributed another 261,000 free-of-charge to target groups. Moreover, the social marketing project sells over 50 million condoms per year. Focus group discussions with members of all AIDSCAP target populations indicate that people who want to use condoms have no difficulty finding them.

Strengthening STI Services

Reliable data about STI prevalence in Nigeria exist only for syphilis; 1993–94 surveys showed a national prevalence rate of 3.8 percent. As a result of AIDSCAP-sponsored training in STI syndromic management, over 200 private doctors, nurses, pharmacists, and nonpharmacy medicine vendors practicing in 15 states now provide more effective STI case management. Based on pre- and post-training evaluation, providers are now more likely to diagnose STIs correctly, offer an effective treatment regimen, provide counseling on prevention, and promote condom use. In addition, trained, nonpharmacy medicine vendors are more likely to refer clients to providers who can legally prescribe antibiotics. Perhaps the most powerful indicator of the importance of AIDSCAP's activities to improve STI treatment capacity is the demonstrated willingness of Nigerian health care professionals to pay for the syndromic management training.

Policy Development

Mindful of the prohibition on collaboration with the Nigerian government, AIDSCAP, through one of its partner NGOs, affected public education policy by assisting in the development and incorporation of HIV/AIDS prevention components into the curricula of university and secondary school students. AIDSCAP/Nigeria's involvement with the private

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sector was more extensive. The program assisted 12 corporations—located in Lagos, Cross River, and Jigawa states and ranging in size from private hospitals to large oil and manufacturing companies—to formulate corporate HIV/AIDS policies and implement HIV/AIDS-prevention interventions in the workplace.

Capacity Building

AIDSCAP/Nigeria focused on building three regional networks of NGOs capable of implementing STI/HIV/AIDS prevention activities. Technical assistance to strengthen the capabilities of partner NGOs focused on four key components: technical skills, management and organizational skills, organizational systems development, and networking and global learning enhancement. NGOs were encouraged to participate in project design and implementation. Results of a capacity building survey conducted with each NGO's staff indicated that capabilities in technical areas (BCC materials development, training of trainers, condom programming) increased dramatically as a result of AIDSCAP assistance. Moreover, all members of AIDSCAP's NGO network reported strengthening of certain key management systems, including finance, budgeting, and project monitoring.

Special Features

Because of political constraints, AIDSCAP/Nigeria worked almost exclusively with the private sector to stop the spread of HIV. As part of this effort, the program's Rapid-Response Fund, one of the largest in AIDSCAP's entire program, provided opportunities for more than 100 local NGOs and community-based organizations to contribute to HIV/AIDS prevention efforts in Nigeria and to gain valuable experience in collaborating with donor organizations and managing interventions. Several of these NGOs were created specifically in response to the HIV/AIDS epidemic and were, therefore, young, small, and inexperienced in implementing activities. However, by capitalizing on their enthusiasm and commitment to stop the epidemic, AIDSCAP/Nigeria helped make these NGOs more effective vehicles for preventing STI/HIV/AIDS in their communities.

In keeping with the current USAID Mission strategy, AIDSCAP/Nigeria integrated its HIV/AIDS prevention activities with the activities of other U.S.-based implementing agencies and Nigerian NGOs addressing health related concerns, such as family planning, maternal and child health, and child survival. This integration, which necessitated planning sessions with all involved organizations, was accomplished by including an STI/HIV/AIDS prevention component into the training curricula for the community outreach workers of these organizations and by developing mechanisms for these organizations to receive and distribute condoms to their target communities.

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Implementing Partners

Africare

B.E. Medical Services, Ltd.

Cross River AIDS Committee

Federation of Muslim Women Associations of Nigeria

Health Matters, Inc.

International Center for Research on Women

Jigawa League of NGOs

Jigawa State Youth AIDS Program

Lagos NGO Consortium

Media Health Alliance

National Council for Women's Societies

NGO Consultative Group

Nigerian Society for Environmental Management and Planning

Nigeria Youth AIDS Program

Nka Iban Uko in Calabar

Program for Appropriate Technology in Health

Society Against the Spread of AIDS

STOPAIDS

University of Calabar

Women in Nigeria

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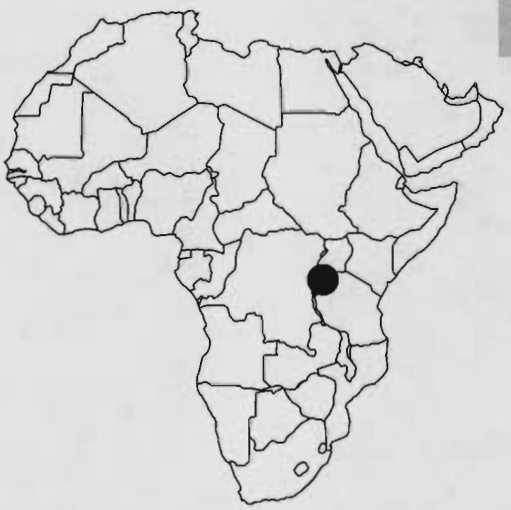
Rwanda



Epidemiology

In 1986, the first national HIV serological survey indicated that HIV seroprevalence was slightly over 1 percent in rural areas, and approximately 18 percent among the urban population. Data from antenatal clinics in Kigali showed that HIV seroprevalence was increasing among pregnant women by approximately 3 percent a year between 1988 and 1990. In 1991, the rate among antenatal women in Kigali was 27 percent, and among semiurban and rural antenatal women the rates were 10 percent and 2.2 percent, respectively. Among sexually transmitted infection (STI) clinic patients in Kigali, HIV rates were 70 percent for women and 49 percent for men in 1991, and rates in commercial sex workers (CSWs) were 90 to 100 percent.

Before the genocide of April 1994, the HIV/AIDS epidemic showed some signs that it had reached a plateau, as 1991 sentinel sites showed decreases in HIV/AIDS rates for both pregnant women and STI patients. It is assumed that HIV spread dramatically during and after the April 1994 war. A variety of factors associated with the war are believed to have affected the epidemiological profile of HIV/AIDS in Rwanda, including massive migrations, breakdown of traditional families and values, sexual violence, and the relocation of hundreds of thousands of rural Rwandans in refugee camps.

A study of 500 pregnant women screened in May 1995 at the Centre Hospitalier de Kigali found that HIV prevelance was 24.5 percent and syphilis prevalence was 10 percent. Rates of HIV infection did not vary based on place of residence before the war, although 41.8 percent of the overall study population were recent migrants to Kigali. In 1996, the Programme National de Lutte Contre le Sida (PNLS) reactivated its serosurveillance system, establishing 10 sentinel posts in rural and urban areas. The 1996 data show seroprevalence rates of 3.6 percent in rural Kigali and 32.6 percent in Kigali city. In three of the ten sites, rates exceeded 22 percent. Among STI patients, the rates were

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54.5 percent at Biryogo (Kigali), 29 percent at the Centre Hospitalier de Kigali, 42.3 percent at Kabgayi (Gitarama), and 13.2 percent in rural Kigali.

Country Overview

Rwanda, a landlocked and mountainous country of approximately 10,000 square miles located in the Great Lakes region of eastern Central Africa, is among the most densely populated and least urbanized countries on the continent. Ninety percent of Rwandans live in rural areas and engage in subsistence farming. Prior to the 1994 civil war and its subsequent population exodus, Rwanda had a population of 7.2 million, primarily Catholic, with a literacy rate of just under 50 percent. Civil war plagued the country intermittently from 1990 through mid-1993, when warring factions signed a peace accord. In April 1994, however, the assassination of the Rwandan president precipitated 3 months of intense warfare and ethnic genocide. It is estimated that close to 1 million people lost their lives. Following the Rwanda Patriotic Army's victory in July 1994, people displaced by the war began returning to their homes. More recently, with the closing of refugee camps in Tanzania in December 1996 and the civil war in Zaire in 1997, most civilian refugees have returned to Rwanda, although some are still internally displaced and waiting resettlement. The country continues to suffer from rebel insurgencies, mostly by Hutu ex-soldiers loyal to the previous regime.

In 1987 the Rwandan Government decided to establish the PNLS. By the early 1990s, seroprevalence among antenatal women had reached a rate of close to 30 percent in the capital city of Kigali.

The USAID-supported AIDSCAP program was designed to contribute to the national efforts to reduce the rate of sexual transmission of HIV by building the capacity of governmental and nongovernmental organizations (NGOs) to implement HIV/AIDS prevention interventions. The project focused on three mutually reinforcing strategies—STI control, accessibility to and acceptability of condoms, and implementation of communication strategies aimed at reducing sexual risk taking—implemented at the national and regional levels. Nationwide activities included condom social marketing, institutional strengthening of the PNLS, and mass media programming. Regional activities included interventions with STI patients, youth, single and married women, and military personnel. Refugees were reached under a separate community-based intervention at the Benako camp in the Ngara district of Tanzania.

Accomplishments

The AIDSCAP/Rwanda program was implemented by the PNLS of the Ministry of Health in collaboration with the Medical Services of the Ministry of Defense, the Gitarama Health Region, the Centre d'Information, Documentation, et Counselling (CIDC), and international and local NGOs. National interventions included the condom social marketing program implemented by Population Services International (PSI); support to the PNLS to coordinate nationwide prevention efforts, with an emphasis on STI control using the syndromic approach; and support to the CIDC to improve the quality of communication resources in Rwanda. The comprehensive and integrated population center activities included education and prevention counseling by peer educators and health care providers for military personnel, antenatal women, single and widowed women, youth, STI patients, and commercial sex workers.

The AIDSCAP Rwanda program distributed over 4 million condoms and sold over 3 million through the condom social marketing program. National STI treatment guidelines were adopted in April 1995, using results from the prewar operations research conducted by AIDSCAP and the Rwanda

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Integrated Maternal Health Project (RIM), and implemented in seven of the 11 medical regions. In a country with low literacy rates, a tradition of oral communication, and a wide reach of radio, mass and alternative media played a key role in diffusing messages on safer sex, condom use, abstinence, and fidelity for both the general population and specific target groups. Rapid-response funds were used to support small interventions to reach CSWs, disadvantaged women and youth, and HIV-positive people with prevention messages, and, in the case of CSWs, with STI treatment at highly reduced cost.

Behavior Change Communication

AIDSCAP/Rwanda's behavior change communication (BCC) strategy included formative and audience research to guide the interventions, the choice of communication channels, and the development of appropriate messages and materials. The strategy also included training of staff and volunteers in the use of prevention messages, demonstrating condom use, and encouraging health-seeking behavior.

The program combined a variety of approaches to influence behavioral change among its target populations. It used the peer educator approach with military personnel, young and single women, youth, and CSWs. Antenatal women and STI patients were reached at primary health care clinics with prevention counseling provided by trained social workers and other health care staff. Community-based outreach programs worked through head-of-household women, elected, head-of-sector women, and community health volunteers to reach women, youth, and CSWs. The combined programs reached over 300,000 people with BCC and prevention messages.

Mass and alternative media were used extensively to support and reinforce the prevention messages being communicated through educational sessions and informal chats. These media activities included fashion shows, song festivals, drama, skits, video presentations, and radio soap operas, music programs, and radio talk shows. A play and discussion guide specifically developed for young adults was part of an HIV/AIDS prevention program introduced in 23 schools in the Kigali prefecture. Over 4,000 media messages were aired, and over half a million educational materials were distributed in support of BCC, condom, and STI activities.

Strengthening STI Services

The AIDSCAP program was instrumental in the adoption of national treatment guidelines, a prerequisite for upgrading STI services in the country. Following a March 1995 consensus meeting on STI case management guidelines, the Ministry of Health, with financial support from the World Health Organization and technical assistance from AIDSCAP, trained a core of 38 trainers in syndromic management, prevention counseling, and partner referral. A total of 521 service providers were trained in syndromic diagnosis treatment of STIs according to Rwandan guidelines. Training also focused on partner referral and other elements of counseling, such as condom use and compliance with prescribed drug regimens. Thirty-one trained social workers reached more than 90,000 antenatal women and STI patients through group prevention counseling at primary health care centers.

An evaluation of the STI component of the AIDSCAP program by the Institute of Tropical Medicine (Antwerp) in February 1997 revealed that the appropriate drug chosen in 94 percent of STI drug prescriptions in the Gitarama Project site, 74 percent of STI prescriptions in the military site, and in 46 percent of STI prescriptions in the PNLS project areas. According to the study, correct case management was found in 93 percent of the STI cases in the Gitarama Health Region, 77 percent in the Kigali Health Region, and 67 percent in the military health center sur-

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veyed. Condoms were available in 11 of the 14 centers surveyed, and the three centers where condoms were not available were affiliated with the Catholic church. The program developed a training manual for syndromic management, a wall chart with syndromic algorithms, and a pocket guide for prescribers, were distributed to all participating clinics.

Condom Promotion and Distribution

Behavioral research data at the time of the program design showed that despite high knowledge of HIV/AIDS and its modes of transmission, condom use was very low. Therefore, the condom programming strategy aimed to increase and improve condom accessibility, educate Rwandans about HIV/AIDS, and promote condom use as an effective prevention strategy.

As a result of PSI's marketing efforts, average national monthly sales reached 230,000 by August 1996. Fifteen hundred condom sales outlets were opened during the 19 months of post-war AIDSCAP support. Additional outlets were established by NGOs and independent wholesalers. Access to condoms has been increased, with 71 percent of condoms being purchased from four widely accessible outlet categories: boutiques/kiosks, clinic/health centers, pharmacies, and community-based outlets.

Social marketing of condoms was effective, despite the mass movement of people and the destruction of the infrastructure during the war, because the private sector was one of the first components of the Rwandan society to reorganize and because people were willing to buy condoms despite severe economic constraints. In addition to the 3.15 million Prudence condoms sold, the project distributed over 1 million condoms through its peer education, outreach, and community-based programs.

Capacity Building

Under the AIDSCAP program, Rwandan NGOs and governmental institutions developed a core staff capable of conducting formative and audience research and developing materials based on effective communication theories and practices. CIDC and other implementing partners now use a systematic process of audience segmentation and research to guide message development and involve their target audiences in the design and pretesting of materials and messages.

Special Features

In response to the displacement of hundreds of thousands of Rwandans, AIDSCAP implemented the first large-scale HIV/AIDS prevention program for refugees. By August 1994, AIDSCAP had reoriented its activities to the Rwandan population living in refugee camps in northwestern Tanzania along Rwanda's eastern border. CARE International, assisted by John Snow, Inc. (JSI), and PSI, launched a community-based STI/HIV/AIDS prevention program in the CARE-managed Benaco camp in Tanzania. The activities gradually expanded to three other refugee camps in the Ngara District. Trained community volunteers and NGO personnel provided information and counseling to 90 percent of the adult population. STI treatment was provided at most NGO outpatient clinics by providers trained by the African Medical Research and Education Foundation (AMREF).

Through continued formative research, the project responded to changing community needs. A home-based component was added to provide help to, among others, people living with AIDS. A group of women volunteers set up a soup kitchen to provide food for the home bound. A crisis intervention team was created to provide social, legal, and medical support to women and young girls who had experienced sexual violence. Young adults were reached in other ways, including adolescent health days, which were held to acquaint teenagers with the

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health care services available to them, and sporting events, such as soccer matches. Not only did these events keep young people occupied, but they also offered opportunities to convey HIV/AIDS messages to large audiences through traditional dance and songs at half-time.

Working with refugees stretches the boundaries of traditional prevention programming. The project's experiences in the Ngara District offered numerous insights for future work with refugees, including the following lessons:

- Planning HIV/AIDS prevention programming for refugees requires flexibility, creativity, and cultural sensitivity. Behavior change comes slowly in any environment, but in a refugee camp where people struggle with survival issues far more real to them than HIV/AIDS, changing sexual behavior is a monumental task. Yet the project has shown that it is possible to successfully engage refugees at many levels to reduce sexual risk taking, largely through empowerment and enabling strategies.

- HIV/AIDS prevention programming for refugees cannot be successful if it does not address the vulnerability of women and young people struggling through social crisis. Women need assistance in developing both self-esteem and opportunities to generate income so they can resist coercive sexual advances that offer short-term financial benefits but are detrimental to their health in the long term. Young refugees also need assistance, especially when their family members have disappeared.

- Coordinating the work of relief agencies and prevention programs is particularly important in a refugee setting. In the Ngara District, several organizations that shared the same objectives were able to divide the tasks involved in both HIV/AIDS prevention and home care to avoid duplication. Daily collaboration and weekly meetings made such coordination possible.

Implementing Partners

Ministry of Health: Programme National de Lutte Contre le Sida

Ministry of Defense: Division of Medical Services

Ministry of Health: Region Medicale de Gitarama

Centre d'Information, Documentation et de Counselling (CIDC)

Population Services International, Kigali (PSI)

CARE International, Kigali

Bilyogo Health Centre, Kigali

Cor Unum, Kigali

Caritas, Kigali

Rafiki Club, Kigali

Refugee Program

Care International, Tanzania

Population Services International (PSI)

John Snow, Inc. (JSI)

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Senegal

Epidemiology

Statistics from the Programme National de Lutte Contre le SIDA (PNLS) of Senegal show that in 1993 there were 911 cumulative documented AIDS cases in Senegal, and the prevalence of HIV among hospital patients in 1993 was 15.9 percent. By May 1995, the number of AIDS cases had risen to 1,573—a 73 percent increase in 2 years. As of June 1997, 80,000 HIV/AIDS infections had been reported. The most recent data from the PNLS show that rates of HIV infection among pregnant women seen at maternity clinics range from 0.5 to 1.5 percent in major cities. The highest levels of HIV prevalence—10 to 16 percent in 1995—are among registered commercial sex workers (CSWs). The overall prevalence rate is currently 1 percent, with the ratio of men to women approximately 3:1. Senegal is characterized by a high prevalence of HIV-2. Persons infected with HIV-2 develop AIDS more slowly than those infected with HIV-1 and may infect others for a longer period while remaining in apparently good health.

Country Overview

Senegal has a population of 8.3 million persons, primarily Muslim and primarily of the Wolof ethnic group. Forty-five percent of the population live in urban areas, with the majority of urban residents living in the cities of Dakar, Thies, and Kaolack.

Following the first identified AIDS case in 1986, the Government of Senegal (GOS), in collaboration with the World Health Organization and other donors, developed a blood screening program, a surveillance system, a public information program, and two Medium-Term plans to fight the epidemic.

Beginning in 1992, AIDSCAP/Senegal sought to strengthen the capacity of Senegalese institutions to implement HIV/AIDS prevention and control programs, with the goal of reducing the rate of sexually transmitted HIV infection in Senegal. The program focused primarily on four geographic regions—Dakar, Thies, Kaolack, and Ziguinchor—and on urban populations. The targeted populations were men

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and women with sexually transmitted infections (STIs); men and women with multiple partners, including CSWs and their clients and regular partners; women in the marketplace; truck drivers and male employees of other industries; and youth.

Accomplishments

The AIDSCAP/Senegal program supported 24 organizations and institutions and 34 local associations, and provided technical assistance and training to PNLS, public and private health care structures, religious and opinion leaders, and educational facilities. The program consisted of targeted interventions to encourage positive behavior change; improve STI service delivery; improve research and surveillance (both behavioral and biological); stimulate policy dialogue to increase the awareness of religious leaders and policymakers of the impact of the epidemic; and improve the quality of HIV/AIDS prevention activities, including condom promotion and distribution, materials development, and mass media campaigns.

Behavior Change Communication

Of the 58 organizations that received AIDSCAP support, 49 conducted targeted behavior change communication (BCC) interventions. This number includes 34 small local associations (such as women's and youth associations) that received Rapid-Response Fund (RRF) grants to conduct short-term activities within their communities and among the members of their associations. These RRFs provided first-time funding for many of these associations.

Behavioral Surveillance Survey

A behavioral surveillance survey (BSS) was implemented during the fifth year of program implementation to collect relevant baseline data on sexual behavior in the following target groups: male and female secondary school students, male and female university students, male workers, and registered CSWs. Data from various knowledge, attitudes, beliefs, and practices (KABP) surveys and data from the first round of the BSS in Senegal suggest that awareness about HIV/AIDS, knowledge of prevention, and the use and availability of condoms all increased during the AIDSCAP program.

1997 BSS Results

- More than 90 percent of persons surveyed have knowledge of two or more methods of prevention.
- 85 to 99 percent of persons surveyed know where to procure a condom.
- 77 to 93 percent of persons surveyed can state their risk of infection with appropriate justification.
- 67 to 81 percent of males reported using a condom during last sex act with an occasional partner.

Strengthening STI Services

The STI component of AIDSCAP/Senegal sought to strengthen the capacity of public and private sector health care providers, located in the target regions, to diagnose and treat STIs, and to integrate education, prevention counseling, and the provision of condoms into STI services. AIDSCAP collaborated with the PNLS and other partners to develop, validate, and disseminate national guidelines for the diagnosis and treatment of STIs. Subsequently, 1,167 health care workers were trained in the use of these guidelines, including STI prevention education, and counseling methods. In addition, equipment was supplied to public and private health care facilities.

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Policy Dialogue

Recognizing the important role of community leaders in behavior change communication, AIDSCAP targeted key religious leaders and policymakers for HIV/AIDS education and policy dialogue. The goal of these interventions was to increase the knowledge of religious and opinion leaders about the HIV/AIDS epidemic and encourage their support for and participation in HIV/AIDS prevention activities. Six regional seminars for opinion leaders and a seventh seminar for parliamentarians were held, as well as two national seminars on HIV/AIDS and religion involving both Muslim and Christian leaders. By the end of the project, both religious and political leaders were making public statements about the HIV/AIDS epidemic in their sermons and political speeches.

Capacity Building

Capacity building was an overriding theme of the AIDSCAP program. Activities in Senegal were evaluated using a comprehensive key informant interview questionnaire (CKIIQ), focus group discussions with representatives of implementing agencies, and a case study on policy dialogue. Thirty-five organizations participated in the CKIIQ, which provided quantitative data on the agencies' perceptions of changes in their organizations' capacity at the completion of AIDSCAP. Implementing agencies reported increased capacity in all areas where technical support and training had been provided, with particularly high increases for BCC education and training, project planning, financial management, and condom promotion and distribution. Agencies also reported increased recognition of their organization, not only by their communities, but also by other organizations working in HIV/AIDS prevention.

Special Features

The Senegal program was characterized by its intense focus on community-level interventions through peer education. BCC activities resulted in the training of 1,022 peer educators, who in turn conducted BCC sessions involving group discussions, video and theater presentations, drama skits, games, songs, and dances. Such participatory activities brought the target audiences together to learn about HIV/AIDS and to discuss the problem with their peers and family and community members. A total of 963,147 condoms were distributed free-of-charge during these and other activities.

Implementing Partners

African Consultants International (ACI)

Association des Postes de Santé Privés Catholiques du Sénégal (APSPCS)

Association des Professeurs des Sciences Naturelles (ASPN)

Association Nationale pour le Bien Être de la Population (ANBEP)

Association pour la Promotion Sociale en Milieux Rural et Urbain (APROSOR)

Association Sénégalaise pour le Bien Être Familial (ASBEF)

Christian Reformed World Relief Committee (CRWRC)

Education Pour la Santé (EPS)

Environnement et Développement du Tiers-Monde (ENDA-Santé)

Fédération des Associations Féminines (FAFS)

Femme Développement Entreprise en Afrique (FDEA)

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Institut Supérieur Africain pour le Développement de l'Entreprise (ISADE)

JAMRA

Mouvement International pour le Développement en Afrique (MIDA)

Programme National de Lutte Contre le SIDA (PNLS)

Radio Kaolack

Radio Ziguinchor

Red Cross

Santé de la Famille (SANFAM)

Social Marketing for Change (SOMARC)

Society for Women Against AIDS in Africa (SWAA)

SUD Communications

Union Groupement Agro-Pastoral pour la Promotion Sociale (UGAPS)

University Cheikh Anta Diop

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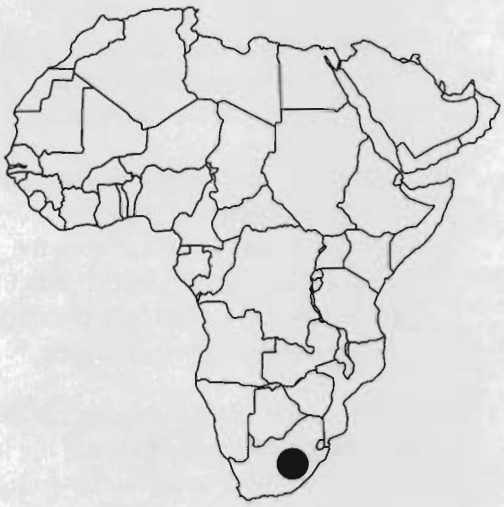
South Africa



Epidemiology

HIV/AIDS was, and to some extent still is, a silent disease to most South Africans. The first case of AIDS in South Africa was reported in 1982, and from 1982 to 1989 men who have sex with men (MWM) accounted for 66 percent of all AIDS cases. After 1988, infection among MWM declined as a proportion of the total reported cases, and cases of heterosexual transmission increased from 23 percent in 1988 to 72 percent in 1992.

AIDS case reports alone, however, provide an incomplete picture of the HIV/AIDS epidemic in South Africa. As diagnosis of AIDS is not a reportable disease, AIDS case reports reflect only those voluntarily reported to the South African Institute of Medical Research (SAIMR). In addition, the diagnosis of AIDS may not be understood by many physicians in South Africa and is often obscured by the presence of a variety of opportunistic infections.

Investigations to determine HIV infection rates in different population groups in South Africa—selected urban and rural populations, mine workers, persons donating blood, and clients attending family planning, antenatal and sexually transmitted infection (STI) clinics—have been undertaken by the Medical Research Council (MRC), the South Africa Institute of Virology, and government and academic institutions. During October and November 1996, the Department of Health conducted the seventh annual national survey in a series of unlinked, anonymous serosurveys of women attending public health service. Based on a sample of 15,044 women screened in all nine provinces, it was estimated that 14.07 percent of the women attending the clinics were infected with HIV by the end of 1996, an increase from 10.04 percent in 1995. Extrapolating from these figures, it is estimated that approximately 2.5 million people in South Africa are living with HIV.

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Country Overview

As South Africa emerges from apartheid, the HIV/AIDS epidemic presents a new socioeconomic threat. Although the country experienced a relatively late introduction of HIV, South Africa now has a well established epidemic, with heterosexual transmission the main mode of transmission.

The primary objective of AIDSCAP's support in South Africa was to build the capacity of indigenous nongovernmental organizations (NGOs) and community-based organizations (CBOs) to provide technically sound and sustainable HIV/AIDS prevention interventions. To achieve that objective, AIDSCAP organized its support around the following seven areas:

- As HIV/AIDS program and CBO staff had been isolated from international and national experiences, AIDSCAP supported international and comparative educational travel. This component of the program sought to expose HIV/AIDS prevention activists to innovative and effective approaches and programs in other African countries.
- AIDSCAP supported pilot projects to demonstrate the effectiveness of innovative HIV/AIDS interventions.
- A small grants program provided funding for NGOs and CBOs to carry out comprehensive, integrated HIV/AIDS prevention activities and to establish coalitions of community-based organizations to strengthen HIV prevention programming.
- Training workshops were included as a means for HIV/AIDS prevention program staff from around South Africa, and particularly from the AIDSCAP focus regions, to exchange experiences, lessons, and strategies.
- Resource centers were established with a broad mandate to facilitate networking and coordination of community-based HIV prevention efforts.
- The HIV/AIDS prevention program of the South African government was significantly altered and intensified in the post-apartheid years. USAID and AIDSCAP provided technical assistance to the Government of South Africa to strengthen peer education and develop a national strategy for condom distribution.
- AIDSCAP's evaluation plan incorporated measurements of process, outcomes, and impact at both the program and activity level. Particular emphasis was placed on indicators for successful capacity building.

Within the scope of its capacity building activities, AIDSCAP sought to reach the following primary and intermediary target groups: adolescent youth, migrant workers, women living with HIV and their families, traditional healers, mass media professionals, and primary health care providers.

Accomplishments

AIDSCAP/South Africa provided funding and program support to 24 implementing agencies, most of whom were indigenous NGOs or CBOs. Several accomplishments were of particular importance. First, most implementing agencies (IAs) felt that their ability to develop, manage, and evaluate interventions had improved as a result of AIDSCAP's support. Second, the government recognized the important contributions of NGOs and CBOs, and this recognition gave them opportunities to inform and influence governmental policymaking. In addition, by the end of AIDSCAP, a national AIDS plan was completed and officially accepted by the Minister of Health. Third, work with traditional healers, the frontline health care providers for most South Africans, proved effective and established a precedent for

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similar activities elsewhere. Finally, a research intervention demonstrated that periodic presumptive treatment of commercial sex workers (CSWs) could reduce STI rates among them and their partners.

AIDSCAP/South Africa Process Data:

- Ten training-of-trainers (TOT) workshops were conducted for 73 females and 10 males.
- One hundred five peer educator (PE) workshops were conducted for over 981 females and 484 males.
- Twenty-two HIV/AIDS awareness workshops were held.
- Thirty-five AIDS-related drama workshops were held, at which 3,425 female and 3,460 male youth were trained.
- Outreach activities and special events reached over 28,792 females, 14,841 males, and an additional 84,308 persons (gender unspecified).
- Over 2,569,922 male condoms and 15,853 female condoms were sold through Population Services International (PSI) subprojects; 109,749 condom promotional materials were produced, of which 98,306 have been distributed.
- Nine capacity building workshops (PE refresher training, project management, computer skills) were conducted. Over 590 PEs were trained in the refresher courses.

Key Outcome Data

By increasing the capacity of local organizations, AIDSCAP contributed to the overall goal of reducing sexual risk taking among target populations in South Africa. An evaluation survey of NGOs and CBOs noted marked improvements in the articulation of contractual agreements, in maintaining updated records, and in the proper use, control, and management of project resources. In addition, IAs greatly improved their process data collection and gained experience in monitoring and reporting project activities. Half of them incorporated gender and development into their interventions, with three specifically targeting gender. Nearly all (98 percent) of the IAs are members of networking initiatives, and 75 percent were involved in policy initiatives at the end of AIDSCAP. At least six broadened their funding base to include other donors.

The increasing number of IAs involved in training, counseling, BCC materials development, advocacy, STI management, condom management (from 5 percent 3 years ago to nearly 88 percent at the end of the project) is testimony to the improvement in organizational capacity. The introduction of peer education and community-based development initiatives as effective strategies for STI management has proven to be a positive initiative with IAs and target audiences. The fact that the government is relying on IAs to help develop policy on HIV/AIDS is a clear acceptance of the role of service providers in this field.

The periodic presumptive treatment project for women at risk in mining communities produced dramatic results. After 9 months of the intervention, the prevalence of STI among the treated women had decreased significantly, and rates of STI among miners presumed to be their sexual partners had also decreased. The overall prevalence of genital ulcer disease dropped by 30 percent and nonulcerative STI rates decreased by 32 percent. The women reported a 20 percent reduction in the number of clients, and reported condom use by clients

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increased from 13 to 29 percent. These results helped convince the medical staff and management of the host company, Harmony Mine, to continue the presumptive treatment intervention and expand it to neighboring areas of the community.

AIDSCAP-supported training for traditional healers made a positive difference in the larger community. Several of the traditional healers trained under AIDSCAP have been hired by local clinics and hospitals as health care workers. Since participating in AIDSCAP-funded workshops, traditional healers who regularly train other healers have incorporated their knowledge of STI/HIV/AIDS into their standard course, creating a multiplier effect. In addition, hospital and clinic staff reported increased numbers of people seeking HIV testing following the traditional healer training sessions.

Various evaluation surveys conducted during the program provided valuable data regarding the knowledge, attitudes, practices, and beliefs of target populations. Awareness among miner populations and CSWs living in and around mining communities was high. Ninety-seven percent of mine workers and CSWs were aware of HIV/AIDS, and 73 percent of mine workers and 83 percent of CSWs cited condoms as a method of preventing HIV/AIDS. In addition, 42 percent of mine workers reported in 1997 that they had started using condoms as a result of becoming aware of HIV/AIDS. Reported condom use, however, remains low: only 12 percent of mine workers reported using condoms every time. Consistent condom among CSWs was much higher: 56 percent reported always using condoms with clients. Only 15 percent of CSWs reported using no form of protection.

Implementing Partners

AIDS Training and Education

Arts for All

Bethesda House

Border Institute for Primary Health

Excelsior High School

Harmony Hospital

Hillbrow Primary Health Care Partnership

Hope Worldwide

Lawyers for Human Rights

National AIDS Convention of South Africa (NACOSA)

National Association for Child Care Workers (NACCW)

National Association of People Living with HIV/AIDS (NAPWA)

National Progressive Primary Health Care Network (NPPHCN)

National Reference Center for STIs

Nyangazezizwe Traditional Doctors Organization

Operation Upliftment for the Homeless and Unemployed

Out-in-Africa Film Festival Committee

Phambili Women's Organization

Population Services International/Society for Family Health

South African Red Cross

The House of Resurrection

Training Institute for Primary Health Care (TIPHC)

University of South Africa Institute for Behavioral Sciences

Vista University

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Tanzania

Epidemiology

By 1995, approximately 82,000 cases had been reported to the Ministry of Health, and the National AIDS Control Program (NACP) estimated that 1.2 million Tanzanians were infected with HIV. HIV prevalence in women seeking antenatal care is over 10 percent, and in one rural site in the Mbeya Region, it has reached 32.5 percent. According to the most recent available data, overall HIV prevalence in the Mara Region was 8.8 percent in urban areas, 6.5 percent in periurban areas, and 2.6 percent in rural areas. In high-risk transmission areas, such as truck stop towns along major transportation routes, substantially higher prevalence rates of HIV and other sexually transmitted infections (STIs) have been reported.

Country Overview

In response to the alarming spread of the virus, the government formed the NACP in 1987 and began activities in 1988. The government has actively engaged nongovernmental organizations (NGOs) in instituting its HIV/AIDS programs. USAID/Tanzania has supported the government's efforts since 1988, initially through AIDSTECH and AIDSCOM programs and, from 1991 to 1997, through AIDSCAP. Building on the previous USAID initiatives, the Tanzania AIDS Project (TAP), a $20-million, 5-year project managed by AIDSCAP, adapted its activities to respond to the expansion of the HIV/AIDS epidemic.

Accomplishments

TAP provided technical and financial assistance directly to more than 20 organizations and indirectly, through NGO clusters, to over 180. TAP sensitized local leaders and policymakers, implemented behavior change interventions, improved clinical STI management, distributed and promoted condoms, provided support to persons and families affected by HIV/AIDS, and conducted research to strengthen interventions. Collaborating with the NACP, TAP also implemented activities to create an enabling environment for community-based initiatives. These activities included training, distributing educational materials, and conducting

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advocacy and policy sensitization at the national level. The combination of community-based and national interventions produced a technically integrated, programmatically comprehensive, and geographically inclusive program.

Supporting Regional NGO Coalitions

The objective of TAP's support for regional NGO clusters was to enable community-based organizations to mobilize local resources for HIV/AIDS prevention and care and to gain the active participation of community leaders. By August 1995, TAP was supporting activities by 180 NGOs in nine regional clustersin Arusha, Dar es Salaam, Dodoma, Iringa, Kilimanjaro, Morogoro, Shinyanga, Tabora, and Tanga. All of the clusters accomplished their objectives. Even more important in the long term, the NGOs formed organizationally sound collaborations that are now positioned to further decentralize the NGO cluster model to the district level.

Workplace Prevention Initiatives

The objectives of the NGO cluster program were also pursued in TAP's other community- and workplace-based activities. These activities included integrating STI care, distributing and promoting condoms, behavior change communication, peer education, and targeted policy and advocacy initiatives. Approximately 100 private businesses developed HIV/AIDS prevention programs for their employees, and 18 companies assumed 50 percent of the operating costs for these programs. In 22 truck stop communities along major transportation routes, TAP implemented comprehensive projects targeting truck drivers, commercial sex workers, merchants, miners, youth, and women.

HIV/AIDS Care and Support

TAP responded to the escalating needs of people living with HIV/AIDS by integrating care and support into the activities of the NGO clusters. Complemented by prevention education, these interventions included upgrading clinical capacity and providing home-based care and pre- and post-test counseling, psychological and social support to AIDS patients and their families, and educational, vocational, and psychological and social assistance to hundreds of AIDS orphans. TAP emphasized collaboration and referrals between health care providers and program-trained traditional healers.

Capacity Building

TAP also increased the capability of implementing partners to manage projects and conduct HIV/AIDS prevention and support activities. To this end, the project organized and conducted training programs for staff from implementing organizations and government agencies. TAP also provided training and support to its implementing organizations through supervisory visits to project sites and intercluster study tours.

Communication and Advocacy

At the national level, TAP attempted to influence social and public policy by reinforcing community-based communication efforts and collaborating with the NACP to educate policymakers about HIV/AIDS. The project worked with partner organizations to produce and distribute educational materials, develop radio and TV broadcasts, and support promotional and educational events (such as World AIDS Day) and interventions with national decision makers. Due in part to these efforts, HIV/AIDS-related issues are prominently, regularly, and accurately featured in the Tanzanian media.

Strengthening STI Services

Over 750 health care providers from NGO clusters and from high-risk areas were trained in STI syndromic diagnosis and treatment, based on guidelines developed by AIDSCAP and adopted by the Tanzanian Ministry of Health. New, upgraded STI clinics are now accessible to target populations in most of

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TAP's project sites. Referral of STI patients to these upgraded facilities was an integral aspect of behavior change interventions. A study of target populations found that 72 percent of women who had sought STI care in the previous 12 months went to TAP-supported clinics; these women reported that peer educators had motivated them to seek care.

Condom Promotion and Distribution

In addition to extensive community- and workplace-based condom distribution, TAP supported a nationwide condom social marketing project. Population Services International repackaged and launched the Salama brand condom as a part of TAP's 1993 World AIDS Day activities, and by the end of the project had sold over 30 million condoms. Condom sales and behavior change were supported and encouraged by an intensive education and promotion campaign. More than 2 million people attended 457 mobile video presentations, and more than 3,111 community-based distribution agents were trained in HIV/AIDS prevention and condom promotion. More than 250,000 informational pamphlets were distributed, and over 2,000 condom prevention messages were communicated through radio, television, billboards, and newspapers.

Evaluation and Research

AIDSCAP evaluated behavior change with process data, cross-sectional survey research of target populations, and qualitative interviews with target audiences. The behavior change data in Tanzania were provided by both primary and secondary sources, including the USAID-funded Demographic and Health Survey (DHS) from 1991, 1994, and 1996 and knowledge, attitudes, beliefs, and practices surveys conducted by TAP in cluster regions.

Knowledge of HIV/AIDS has been consistently high: the 1991 DHS reported that 90 percent of males and females knew of AIDS and the 1994 and 1996 DHS survey showed that awareness of AIDS was almost universal. In the 1994 DHS, 36 percent of females and 49 percent of males cited condoms as a way to avoid HIV infection. The 1996 survey found improvement in knowledge of prevention methods, with 39 percent of females and 55 percent of males citing condoms. The DHS results suggest that the percentage of respondents with more than one sex partner is decreasing, especially among unmarried respondents.

There was no significant difference between the 1994 and 1996 DHS data regarding condom use with last nonregular partner. In the 1996 DHS, 17 percent of females and 35 percent of males reported using a condom the last time they had sex with a nonregular partner. However, the 4-region TAP KABP showed that 54 percent of youth (no gender distinctions), 38 percent of women, and 46 percent of men reported condom use with their last nonregular partner. The higher rates of reported condom use among samples from AIDSCAP intervention regions, when compared to DHS data, suggest that the behavior change interventions are having the intended effects.

Special Features

Two aspects of TAP set the project apart from its peers. First, by developing and supporting coalitions of community-based NGOs, TAP has demonstrated a commitment to achieving technically, institutionally, and financially sustainable projects. The NGO cluster exemplifies the idea that sustainable health interventions must be community based. TAP's experience shows that, given appropriate support, coalitions of community-based NGOs can be robust mechanisms for HIV/AIDS interventions. After 3 years of operation, TAP's NGO clusters have started weaving HIV/AIDS prevention and care into the very fabric of Tanzanian life.

The second outstanding feature of the project is TAP's goal of reducing the social and economic consequences of HIV/AIDS. By supporting ac-

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tivities to strengthen Tanzanians' ability to cope with these severe consequences, TAP has embraced the important notion that HIV/AIDS prevention and care are not distinct domains, but exist on a continuum of programmatic opportunities and urgent needs. Such a holistic outlook has produced an effective, comprehensive response to the HIV/AIDS epidemic in Tanzania.

Implementing Partners

AIDS Intervention in Kilimanjaro and Arusha (AIKA), Arusha Cluster (26 NGO members)

Walio Katika Mapambana na AIDS Tanzania (WAMATA), Dar es Salaam Cluster (12 NGO members)

World Vision of Tanzania, Dodoma Cluster (11 NGO members)

Family Planning Association of Tanzania (UMATI), Iringa Cluster (41 NGO members)

AIDS Intervention in Kilimanjaro and Arusha (AIKA), Kilimanjaro Cluster (37 NGO members)

Anglican Diocese of Morogoro, Morogoro Cluster (13 NGO members)

World Vision International, Shinyanga Cluster (12 NGO members)

Makoye Resources and Technologies Agency (MARTEA), Tabora Cluster (12 NGO members)

Tanga AIDS Working Group (TAWG), Tanga Cluster (6 NGO members)

African Medical Research and Education Foundation (AMREF)

Tanzania Council for Social Development (TACOSODE)

Organization of Tanzanian Trade Unions (OTTU)

Pastoral Activities and Services for AIDS, Dar es Salaam Archdiocese (PASADA)

Tanga AIDS Working Group (TAWG), home care project

Centre for Educational Development in Health, Arusha (CEDHA)

Primary Health Care Institute, Iringa (PHCI)

Infectious Disease Center (IDC)

Muhimbili University Medical Centre

Population Services International

Health for All Volunteers Trust

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Zimbabwe

Epidemiology

HIV/AIDS is a serious problem in Zimbabwe, with an estimated 1 million people, or 22 percent of all adults in the country, infected with HIV. By September 1996, over 61,000 AIDS cases had been reported, but the true number of cases is estimated to be about 200,000. Young women (aged 15 to 19) are reported to have HIV/AIDS at five times the rate of young men in the same age group. Sentinel surveillance data from 1992 shows HIV prevalence rates ranging from 10 percent of rural antenatal clinic attendees to 60 percent of clients in an urban STI clinic. A 1995 study of 2,876 clinic attendees from six Harare antenatal clinics found that 892 (32 percent) of the women were infected with HIV. The mean age of that cohort was 21.3 years.

Country Overview

AIDSCAP/Family Health International was contracted by USAID in 1994 to support implementation of the first stage of the USAID/Zimbabwe Prevention and Control (ZAPAC) Project in conjunction with UNICEF and the Government of Zimbabwe National AIDS Coordination Programme (NACP). The AIDSCAP program focused on behavior change communication (BCC) interventions in the workplace. The specific target groups were commercial farm workers, transport workers, military personnel and their families, and commercial sex workers (CSWs). As in many other African countries, mobile populations found in or around major commercial centers and transport routes have higher HIV infection rates.

Accomplishments

The AIDSCAP strategy for reducing high-risk behavior among target groups was to train peer educators and support their efforts with BCC materials, including videos. As a result of behavior change activities implemented through peer educators in targeted regions

- 25,877 peer educators from rural and urban communities countrywide, including army and airforce camps, were trained.

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- 2,307,712 people were educated by peer educators in worksites, along transport routes, on commercial farms, at military bases and in surrounding communities.

- 416,370 materials were produced and/or distributed.

- 19,450,770 condoms were distributed in rural and urban areas, at worksites, in bars and hotels along transportation routes, and in surrounding communities.

By focusing BCC workplace interventions on families as well as employees, the program helped workers realize the importance of educating and protecting their families. AIDSCAP also supported a range of media activities to establish and sustain an environment conducive to behavior change among targeted populations. These included a critical analysis of Zimbabwe media and HIV/AIDS reporting, a workshop for media gatekeepers and policymakers, radio and TV programs, a mass media program evaluation, and two columns about HIV/AIDS in national newspapers. With AIDSCAP support, the University of Zimbabwe developed an HIV/AIDS training module for postgraduate students enrolled in the diploma program for mass communications and media development.

Key Outcome Data

Both quantitative surveys and qualitative studies (focus group discussions, key informant interviews, and in-depth interviews) of HIV/AIDS knowledge, attitudes, beliefs, and practices were carried out by several evaluation research organizations. In 1995, baseline quantitative data was collected for commercial farm workers, youth, transport workers, CSWs, and military personnel. During the next year, research was conducted with railway workers, sugar plantation workers, and CSWs living on the Triangle sugar estate. And in 1997, a second data point was collected for commercial farm workers, youth, transports workers, and CSWs to provide comparative data on these populations. Population Services International (PSI) also conducted a general population survey in 1997.

This research showed high knowledge levels (knowledge of at least two preventive practices) at baseline, with slight increases at the second data point (with the exception of CSWs along truck routes, who showed a slight decrease from 84.2 to 82.3 percent). Knowledge levels increased for transport workers from 88 to 94 percent, for female commercial farm workers from 90 to 91.4 percent, and for male commercial farm workers from 88.8 to 92.8 percent. In comparison, the 1997 general population survey showed 44 percent of both males and females were able to cite at least two methods of HIV prevention and 57 percent were able to acquire a condom.

Despite the high levels of HIV/AIDS knowledge among AIDSCAP targeted groups, respondents in all study populations underestimated their chances of getting infected with HIV. Sixty-three percent of male commercial farm workers and 58 percent of female farm workers considered themselves at no risk in 1995. In 1997, the numbers for both show a decrease to 44 percent of men and 33 percent of women who believed they were not at risk.

Condom use levels increased in all groups, except CSWs along truck routes. Reported condom use among youth in 1995 was surprisingly high at 52.7 percent for males and 62.5 percent for females. The two most common methods cited by members of all target groups as examples of behavior change to avoid HIV/AIDS were condom use and partner reduction.

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Implementing Agencies

AIDS Action Committee, Triangle Ltd.

Bulawayo City Health Services Department

Commercial Farmers Union

CONNECT

Delta Corporation

Department of Community Medicine, University of Zimbabwe

Department of English, University of Zimbabwe

Dexter Enterprises

Institute of Tropical Medicine

National Employment Council for the Transportation Operating Industry

National Railways of Zimbabwe Health Safety Branch

Women and AIDS Support Network Zimbabwe

Zimbabwe Broadcasting Corporation

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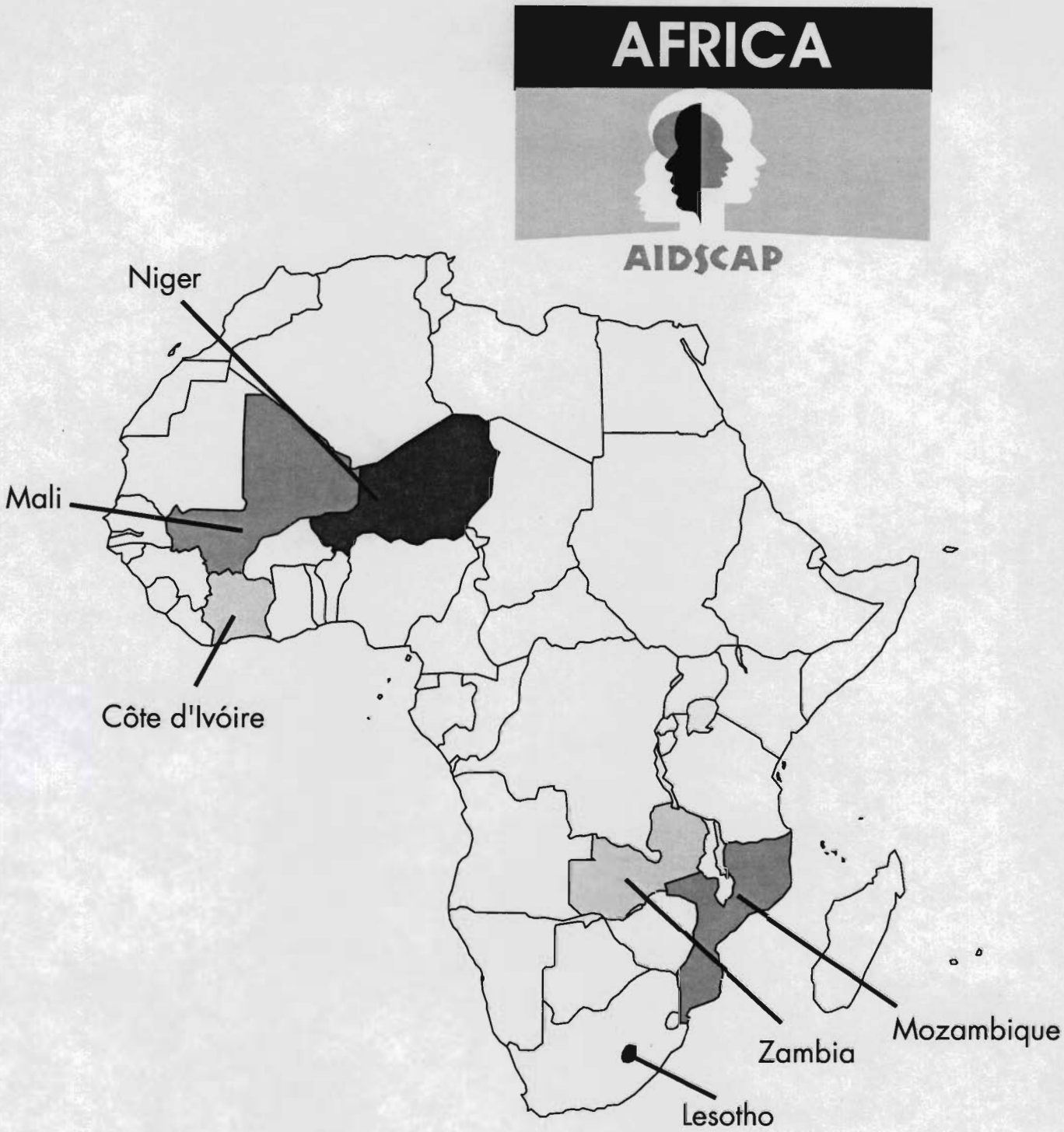

Associate Countries

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Côte d'Ivoire

Epidemiology

AIDS was first diagnosed in Côte d'Ivoire in 1985. During the epidemic's early stages, the HIV prevalence rate was about 1 percent among the general urban population, with no detectable presence in rural populations. However, by 1995, HIV prevalence among the sexually active population in both urban and rural areas had reached 10 percent, the total number of persons living with HIV exceeded 640,000, and the number of persons with AIDS had climbed to 14,655. By 1998, the World Health Organization (WHO) projects that there will be over 25,000 people living with AIDS and over 1 million persons with HIV in the country. Côte d'Ivoire has the sixth highest rate of HIV prevalence in Africa and the highest prevalence of any West African country. Both HIV-1 and HIV-2 have been identified in the country, but HIV-1 is five times more common.

Sexually transmitted infections (STIs) have long been a problem in parts of rural Côte d'Ivoire, and the number of STI cases among youth is growing at an alarming rate. In addition, the HIV/AIDS epidemic has been exacerbated by certain social factors. First, because of the Liberian civil war, more than 300,000 Liberians immigrated to Côte d'Ivoire, placing additional strains on an already overburdened health care system. Moreover, destitute refugees often turned to commercial sex to survive, increasing the possibility for the transmission of STI/HIV/AIDS. Second, Côte d'Ivoire's western regions, which produce coffee and cocoa, receive large numbers of buyers and transporters during harvest time. These people often engage in sexual risk taking with commercial sex workers, who are attracted to the area by the influx of potential clients.

Country Overview

The population of Côte d'Ivoire is estimated at 14.7 million, and the country has the highest rate of natural population increase in West Africa. Almost 75 percent of the country's inhabitants are 29 years of age or younger. This young, rapidly growing population is comprised of over 60 independent ethnic groups, each

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with numerous tribal affiliations in neighboring countries. These affiliations, coupled with an economy performing better than those of other nations in the region, have fueled an immigration of impoverished or unemployed persons to Côte d'Ivoire, especially to Abidjan. Despite the influx of persons to the city, however, 56 percent of Ivoirians still live in rural areas. Approximately 60 percent of the nation's workforce are agriculturists.

Recognizing the threat of HIV/AIDS, the Ministry of Health and Social Welfare launched a multisectoral prevention program involving numerous nongovernmental organizations (NGOs) and six Ivoirian ministries. Most prevention activities focused on Abidjan and a few other cities. However, as HIV/AIDS prevalence has risen in rural areas, prevention activities targeting rural populations have become necessary. In 1993, to assist Côte d'Ivoire in curtailing the epidemic in rural areas, AIDSCAP supported Africare, an NGO with extensive experience in rural development, in the implementation of a 3-year, $500,000 STI/HIV/AIDS prevention program targeting the approximately 50,000 sexually active persons (aged 15 to 25) living in 60 villages in the rural Guiglo district. In addition to being one of the few programs focusing on rural populations, especially youth, the project was noteworthy because Guiglo included a large community of Liberian refugees among its target population and because the program integrated STI/HIV/AIDS prevention into primary health care services in villages.

Accomplishments

In collaboration with AIDSCAP, the National AIDS Advisory Commission, the local health department, and a large condom social marketing project implemented by Population Services International, Africare established a community-based STI/HIV/AIDS prevention program that promoted the reduction of sexual risk taking and distributed condoms in over 200 villages in Guglio district. Creation of a local AIDS advisory committee increases the likelihood of the continuation of project activities and has fostered cooperative, coordinated action among local community-based organizations and agencies involved in STI/HIV/AIDS prevention. Project staff attained these achievements despite the civil unrest and constant movement of the refugee population in western Côte d'Ivoire caused by incursions of armed Liberian groups.

Behavior Change Communication

Behavior change communication (BCC) activities empowered individuals with knowledge and skills needed to protect themselves from STI/HIV/AIDS by creating a network of 90 volunteer health educators (VHEs) who provided prevention education to over 150,000 persons. Educational activities included small group sessions, presentations, drama skits conducted at village organizations and schools, and other communitywide events. Twenty-five VHEs were Liberian refugees, whose awareness and educational activities reached 23,835 fellow Liberian refugees. To reduce sexual risk taking among students, Africare helped the STI/HIV/AIDS committees of Guiglo's secondary schools implement a range of educational activities, ranging from one-on-one discussions to campus-wide activities, which were attended by more than 8,900 students. More than 40,000 educational materials, such as stickers and newsletters, were produced and distributed to members of target populations.

Moreover, to integrate STI/HIV/AIDS prevention into primary health care services offered to villagers, VHEs also received training in first aid, midwifery, and the management of health huts and small pharmacies. As a result of this activity, beneficiary villages now have a comprehensive, community-based health care system where affordable and professional care can be obtained.

Results of a postintervention knowledge, attitudes, beliefs, and practices (KABP) survey of 1,000 persons aged 15 to 25 from 30 target

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villages highlighted the program's impact on the target population:

Key Findings of 1996 KABP Survey

- 84 percent had received STI/HIV/AIDS information from a VHE
- 96 percent had obtained greater knowledge of HIV/AIDS transmission modes
- 47 percent had reduced their number of sexual partners
- 28 percent reported greater acceptance or use of condoms.

Condom Promotion and Distribution

VHEs received training in condom storage, sales, and promotion and functioned as vendors for the national condom social marketing project. The social marketing project also established sales points at small pharmaceutical depots and stores located in villages throughout the district. By the end of the project, 190,996 condoms had been sold or distributed free-of-charge at promotional events to target populations.

Capacity Building

Creation of a local AIDS Advisory Committee (AAC) was a milestone for STI/HIV/AIDS prevention in Guiglo. The AAC, consisting of local NGO representatives, health care providers, and community representatives, oversaw the project's educational activities, established linkages with local and regional private organizations and government agencies, and coordinated outreach efforts in the district. By assuming managerial responsibility for all project activities, including recruitment, training, and supervision of VHEs, the AAC ensured the continuation of STI/HIV/AIDS prevention activities for target populations. Moreover, integration of prevention activities into the primary health care services offered to villagers increased the likelihood that authorities would consider STI/HIV/AIDS management a basic part of primary health care and be more willing to support related efforts in the future.

Implementing Partner

Africare

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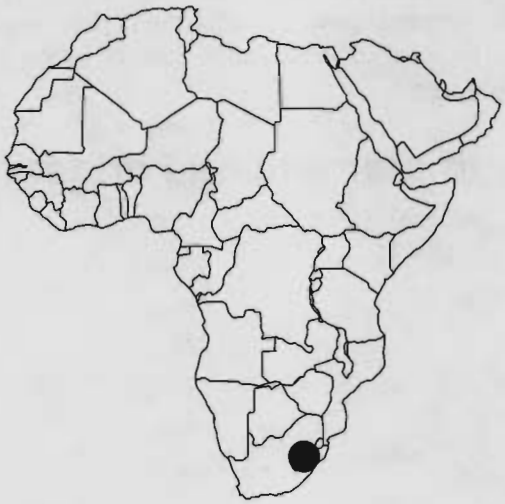
Lesotho



Epidemiology

AIDS was first reported in Lesotho in 1986, and by 1993 the cumulative number of AIDS cases had reached 348. Sentinel surveys conducted in 1993 among lowland populations showed HIV prevalence rates of 12 to 21 percent among samples of sexually transmitted infection (STI) patients and from 3 to 6 percent among antenatal clinic attendees. Data regarding HIV seroprevalence among highland populations are limited but suggest increasing prevalence.

Syphilis prevalence rates among lowland populations range from 7 to 9 percent, and STIs account for a significant morbidity among Basotho adults. Data collected by the Ministry of Health from 1983 to 1993 reveals that STIs are the second most common reason for outpatient visits to health care facilities in Lesotho. Sentinel surveillance data shows an alarming increase in the number of teenage STI patients, who accounted for 9.4 percent of all patients tested. Migration of many Basotho workers, who leave their families in Lesotho to work in South Africa, is a contributing factor to HIV/STI transmission because these workers frequently establish sexual relationships with South African women, and because their spouses in Lesotho may resort to commercial sex to increase their incomes.

Country Overview

The Kingdom of Lesotho, which is completely surrounded by South Africa, has a population of 1.8 million persons and is growing at an annual rate of 2.6 percent. Eighteen percent of the population live in urban areas. Lesotho has close economic and ethnic ties with South Africa and is economically dependent on its industrialized neighbor. Only 34 percent of Basotho households derive their main source of income from farming and livestock. Many Basotho find work in South Africa, and about 116,000 Basotho work in South African mines. A severe drought over the past 3 to 5 years has greatly reduced domestic food production, making the country even more dependent on South Africa. As the economic situation worsens (Lesotho's unemployment rate is

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approaching 30 percent), highly skilled professionals are emigrating to South Africa, resulting in a labor shortage in Lesotho.

With support from USAID/Lesotho, AIDSCAP initiated a two-year program to assist Lesotho's Ministry of Health (MOH) and nongovernmental organizations (NGOs) in reducing the sexual transmission of HIV among highly vulnerable groups, principally through STI prevention and control interventions, peer education to promote behavior change, and condom promotion and distribution.

Accomplishments

Although the AIDSCAP program ended prematurely with the closing of the USAID Mission, AIDSCAP was instrumental in strengthening the MOH's STI control services. In addition, AIDSCAP financial support and technical assistance to one indigenous NGO and two U.S. NGOs operating in Lesotho strengthened the capacity of these organizations to provide HIV/AIDS prevention information and condoms to high-risk groups, particularly in nonclinical, rural settings.

Strengthening STI Services

AIDSCAP's technical assistance to the MOH, coupled with its successful efforts to engage other international donors and coordinate their activities for STI control and prevention, resulted in the creation of a comprehensive STI control program for the entire country. Four elements comprised the STI component of the AIDSCAP/Lesotho program. First, with assistance from the World Bank, AIDSCAP-supported researchers completed etiological studies of nearly 7,000 STI cases and used these data to develop appropriate syndromic management protocols for STIs in Lesotho. Second, AIDSCAP, in collaboration with the MOH's STI and AIDS units, provided training in syndromic STI case management to all physicians and to providers in a majority of the country's government clinics. Third, AIDSCAP provided technical assistance in the development of reporting forms, partner referral forms and procedures, and drug use forms to support clinic-based STI control activities. Fourth, AIDSCAP dialogue with international donors, such as the World Bank and the European Union, generated interest in STI control, and these organizations provided financial support that enabled the MOH to obtain necessary laboratory supplies and drugs.

Behavior Change Communication

Behavior change communication (BCC) activities provided groups vulnerable to STI and HIV infection with the necessary knowledge and skills to reduce sexual risk taking. AIDSCAP and its collaborating NGOs developed a network of 146 peer educators who provided information and support to four targeted communities. One project promoted safer sexual practices by members of the professional football (soccer) teams that are so popular in Lesotho, particularly among the youth. More than 380 players and coaches not only received HIV/AIDS prevention information and condoms, but also participated in a "Footballers Against AIDS" educational campaign that targeted the wider community and was publicized in the mass and sports media.

With technical assistance from AIDSCAP's BCC unit, approximately twenty MOH and NGO staff members acquired skills in BCC materials development and designed and produced materials for peer educators and STI clinic attendees. Over the life of the program, AIDSCAP-supported peer educators distributed over 600,000 condoms and 10,000 educational materials to target groups.

Condom Promotion and Distribution

With funding from USAID/Lesotho, AIDSCAP subcontractor Population Services International developed an aggressive social marketing campaign to promote and sell Lovers Plus condoms

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to target populations in urban and periurban Lesotho. In 14 months, 250,000 condoms were sold through approximately 270 nonpharmacy outlets that had been established in locations convenient for groups at high risk of STI/HIV infection. Although initially controversial, the promotional campaign, which included radio, billboards, face-to-face communication, and the innovative use of puppet troupes, proved highly popular.

Capacity Building

Despite the relatively short duration of the program, AIDSCAP/Lesotho significantly improved the capacity of the MOH and its partner organizations to implement STI/HIV/AIDS prevention programs. As a provider of technical assistance and coordinator of STI-related donor activities, AIDSCAP helped to develop and institutionalize a national STI control program. Moreover, AIDSCAP's work with NGOs helped these organizations reach target populations with effective educational activities.

Implementing Partners

CARE International

Lesotho Red Cross Society

Lesotho Ministry of Health

Population Services International

South African Institute for Medical Research

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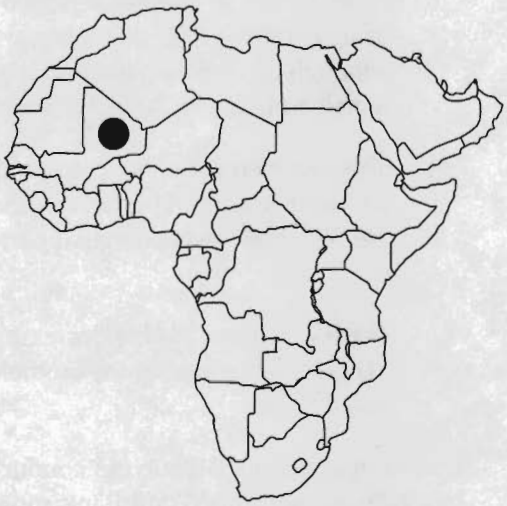
Mali



Epidemiology

Although less severe than the HIV/AIDS epidemic in central and East Africa, the epidemic in Mali is a serious public health problem with an impending threat of rapid expansion. The first AIDS case was diagnosed in Mali in 1985, and within 10 years, 2,600 cases had been reported to the Ministry of Health. 1992 regional survey data compiled by the International Program Center of the U.S. Bureau of the Census showed HIV prevalence rates of 1 to 5 percent of the general population. In all regions except Sikasso, rates were higher among women than among men. HIV prevalence rates among commercial sex workers (CSWs) ranged from 16 percent in Gao to 74 percent in the capital city of Bamako and the regions bordering Côte d'Ivoire.

Country Overview

Mali, one of the landlocked Sahelian countries of West Africa, has a predominantly Muslim population of close to 10 million. Recognizing the need for early intervention in the epidemic, USAID committed support to the National AIDS Control Program (NACP) in 1990. These funds enabled AIDSCAP and the NACP to continue and expand a pilot intervention for brothel-based CSWs in Bamako that had been implemented by Family Health International (FHI) in 1988 with USA for Africa support. The broader two-year education and condom distribution project aimed specifically at educating CSWs and their potential clients about HIV/AIDS, the means of HIV transmission, and ways to reduce sexual risk taking. Encouraged by evaluation research indicating a significant increase in knowledge of HIV and condom use, USAID, through AIDSCAP, continued to support an expanded intervention from September 1992 through March 1995.

AIDSCAP/Mali targeted mainly women with multiple partners (WMPs) in the city of Bamako and the Segou and Sikasso districts with HIV/AIDS education and condom promotion and distribution. A complementary outreach project targeted the clients of WMPs through behavior change communication (BCC) sessions, drama presentations, and informal visits to bars and

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brothels. The ultimate goal of the intervention was to promote behavior change that reduces transmission of HIV and other sexually transmitted infections (STIs) among WMPs, bar patrons, and other groups at high risk, including transport workers and military personnel. The project also funded and trained local nongovernmental organizations (NGOs) to run HIV/AIDS prevention projects in Bamako.

Accomplishments

The AIDSCAP project, in collaboration with both national and international NGOs and governmental organizations, contributed to enhanced awareness of the existence and the dangers of HIV/AIDS among a large proportion of primarily urban Malians. Through its distribution of more than 2 million condoms free-of-charge, the program tackled existing prejudices and taboos and created a climate in which safer sex is increasingly negotiable. The quality of the project's relationship with WMPs made the use of condoms a group-enforced, standard code of behavior.

Sixty-eight bars and 15 brothels participated in the project, which trained a total of 328 peer and community educators. Those trained included 102 WMPs, 46 bar managers, 34 drivers, 60 military personnel, 22 health care providers, and 64 other persons. More than 150 brothel-based WMPs received systematic STI diagnosis and treatment during the life of the project, and over 16,700 target group members were educated on STI/HIV/AIDS prevention. In addition, AIDSCAP trained more than 200 NGO staff and local youth as HIV/AIDS peer and community educators. NGO initiatives reached an additional 1,849 individuals through interpersonal educational sessions, 24,976 through discussion groups, 25,256 at popular and cultural events, 37,691 at sports events, and more than 27,000 through local radio broadcasts.

Key findings of a knowledge, attitudes, beliefs, and practices (KABP) survey conducted at the end of the project include the following:

- Knowledge about HIV/AIDS and its transmission and prevention was high (94 to 95 percent) among all target groups.
- Close to 100 percent of brothel-based WMPs in Bamako reported using condoms with their clients, although use with regular partners remained between 30 to 40 percent.
- Sixty-five percent of bar patrons and transport workers reported condom use with their last nonregular partner.
- There was a remarkable decrease in STI prevalence among the brothel-based CSWs.

Results from several STI surveys conducted by AIDSCAP and the World Bank showed that from 1991 to 1994

- prevalence of gonorrhea decreased from 72 to 11 percent.
- prevalence of *Trichomonas vaginalis* decreased from 15.6 to 4.1 percent.
- prevalence of syphilis decreased from 24 to 3.2 percent.

Many of the small, indigenous NGOs that started HIV/AIDS interventions under AIDSCAP's small grants program have since received long-term funding for activities in HIV/AIDS prevention and/or family planning through the Groupes Pivot et Survie de l'Enfant, a USAID-funded NGO umbrella organization, and Plan International, which is also funded by USAID. The training and experience received by these NGOs facilitated their access to such support.

Implementing Partners

Ministry of Health, Solidarity, and the Elderly

University of Washington

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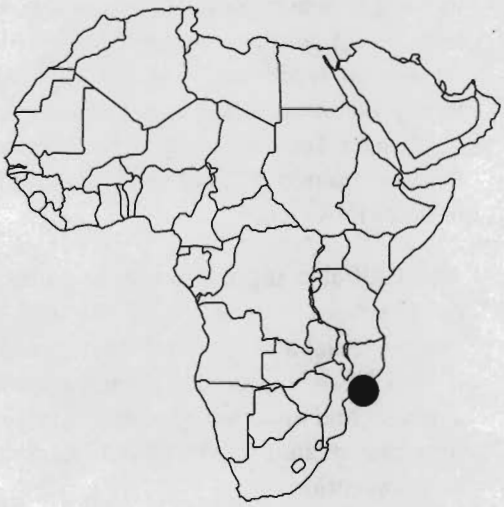
Mozambique



Epidemiology

The national AIDS control program (NACP) estimates current adult HIV prevalence in Mozambique at about 8 percent, an increase from an average urban prevalence of 3 percent in 1987. Epidemiological surveillance data collected from 10 sentinel sites in provincial capitals and major commercial centers throughout the country indicate that the situation is deteriorating in key areas. Manica province, for example, registered an increase in HIV-positive women attending antenatal consultations from 11 percent in 1994 to approximately 20 percent in 1996, while HIV prevalence among antenatal attendants in the province of Tete increased from 18 to 22 percent. Of the reported 3,318 AIDS cases, slightly more than two-thirds occurred in the 20 to 39 age group. Sexually transmitted infection (STI) prevalence has also been increasing, with districts reporting an average of 801 cases per 100,000 population in 1996 compared to 640 per 100,000 in 1995.

Country Overview

The HIV/AIDS epidemic in Mozambique is at a critical junction. While HIV appears to have reached Mozambique later than neighboring countries, the movement of HIV across its borders has increased, resulting in rapid increases in HIV transmission. Factors fueling the epidemic include nearly 30 years of war, labor migration, major transportation routes to neighboring high-prevalence countries, rapid urbanization, high levels of poverty, insufficient health infrastructure, and significant rates of STIs. In addition, from 1993 to 1996 almost half of the population of Mozambique was highly mobile, including more than 1.7 million refugees returning from neighboring countries, 5.7 million internally displaced persons, and 270,000 demobilized soldiers and their families.

In fiscal year 1993, USAID/Mozambique funded AIDSCAP to conduct an assessment of the status of STI/HIV/AIDS, identify gaps in prevention programming, and recommend program areas for USAID. A limited number of activities would

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be implemented in fiscal year 1997, based on opportunities identified by the assessment.

The five-month AIDSCAP/Mozambique project was launched in April 1997. In line with the USAID Mission strategy, AIDSCAP/Mozambique sought to strengthen the capacity of private voluntary orgsnizations and nongovernmental organizations (NGOs) working in HIV/AIDS prevention and to provide technical support to the Ministry of Health (MOH).

Accomplishments

AIDSCAP strengthened the MOH and NGOs by providing technical and material support to develop BCC materials (print materials, radio broadcasts, video and local theater productions) and to train community-based providers and peer educators in STI/HIV/AIDS prevention and condom promotion.

A video was produced to train local condom promotion groups in theater techniques that could be used to educate audiences about HIV/AIDS prevention. AIDSCAP trained a local actor, who in turn trained theater group participants in eight provinces to use drama to convey prevention messages and stimulate discussion about HIV/AIDS. In addition, videos of six different plays were produced for distribution. Population Services International's one-minute radio spots, already airing in Portuguese, were translated into 10 local languages.

The HIV/AIDS information, education and communication task force of the NACP, supported by AIDSCAP, produced a manual for community-based peer educators, a packet for STI clinic clients, and a translation of *The Silent Epidemic*, the Kenyan video on STIs. The manual for community-based educators was developed and pretested, and 5,000 copies were produced and distributed. Clinic packs, which contained two partner referral cards, two pamphlets with STI information, condoms, and condom use instructions, were also pretested, and 50,000 were produced and distributed. In addition, six AIDSCAP BCC booklets and two new episodes of the popular comic book, *Emma Says*, were translated into Portuguese and produced for distribution.

Ten community-based educators received training to teach community-based volunteer health workers about STI/HIV/AIDS prevention, reproductive and sexual health, family planning, and gender issues. As a result, a total of 406 volunteer health educators were trained in 22 villages in two districts in Gaza Province.

AIDSCAP also supported a new group for out-of-school male youth in Maputo. The group's social activities and sporting events developed and nurtured an interest in healthy activities and included educational sessions on topics related to STIs/HIV/AIDS control and prevention.

Implementing Partners

Mozambique Red Cross

Muleide

Population Services International

Save the Children

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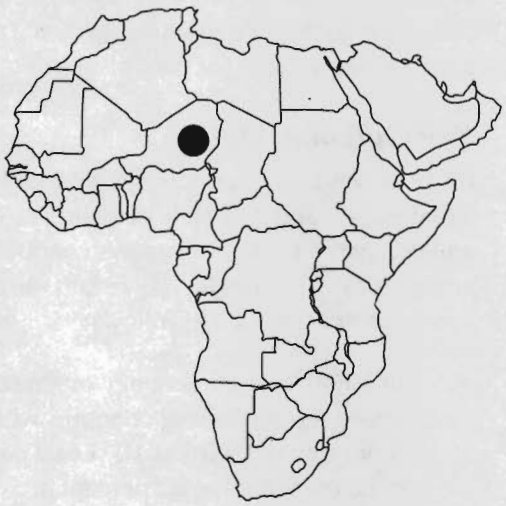
Niger



Epidemiology

The first AIDS case in Niger was reported in 1987, and by December 1994, 1,729 cumulative AIDS cases had been reported. Data from HIV sentinel surveillance in Niger show a prevalence of less then 1 percent in the general population. The national AIDS control unit's 1992 sentinel data found HIV prevalence of 1.1 percent among women attending antenatal clinics in the capital city of Niamey, 1.4 percent for the Tahoua region, 0.89 percent in Maradi, and zero prevalence in Zinder. Prevalence was higher among high-risk groups, with HIV prevalence rates for commercial sex workers (CSWs) at 14 percent in Arlit and 15.4 percent in Niamey in 1993. A 1994 study found that 3 percent of truckers in Niamey and Dosso were infected with HIV.

The eleventh most frequently diagnosed disease at health care facilities is sexually transmitted infection (STI). In Niamey, syphilis prevalence was 4 percent among pregnant women and 26.8 percent among CSWs in 1993. Of 2,133 clients treated at a Niamey public STI clinic from 1993 to 1994, 19.6 percent were diagnosed with chancroid, 40.5 percent with gonorrhea, and 2.5 percent with syphilis.

Country Overview

Niger is a largely agrarian Sahelian country with an estimated 1993 population of 8.6 million. The vast majority of the people live in the southern quarter of the country, where the land is most suited to agricultural activities. Farming and herding are the major economic activities of 80 percent of the population.

In 1991, due to the rise in HIV prevalence among its clients, the Directorate of Hygiene and Mobile Medicine (DHMM) initiated a 20-month pilot HIV/AIDS prevention project with Family Health International to reinforce its STI diagnosis and prevention activities with CSWs and STI patients. The success of this intervention led to an expanded HIV/AIDS prevention project in 1992, which was supported by USAID through AIDSCAP and implemented by the

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Directorate of Surveillance, Epidemiology and Prevention (DSEP, formerly DHMM). The goal of AIDSCAP/Niger was to reduce the rate of STI/HIV infections among high-risk groups in Niamey.

Accomplishments

The AIDSCAP-supprted project targeted CSWs, truck drivers, and STI clients, offering peer education, condom promotion and distribution, and improved STI diagnosis and treatment. It was implemented by DSEP, which also serves as an urban referral center for the diagnosis and treatment of STIs. By the end of the project, a total of 6,737 target population contacts had been made and more than 1.14 million condoms had been distributed.

Behavior Change Communication

Peer education was the primary behavior change communication (BCC) strategy employed in Niger. The CSW component covered eight urban communities in Niamey, training 29 CSWs as peer educators and educating 3,431 CSWs about HIV/AIDS prevention. End-of-project knowledge, attitudes, beliefs, and practices (KABP) surveys indicated an increase in condom use and more accurate risk perception among CSWs as a result of peer education activities. Transport workers in three unions and one trucking company also participated in peer education activities, which reached 1,173 truckers with BCC messages through the efforts of 57 trained volunteers. Educational materials such as buttons, T-shirts, bumper stickers, and key chains were produced and distributed to reinforce BCC messages.

Strengthening STI Services

AIDSCAP trained 10 DSEP clinical staff in diagnosis and treatment of STIs, and four laboratory staff in STI diagnostic techniques. It also provided diagnostic reagents to the DSEP laboratory. STI clinic staff counseled 2,133 STI patients in risk assessment and HIV/AIDS prevention. In addition, more than 10,000 screening tests for syphilis were performed on blood from antenatal clients and STI clinic attendees. With AIDSCAP technical assistance, health care professionals from all regions of Niger worked to develop national STI treatment guidelines, which included diagnostic and treatment protocols. These protocols were subsequently submitted to the Programme National de Lutte Contre le SIDA for pilot testing.

Key Outcome Data

KABP surveys were conducted among 200 female CSWs and 200 male truckers in 1994 and compared to similar surveys conducted among CSWs in 1991. The results of the survey comparison are as follows:

- In 1994, 96.4 percent of women surveyed reported using condoms with 5 or more of their last 10 sexual partners, compared to 22 percent in 1991.
- In 1994, 57 percent of men surveyed reported having sexual relationships with CSWs, and only 13 percent of these men reported using condoms. No baseline comparison is possible because men were not surveyed in 1991.
- Over 80 percent of women perceived their risk of HIV/AIDS infection as high in 1994, compared with 2 percent in 1991.
- In 1994, 75 percent of men surveyed reported their risk of HIV/AIDS infection as high.

Implementing Partners

Direction de la Surveillance Epidémiologique et de la Prevention (DSEP), Ministère de la Santé Publique

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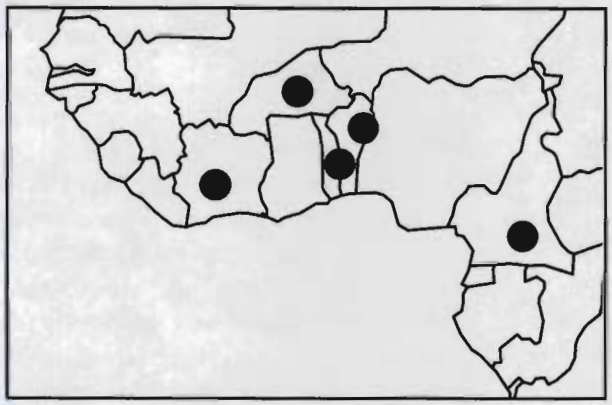
West Africa



Epidemiology

The West African countries of Benin, Burkina Faso, Cameroon, Côte d'Ivoire, and Togo, with a combined population of approximately 48 million, have more than 22,000 AIDS cases. Moreover, HIV seroprevalence among sexually active populations in these countries ranges from 3.1 percent in Benin to 10 percent in Côte d'Ivoire and parts of Burkina Faso. Côte d'Ivoire has the highest HIV prevalence in West Africa. Migration, sex with multiple partners, women's lack of decision-making power, and untreated STIs have exacerbated the STI/HIV/AIDS situation in the region. Migration across international borders to trade or find employment occurs on a massive scale and plays a major role in the spread of the epidemic. For example, an estimated 300,000 persons travel yearly on the Ouagadougou, Burkina Faso to Abidjan, Côte d'Ivoire route. Migrant workers stay in host countries for 5 to 9 months a year, and often engage in sex with multiple partners or commercial sex workers (CSWs) while away from their families. Other migrant workers resort to commercial sex to survive and support their families. Moreover, social and cultural norms throughout West Africa generally give women minimal sexual decision-making power. As a result, women and girls are particularly vulnerable to the threat of HIV/AIDS. Access to reproductive health services, including treatment for sexually transmitted infections (STIs), is limited for most West Africans.

Overview

West Africa, 3.1 million square miles of the African continent stretching from Senegal to Cameroon, consists of 19 countries and is inhabited by more than 206 million people. Although the region shows considerable geographical, social, and cultural diversity, the countries constituting West Africa share similar transnational concerns and constraints in providing reproductive health and STI/HIV/AIDS prevention services. In 1996, in recognition of the potential effectiveness and cost-efficiency of developing regional approaches to address these concerns, USAID's Regional Economic Development Services Of-

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fice (REDSO) for West and Central Africa, in collaboration with numerous American and African nongovernmental organizations (NGOs), initiated the five-year Family Health and AIDS (FHA) Project in West and Central Africa. AIDSCAP assisted in the development and start-up of this project's STI/HIV/AIDS component, which targeted five West African nations—Benin, Burkina Faso, Cameroon, Côte d'Ivoire, and Togo—and consisted of five primary program areas: HIV/AIDS counseling and testing, HIV/AIDS prevention among migrants, STI case management, gender-sensitive prevention programming, and NGO capacity building.

Accomplishments

Counseling and Testing

AIDSCAP assisted an Ivoirian NGO, Espoir/Centre d'Information et de Prévention du SIDA en Côte d'Ivoire (ESPOIR-CIPS), in assessing the type and quality of, and demand for, HIV counseling and testing (C&T) services in Benin, Burkina Faso, Cameroon, and Togo. Based on the assessment, a plan was developed to strengthen each country's C&T services. In addition, initial management training was conducted with ESPOIR-CIPS to develop its capacity to function as a resource and training center for the region.

HIV/AIDS Prevention Among Migrants

Three NGOs began an HIV/AIDS prevention intervention among migrants with technical assistance from AIDSCAP. The Association des Femmes Africaines Face au SIDA au Burkina Faso, Economie Formation et Développment en Côte d'Ivoire, and the Union des Routiers Burkinabè de Lutte Contre le SIDA, created a cross-border network of 103 truck drivers, CSWs, and migrant plantation workers who served as peer educators along the main road between Burkina Faso and Côte d'Ivoire. AIDSCAP assisted in identifying and training the peer educators, who subsequently provided over 2,550 peers with skills to reduce sexual risk taking and distributed over 33,000 condoms. AIDSCAP also assisted in the development of a variety of behavior change communication materials, such as leaflets, posters, billboards, TV and radio spots, and condom demonstration models, to support the peer educators. To ensure an adequate condom supply, the NGOs, with the assistance of condom social marketing projects operating in Côte d'Ivoire and Burkina Faso, established condoms sales outlets readily accessible to truckers, CSWs, and migrant workers.

Strengthening STI Services

To support the efforts of the Johns Hopkins Program for International Education and Training in Reproductive Health and the Morehouse School of Medicine to integrate STI management into family planning services, AIDSCAP sponsored a training-of-trainers workshop in syndromic STI case management for 16 clinicians from family planning clinics operated by the International Planned Parenthood Federation's affiliate in Côte d'Ivoire. As a result of this initiative, one Ivoirian clinic will now serve as a regional center for future training in syndromic STI case management.

Gender-Sensitive Programming

AIDSCAP, Johns Hopkins University, and REDSO's Women in Development Unit conducted a workshop in which participants from regional ministries of health, partner NGOs, and chapters of the Society for Women in AIDS in Africa designed pilot initiatives sensitive to the problems and HIV/AIDS prevention needs of West African women and girls. Participants also developed guidelines for the use of a funding mechanism to implement the proposed pilot programs.

Capacity Building

AIDSCAP collaborated with the Cameroon Health Project in strengthening the management skills of the three African NGOs implementing the FHA Project. Technical assistance focused on transfer of program design, budgeting, training of peer educators, evaluation, and reporting skills.

Implementing Partners

Academy for Educational Development

Association des Femmes Africaines Face au SIDA au Burkina Faso

Cameroon Health Program

Economie Formation et Développement

Espoir/Centre d'Information et de Prévention du SIDA en Côte d'Ivoire

John Snow, Inc./Research and Training Institute

Johns Hopkins Center for Communications Programs

Morehouse University

Population Services International

Tulane University School of Public Health and Tropical Medicine

Union des Routiers Burkinabè de Lutte Contre le SIDA

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Zambia

Epidemiology

As early as 1990, HIV prevalence in Zambia was among the highest in the world. Although HIV/AIDS epidemiological data were not comprehensive and were at times ambiguous, 1990 sentinel survey results showed an HIV prevalence of over 25 percent among urban and periurban antenatal attendees. Data from university students donating blood in Lusaka in 1990 found that 22 percent were HIV-positive. The impact of these high prevalence rates among groups considered representative of the general public will be dramatic increases in morbidity and mortality, decreased productivity of the workforce, and the deterioration of social structures.

Clients at sexually transmitted infection (STI) clinics are at particularly high risk of contracting HIV infection. Of the approximately 170,000 cases seen each year at the 47 STI clinics under Zambia's national STI program in the early 1990s, an estimated 55 to 75 percent were HIV-positive.

Gonorrhea is the most commonly diagnosed STI in Zambia. In 1993, gonorrhea represented 21.8 percent of all reported cases of STIs in the 38 clinics reporting to the national STI unit. At that time, laboratory facilities were used for diagnosis in 75 percent of cases of urethral discharge in men. Penicillin-resistant gonorrhea was first identified in Zambia in 1980.

Country Overview

According the Ministry of Health (MOH), STIs are one of the five primary reasons for outpatient clinic attendance among adults in Zambia. In 1993, when the STI control program was joined with other programs to form the Zambian National AIDS/STI/Tuberculosis/Leprosy Program, the need to increase the capacity to diagnose and treat STIs at first encounter with the health care system was identified as a fundamental goal.

AIDSCAP sought to reduce the incidence and transmission of STIs through improved case management and greater availability

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and access to prevention information. The primary target groups were health care providers who could be trained in syndromic management and community members who could be trained as peer educators. The secondary target groups were community members who either had an STI or were at risk of contracting an STI.

Accomplishments

AIDSCAP supported three projects in Zambia: a gonococcal susceptibility study conducted in conjunction with UNICEF and two training and behavior change communication materials development interventions.

In 1995, a study was carried out to determine the antibiotic susceptability of *Neisseria gonorrhoeae* and to identify the possible factors influencing the infection pattern in selected populations in Lusaka and Ndola. This information could then be used to make recommendations for appropriate treatment guidelines for gonococcal urethritis. A total of 218 isolates were tested, the majority from the Lusaka area. Based on the study findings, which were shared with the MOH, AIDSCAP recommended that penicillin and tetracycline be abandoned as treatment for gonococcal infection and identified alternative drugs (streptomycin, ciprofloxacin, cefriaxone, and Kanomycin).

AIDSCAP also supported Project Concern International to upgrade the training facilities at University Teaching Hospital and assist with the development of a 3-week residential course, including clinical practice, to train trainers of clinical officers, midwives, and nurses in syndromic STI management. Forty-six health care providers were trained at the district level. As a result, for the first time Zambia has nurses and clinical officers at the district level trained in these STI management skills. In addition, teaching aids, which included color slides, manuals, and wall charts, were developed and distributed.

With AIDSCAP support, Morehouse University trained 69 health care providers from 41 public, parastatal, and private clinics in the Ndola urban area in the syndromic approach to STI management. In addition, 12 peer educators were trained, who in turn reached 18,751 community members with STI/HIV/AIDS prevention messages. Four STI clinics were upgraded, and a total of 1,383 STI clients were treated over a 5-month period. More than 1.8 million brochures and posters were produced in several indigenous languages, 2,000 syndromic management cards were distributed to health care providers, and 1,230 video cassettes of 10 video dramas and 40 audio cassettes of 10 radio dramas were produced and distributed in both English and indigenous languages.

Surveys to assess the quality of STI case management were carried out in Ndola health facilities before and after the training of health care providers in the syndromic approach. The results for World Health Organization (WHO) prevention indicator 6 (PI 6), which measures the proportion of individuals presenting with specific STIs in health facilities who are assessed and treated according to national standards, showed that there was a statistically significant improvement in physical examination and treatment of STI patients from one survey to the other. However, at 33 percent, the score for treatment was still low.

WHO PI 7 measures the proportion of patients presenting to health facilities with STI symptoms who receive appropriate condom and partner notification advice. The results of the PI 7 survey indicate that although there was a numerical increase in the positive scores for condom advice and partner notification, as well as for the overall final score for both variables from one survey to another, the differences were not statistically significant. The scores for the second survey, however, were high, with 73 percent of the surveyed clients receiving appropriate condom advice and 98 percent receiving partner notification advice.

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Implementing Partners

Institute of Tropical Medicine

Project Concern International

Morehouse School of Medicine

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Major Countries

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India

Epidemiology

HIV was first detected in India in 1986. As of mid-1997, more than 50,000 people are living with HIV, and the Joint United Nations Programme on HIV/AIDS estimates the prevalence of infection is 1 to 3 million. If prevalence estimates are correct, India has more cases of HIV infection than any other country. Detection of HIV trends is difficult, however, as there is no uniform, nationwide surveillance method among India's 35 state governments. However, patterns of frequent male contact with commercial sex workers (CSWs), high rates of sexually transmitted infections (STIs), low condom use rates, and injecting drug users in parts of the country suggest that the epidemic will increase unless major prevention efforts are initiated. The primary mode of HIV transmission is heterosexual, although bisexual and homosexual transmission occurs.

Country Overview

The world's largest democratic country, India is home to more than 900 million people and at least 35 major and 200 minor languages. In its 50 years of independence, India's economy has grown significantly. The country boasts a burgeoning middle class and the world's largest movie industry. Despite these indicators of growth, however, more than 60 percent of the population live below the poverty line and illiteracy rates are more than 50 percent, with estimates as high as 80 percent for women. The population also suffers high morbidity and mortality from malaria, tuberculosis, leprosy, cholera, and other diseases. Recently, India has experienced political instability, with the resignation of three prime ministers in the past 2 years and four changes of multiparty ruling coalitions in the past 4 years.

In this climate of uncertainty and change, AIDSCAP, in 1992, assisted USAID/India in the design of a 7-year, $10 million AIDS Prevention and Control (APAC) Project in the state of Tamil Nadu (population of 55 million). The state of Tamil Nadu was chosen as a demonstration state for a comprehensive HIV/AIDS control program because of the interest of state officials and the significant

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rate of HIV infection. The AIDSCAP/India program was designed to build the capacity of nongovernmental organizations (NGOs), especially those involved in the APAC Project, which is implemented by Voluntary Health Services. Long negotiations between USAID and state and federal government officials in India delayed the initiation of APAC by more than 2 1/2 years. During this period, however, AIDSCAP was able to provide modest funding to NGOs to initiate formative research activities and pilot projects through rapid response grants.

In addition to fulfilling its capacity building role in Tamil Nadu, AIDSCAP was able to support demonstration projects and major policy initiatives in other regions with complementary funds from the Asia/Near East Bureau. An AIDSCAP private voluntary organization (PVO) grant enabled PLAN International and a local NGO, MYRADA, to implement a community intervention in Karnataka, one of Tamil Nadu's neighboring states. The project initially targeted *devadasis* (women who tend the temples of a Hindu goddess and support themselves through commercial sex), but soon widened its range to include the general population, becoming one of the first comprehensive HIV/AIDS prevention projects in the country. Through outreach workers, street plays, folk music programs, wall painting competitions, training programs, and STI clinic staff, the project communicated STI/HIV/AIDS prevention messages to more than 1.3 million people and distributed more than 68,000 condoms and 380,000 materials. In 199697, AIDSCAP, at the request of USAID/India, supported a number of pilot projects, including outreach to low-income populations and injecting drug users, in Delhi.

Accomplishments

AIDSCAP/India provided initial funding for a number of innovative intervention and research activities in Tamil Nadu to stimulate activities and build experience in the region while waiting for the approval of the APAC Project. It has also served as a resource center in the region for both NGO and government agency staff. AIDSCAP successfully assisted APAC in the early initiation and implementation of a project now seen as a model, comprehensive, statewide HIV prevention and control program. Nationally, the AIDSCAP/India program played a leading role in stimulating discussion on the growing epidemic among policymakers and in raising issues about gender and people living with HIV/AIDS (PLWAs).

Behavior Change Communication

With six rapid-response fund grants, the PVO grant to PLAN and MYRADA, workshops, and support to APAC, AIDSCAP was able to initiate a number of pilot interventions among target populations. These interventions included peer education activities with college students; a low-cost newsletter for semiliterate readers; street plays in low-income areas; an educational film for transvestites and men who have sex with men; and outreach to truckers and *devadasis* in Karnataka. Through directly supported AIDSCAP activities, more than 26,720 people were trained, 1,408,227 people were educated, 468,955 materials were distributed, and at least 46 mass media events were held.

During its last month of implementation in June 1997, AIDSCAP/India sponsored a training-of-trainer's workshop for NGO staff persons in behavior change communication (BCC) for HIV/AIDS prevention projects. More than 30 NGOs from across the country were represented. AIDSCAP also worked with APAC staff to design their BCC strategy.

Condom Promotion and Distribution

In 1993, AIDSCAP commissioned Population Services International to conduct a condom availability and accessibility study in Tamil Nadu in preparation for APAC. The report noted that the wide availability of free condoms from the government, as well as condoms in the market place, limited the need for extensive

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condom social marketing. Further research on condom quality was conducted in 1996, and at APAC's request, samples were tested in Family Health International's laboratories. The results suggested the need for improved packaging and storage of condoms in order to maintain quality. Through the PLAN/MYRADA project in Karnataka and the demonstration projects in New Delhi, approximately 78,934 condoms were distributed free-of-charge and 64,190 were sold.

Strengthening STI Services

AIDSCAP provided technical assistance in STI case management throughout the life of AIDSCAP in India. In 1993, the STI advisor from the Asia regional office reviewed the National AIDS Control Organization (NACO) manual on syndromic treatment and developed a manual for training nonspecialist health care practitioners. In addition, AIDSCAP staff conducted a number of STI case management training workshops for physicians in Tamil Nadu and Karnataka. AIDSCAP also assisted APAC in designing its STI control strategy and identifying research issues.

Policy Development

AIDSCAP and USAID/India were able to stimulate a number of policy initiatives. Through consultations with internationally recognized epidemiologists, NACO staff, and key government officials, both state and federal officials began identifying more systematic methods for conducting HIV surveillance. A national law conference on HIV/AIDS and Human Rights, partially supported by AIDSCAP, was the first HIV/AIDS event in the country to draw the attention of the president and prime minister. AIDSCAP also influenced the media at statewide and national workshops on reporting on HIV/AIDS.

Capacity Building

AIDSCAP's primary role in India was building the capacity of institutions rather than direct project implementation. It did so through technical assistance and sponsorship of key individuals to local, national, regional, and international training events to strengthen skills in BCC, STI case management, epidemiologic projections and modeling, HIV/AIDS reporting, and program management. By disseminating HIV prevention and control data and sponsoring advocacy activities, AIDSCAP stimulated the creation of a significant number of HIV prevention projects across the country and developed the expertise of local institutions to design, manage, and evaluate such projects.

Special Features

Three unique features of the AIDSCAP/India program are its (1) work to support the first PLWA organizations in India (one in Tamil Nadu and one nationwide); (2) initiatives in raising awareness of the women's risk of HIV infection through state and national workshops as well as formative research; and (3) support of cross-border interventions with mobile populations along the India-Nepal border. In each of these areas, AIDSCAP has led the way in calling attention to the needs of these vulnerable populations.

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Implementing Partners

All India Women's Conference

Bhoruka Research Centre for Hematology and Blood Transfusion

Community Aid and Sponsorship Program

CEDAC Communications Pvt., Ltd.

India Institute of Health Management Research

Indian Law Institute

JAGORI/Positive Life

MCRC

Mindspace

MYRADA

Nalamdana Charitable Trust

PLAN International

Seva Trust/Society for Demographic Research and Training

Society for AIDS Awareness and Prevention

Society for the Promotion of Youth and Masses

Sulabh International Institute of Health and Hygiene

Tamilnadu Network of Positive People

Tamil Nadu State AIDS Control Society

World Vision of India

YRG Care for AIDS Research and Education

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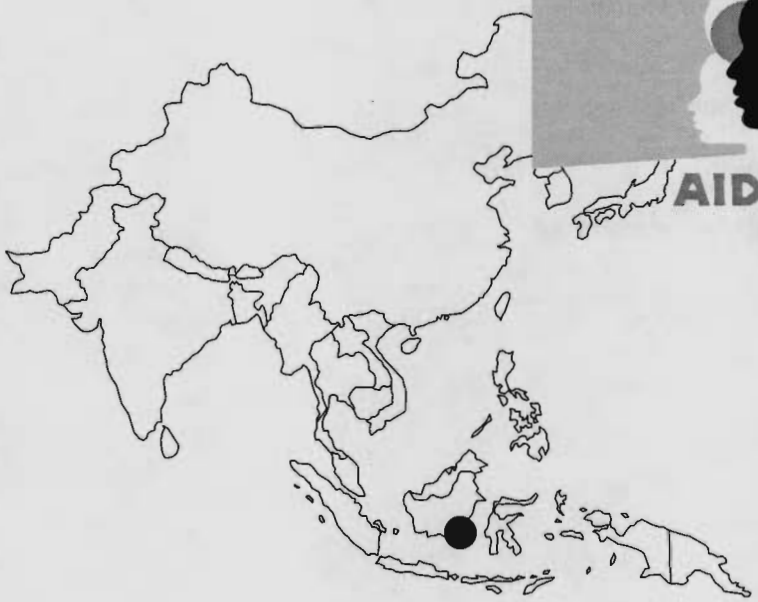
Indonesia



Epidemiology

HIV infection has not reached an epidemic stage in Indonesia. AIDS case reports and HIV seroprevalence data indicate that the spread of HIV in Indonesia is following a pattern more like the one observed in the Philippines and Sri Lanka than the pattern seen in Thailand, India, or other Asian countries with well-documented epidemics. A cumulative total of 550 HIV-positive individuals (136 living with AIDS) had been reported to the Ministry of Health as of June 30, 1997. The actual number of individuals living with HIV, however, could easily be 10 times higher.

Several factors contribute to the spread of HIV in Indonesia. An extensive commercial sex industry reaches rural and urban areas, and there is high mobility of commercial sex workers (CSWs) throughout the archipelago. In addition, CSWs cater to a large number of mobile men, including land and sea transport workers and migrant laborers in construction and mining.

Country Overview

Indonesia is the fourth most populous nation in the world, with an estimated population of 190 million. It is an archipelago of more than 13,000 islands stretching over 3,200 miles and 3 time zones. Sixty percent of the population reside on the island of Java, one of the most densely populated islands on earth.

The HIV/AIDS Prevention Project (HAPP), is a five-year, $20-million USAID project that supports the implementation of the national HIV/AIDS strategy of the Government of Indonesia (GOI). In November 1995, the HAPP implementation plan was designed for a five-year period. The plan was approved by Indonesia's communicable disease control and environmental health director in May 1996, HAPP activities were initiated in July 1996.

HAPP was directed by the Ministry of Health (MOH), with technical assistance and subproject administration assigned to AIDSCAP. The HAPP team also included seconded

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staff from the Futures Group in the area of condom social marketing and from the Centers for Disease Control and Prevention in the area of sexually transmitted infection (STI) control. HAPP is an integrated HIV/AIDS prevention project comprised of four major technical components: (1) improved management of STIs, (2) behavior change communication (BCC), (3) improved access to and promotion of condoms, and (4) policy support and dissemination. The geographic focus of the program is North Jakarta and Surabaya, which are both located on the island of Java, and Manado. The target audience included youth, female CSWs, other women at risk, clients of CSWs, commercial sex and brothel managers, and *waria* (transvestites).

Accomplishments

During its first 10 months of implementation, HAPP was active at the community level, funding 38 subgrants, eight small grant activities, and eight activities directly funded by the HAPP office for a total of 54 interventions and activities.

Behavior Change Communication

HAPP supported the national BCC strategy developed by the GOI. At the beginning of the project, neither the appropriate BCC curricula nor the skills to develop needed curricula existed. Therefore, a curriculum development activity was designed and initiated as an action-learning process, by which outreach workers and trainers were involved in developing a behavior change, theory-based set of training modules.

The project collaboratively developed and disseminated materials ranging from stickers to TV and radio drama. Outreach to target audiences was achieved through a network of implementing agencies (IAs) that recruited and supported outreach workers and peer educators who, in turn, promoted and supported the adoption of safer sexual practices by target audiences. Stronger links were also initiated between IAs, local governments, provincial AIDS commissions, and private businesses. HAPP carried out coordinated mass media activities by buying-in to an ongoing mass media collaboration with the Center for Health Education. The buy-in provided funding for broadcast of a previously developed set of TV spots and development and broadcast of media targeting youth.

Condom Promotion and Distribution

HAPP supported a wide range of condom social marketing activities, including condom quality assurance, operations research, training for CSWs in condom negotiation, mass media promotions, and other marketing efforts. The project funded special task force teams in designated intervention areas to increase availability of condom supplies. Condoms are now readily available to clients and CSWs in the red light districts of North Jakarta. Evaluation and monitoring of the condom component was completed in July 1997.

Increasing the acceptance and use of condoms was a project priority. In 1996, studies reported that only 14 to 30 percent of CSWs used condoms with their clients. By June 1997, the percentage of CSWs targeted by the project who were using condoms was 89 percent in Surabaya and 90 percent in North Jakarta.

Strengthening STI Services

Guidelines for the management of patients with STIs are a cornerstone of any national STI prevention program. The recent development and promulgation of STI management guidelines by the MOH was therefore a major achievement. HAPP was a partner in developing the guidelines and used them in its STI clinical training. High STI rates among CSWs, along with guidance from HAPP staff on the effectiveness of Thailand's national condom policy, persuaded the GOI to issue a formal declaration requiring 100 percent condom use in commercial sex—a major step forward in the effort to combat HIV/

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AIDS in Indonesia. HAPP supported improvements in clinic-based STI activities for men and women by providing STI management and lab skills training to health care providers at HAPP sites and by supplying laboratories with essential equipment.

Capacity Building

Advocacy, capacity, and policy support were built through study tours for government and religious leaders. These tours allowed Indonesian leaders to observe and discuss HIV prevention activities in the Asian region as well as in key areas of Indonesia. HAPP provided follow-up meetings that encouraged dissemination of learning from the study tours. Other capacity building and networking activities for IAs and local governments included training in STI management, participatory evaluation, training skills development, curriculum development, condom negotiation, outreach, and other interpersonal communication skills. IAs also received training in proposal writing, budgeting, financial management, and programmatic reporting.

Behavior Surveillance

HAPP worked with the MOH to adapt its behavior surveillance surveys (BSS) methodology to follow trends in sexual behavior in Indonesia. Several findings from the first round of surveys suggest a relatively modest risk of STI /HIV among the general population. The age of first intercourse is relatively high (20–24 years), there is a low prevalence of concurrent partnerships among women (with only 1.5 percent of female factory workers admitting to having more than one sex partner in the past year), and commercial sex is limited (with, for example, sailors and seaport laborers reporting an average of only 2.5 CSW contacts per year). Other findings, however, suggest a higher level of CSW contacts (mainly at brothel complexes), and a low level of condom use in commercial sex (17 percent).

Special Feature

Islam plays a strong role in the Indonesian culture, and the Islamic leaders have taken on the responsibility of providing guidance on HIV/AIDS issues to the people of Indonesia. Their approach, in comparison to that of religious leaders in other Muslim and non-Muslim countries in the region, is a decidedly compassionate and liberal one. Islamic religious leaders commented on how their study tour assisted them in validating their current open-armed policy of care and support to people with HIV/AIDS. These experiences led to the Second National Workshop of Islamic Religious Leaders on HIV/AIDS in June 1997, where issues of care and support for people with HIV/AIDS were addressed. Sponsored by HAPP, the workshop was held under the auspices of the National AIDS Commission and all provinces were represented. It resulted in

- the development of Islamic religious guidelines for giving support to and caring for people with HIV/AIDS.
- the development of a plan of action for implementing the guidelines.
- a statement rejecting euthanasia for people suffering from AIDS.
- a statement reinforcing the principle of respect and dignity toward all humans, including people living with HIV/AIDS.
- a statement calling for no discrimination or isolation practices toward people living with HIV/AIDS.
- a statement recommending the creation of an environment conducive to HIV/AIDS prevention and control.

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Implementing Partners

Center of Health Education, MOH

The Futures Group

Communicable Disease Control/Environmental Health, MOH

Program for Appropriate Technology in Health

Center for Health Research, University of Indonesia

Project Concern International

Private Agencies Collaborating Together (PACT)

Yayasan Bahagia Harapan Kita

Yayasan Prospectiv

Yayasan Mitra Indonesia

Atmajaya Research Center

Yayasan Mitra Masyarakat

Yayasan Pelit Kasih Abadi

Yayasan Abdi Asih

Yayasan Pelita Ilmu

Ikatan Ahli Kelehatan Masyarakat

Yayasan Investasi Kemanusiaan

Ikatan Dokter Indonesia

Center for Health Education, MOH

PKBI Daerah Jawa Timur

Yayasan Kusuma Buana

Yaysan Jaringan Epidemiology

Pusat Media dan Pelatihan AIDS

Population Services International

Working Group on AIDS Control, National AIDS Control Commission

The Indonesian Council of Islamic Religious Leaders (Majelis Ulama Indonesia)

APB-Target

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Nepal

Epidemiology

The National Centre for AIDS and STD Control (NCASC) reported 647 HIV infections and 136 AIDS cases by mid-1997. Given Nepal's public health structure and its limited HIV/AIDS surveillance system, the actual number of AIDS cases may be 5 to 10 times the reported number and the number of HIV infections may be 20 to 30 times the detected number. A large proportion (up to 50 percent) of these infections were most likely acquired in India.

Country Overview

After the first case of AIDS was discovered in 1988, the World Health Organization (WHO) provided His Majesty's Government (HMG) with technical assistance to set up a National AIDS Control Program and develop Medium-Term Plan I (MTP I). Following the implementation of the MTP II in 1993, HMG, in collaboration with WHO, the European Community (EC), and other donors, developed a blood screening program, a sentinel surveillance system, and sexually transmitted infection (STI) management guidelines. In 1996, the development of a policy paper on HIV/AIDS and STI control established HMG's commitment to manage STI/HIV/AIDS prevention as a priority multisectoral program.

Beginning in 1993, AIDSCAP/Nepal sought to reduce the rate of STIs in the Terai region of Nepal by reducing the high-risk behavior of commercial sex workers (CSWs) and their clients. The Terai was chosen because it stretches along Nepal's long border with India, a country in which numerous pockets of HIV infection had already been identified. The high volume of traffic between the two countries resulted in a high probability of sexual contact due to the labor migration of both Indian and Nepalese men across the borders, and domestic migration of Nepalese men and women from rural areas to Nepal's border cities. In addition, there were reports of the trafficking of Nepalese women to be sold into sexual slavery in India. These patterns of interaction put persons living, working, and traveling in this heavily populated region at risk of contracting HIV infection.

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USAID supported AIDSCAP/Nepal's strategic plan with special HIV/AIDS program funding from the Asia/Near East Bureau, and later with direct support from its Mission in Nepal.

Accomplishments

Prior to the design of interventions, AIDSCAP supported a rapid assessment of sexual networking in five urban areas and adjacent satellite towns in the Terai. The assessment confirmed an underground commercial sex industry and highlighted CSW mobility and client demand along major transport highways leading to India. As a result of its findings, geographical coverage of the project was refocused from an east-west urban strategy to one focused on 435 kilometers of highways in the Central region.

Behavior Change Communication

Through AIDSCAP, USAID supported indigenous organizations to develop and implement community-based outreach education. Working in highway halting points, urban centers, small communities, and at the Birgunj-Raxaul border, field workers reached CSWs, other marginalized women with multiple partners; and transient workers, including truck drivers, military personnel, police, students, and migrant workers. As the project progressed and field workers gained confidence, 545 peer educators were trained. By the end of the project, 2,600 CSWs and 36,500 CSW clients had been reached.

Strengthening STI Services

In an effort to ensure access to effective STI services at the first point of contact with service providers, AIDSCAP worked to strengthen private sector service delivery in the program area with three partners: Nepal Medical Association (NMA), Nepal Chemists and Druggists Association (NCDA), and Family Planning Association of Nepal (FPAN). The NMA developed a training curriculum on the syndromic management of STIs that was later modified for chemists and formed the core of a training curriculum developed by the EC to train nurses and paramedics. The NMA trained 50 physicians in syndromic management of STIs, and the NCDA trained 32 trainers of trainers and 631 community chemists (approximately 72 percent of chemists serving target populations in the project area).

AIDSCAP supported FPAN in the integration of STI services into three of its existing clinic and community outreach family planning and maternal-child health care sites. Health care providers were educated on the syndromic approach and clinics were renovated and equipped. In 14 months, 1,275 clients were treated for STIs at the three clinic sites. Support to establish a revolving drug fund for STI drug supply made it possible to supply clients with lower-cost medications (15 percent below market price).

Condoms

To increase overall accessibility and demand for condoms for disease prevention, AIDSCAP collaborated with the Futures Group International Social Marketing for Change Project, Nepal Contraceptive Retail Sales Company (CRS), and Stimulus, a Kathmandu-based advertising firm. CRS expanded its retail sales base beyond the traditional chemist's shops to include outlets in tea shops, restaurants, lodges, and general goods shops adjacent to the highway and in key urban areas. CRS condom sales in the 22-district Terai region expanded by 189 percent from 1993 to 1996, with approximately 4 million condoms sold in the Terai in both 1995 and 1996. The increased demand for condoms was influenced by a strong multimedia campaign that included a campaign logo and slogan, an animated condom character, TV advertising spots, radio shows, a nationally televised videodrama, and various print media. Between 79 and 93 percent of CSWs and clients surveyed report hearing the condom campaign slogan.

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Policy Development

AIDSCAP provided technical assistance in epidemiologic modeling to the NCASC and initiated policy dialogue among key stakeholders to create an environment in which the government and the private sector could better mobilize resources to control STI/HIV/AIDS. Seventy-five representatives from government, nongovernmental organizations (NGOs), donors, and the media attended the AIDSCAP/NCASC-sponsored presentation on the epidemiological situation and HIV/AIDS projections for Nepal. In addition, AIDSCAP supported an Asia study tour, orientation workshops on the management of HIV/AIDS for members of Parliament, and workshops for local journalists. AIDSCAP policy initiatives ceased in 1995, when the Minister of Health discontinued the practice of working with international NGOs on HIV/AIDS policy issues.

Key Outcome Data

- More than 44 percent of patients seeking services for urethral discharge from trained chemists receive treatment in accordance with national guidelines, compared with 0.85 percent before project intervention.
- Between 21 percent (trained chemists) and 100 percent (FPAN clinics) of persons seeking STI treatment receive appropriate prevention education.
- Over 74 percent of CSWs surveyed in the Central region can name at least one correct way to prevent HIV transmission.
- Between 77 and 92 percent of persons surveyed in the Central region report realistic perceptions of risk.
- Of CSWs surveyed, 61 percent reported using a condom with their last client, compared to 35 percent at project start-up.

Implementing Partners

Contraceptive Retail Sales (CRS)

The Futures Group International, Inc.

General Welfare Pratisthan

Lifesaving & Lifegiving Society

Nepal's Chemist and Druggist Association

Nepal Medical Association

New ERA

Population Services International (PSI)

Program for Appropriate Technology in Health (PATH)

Save the Children/United States

Stimulus Advertisers

Valley Research Group

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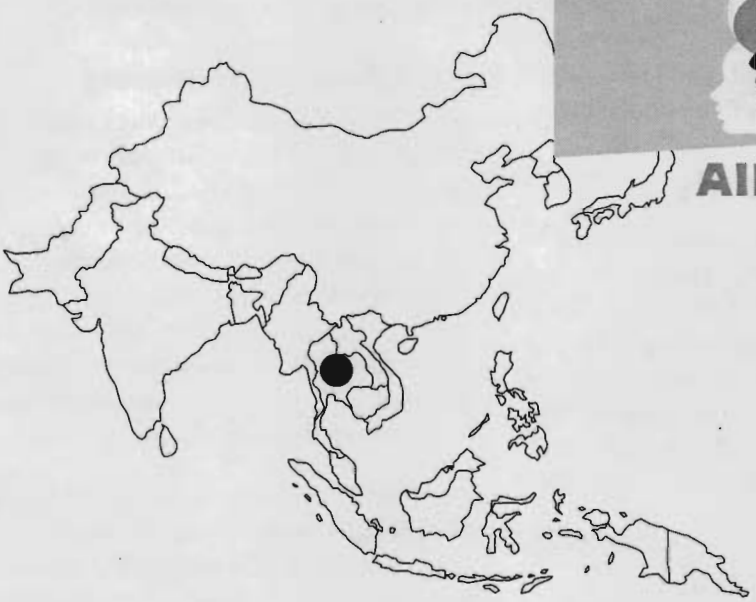
Thailand



Epidemiology

Data from HIV sentinel surveillance of the female population in Bangkok were beginning to show significant levels of infection by 1992. For all three sentinel populations of women (direct and indirect commercial sex workers [CSWs] and antenatal clinic clients) the level of HIV infection in Bangkok was higher than for the rest of Thailand. One-third of direct (brothel-based) CSWs in Bangkok were infected, compared to one-fourth nationally. The prevalence of HIV infection among Bangkok's indirect CSWs (who usually work out of bars, restaurants, and night clubs) was twice that for all of Thailand. Finally, in 1992, infection in young married women in Bangkok surpassed the national average.

Country Overview

When AIDSCAP/Thailand was launched in 1992, the Royal Thai Government had already established a national program that was focused on provinces outside of Bangkok. International donor assistance, guided by the first Medium-Term Plan of the Ministry of Public Health, was steered mostly toward the northern region of Thailand, where the epidemic was spreading rapidly.

The urban province of Bangkok, which was not directly targeted for prevention activities, experienced a significant migration of unattached lower-income men and women in the peak age range for sexual activity (estimated at 10,000 persons per month in 1992). It became clear that the HIV/AIDS epidemic was present among the general population and was no longer confined to the core population of CSWs and their clients. At the request of Thailand's National AIDS Control Program, USAID supported AIDSCAP to design a comprehensive HIV prevention program for the lower-income population of Bangkok. The goal was to slow the transmission of HIV in the Bangkok population aged 15 to 29 with a comprehensive program of mutually reinforcing interventions.

When AIDSCAP began implementation, services for sexually transmitted infection (STI)

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treatment, condom distribution, and behavior change communication (BCC) existed in Bangkok, but they were small-scale and not readily accessible. By forging an alliance of prevention agencies and creating a program identity (Bangkok Fights AIDS), AIDSCAP sought to promote community action and targeting of services to the most vulnerable populations.

Accomplishments

A total of 28 subprojects were implemented by 20 agencies from the public, private, and university sectors under AIDSCAP. These subprojects provided approximately 9,000 persons with curriculum-based training, reached more than 200,000 lower-income women and men with BCC messages, and distributed more than 800,000 BCC materials and 1.6 million condoms free-of-charge.

Community Mobilization

AIDSCAP supported the Faculty of Public Health at Mahidol University to work through district AIDS committees (DACs) to identify and strengthen networks of members of high-risk communities. Technically skilled agencies directed targeted communications to these vulnerable networks through a variety of channels. In addition, clinical service structures were strengthened to increase access to STI services, counseling, and condoms. Throughout this process, community networks were identified, created, and reinforced to increase the opportunities for communication and diffusion of STI/HIV/AIDS information to other networks.

Behavior Change Communication

AIDSCAP used mass media, outreach, public relations, and interpersonal and peer education communications to reach female and male CSWs, adolescents and married women in low-income communities, and female and male wage earners in large formal and small informal worksites. As a result of BCC activities, these target groups, with the exception of non-CSW single women, reported adopting safer sexual behaviors. As shown by behavioral surveillance surveys (BSS) of members of target groups showed increases in condom use in high-risk situations, and a decline in the proportion of men visiting CSWs.

Strengthening STI Services

AIDSCAP developed projects to extend and strengthen the ability of Bangkok service providers to rapidly diagnose and treat STIs in the target population of lower-income young men and women and to conduct outreach BCC. Eleven Bangkok Metropolitan Administration (BMA) STI clinics and their laboratories received the necessary equipment to diagnose and treat STIs, and the hours of operation were extended in two clinics.

Competency-based training curricula in STI management were developed, and physicians in the public and private sectors and nurses and laboratory technicians in the public sector were trained in the syndromic approach. Laboratory technicians were also trained to improve quality control and other standardized laboratory procedures, to perform more diagnostic tests, and to implement the new systems. Nurses who provide STI services under the direction of a physician received training in the national guidelines for the syndromic approach, HIV prevention, compliance with medical prescriptions, and partner notification. In addition, approximately 900 outreach staff members from 60 BMA clinics were trained in outreach education.

As persons with STIs in Thailand frequently seek treatment from pharmacies without prior medical diagnosis of their illness, AIDSCAP supported the development of a model intervention for improving pharmacy-based STI diagnosis, referral, and prevention services. AIDSCAP trained pharmacists and nonpharmacist staff from 210 drugstores in Chiang Mai, where a successful pharmacy training program in contraceptive services had been conducted in 1990. The training

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project was later replicated in Bangkok with funding from the European Community.

Condoms

With condom availability already high in Bangkok, AIDSCAP focused on addressing cultural barriers to condom use through BCC materials, community outreach, and mass media. For example, AIDSCAP attempted to modify social norms in a way that would allow single women to be more assertive in condom use. Booklets, pamphlets, and videos encouraged women to acquire condoms themselves and insist on their use if they were unsure about their partner.

Key Outcome Data

BSS were conducted at intervals among cross sections of Bangkok population groups that were similar to those targeted by AIDSCAP interventions. Surveys were administered to school youth; employees of offices, factories, and brothels; male STI clinic patients; and antenatal clinic patients. The five survey rounds revealed a decline in the proportion of men visiting CSWs and a significant increase in condom use in high-risk situations. In addition, condoms were reportedly used more consistently. Single females reported no increase in sexual activity.

Key findings include the following:

- 93 to 94 percent of men surveyed in 1996 among various populations in Bangkok reported using a condom during their last sexual contact with a CSW, compared with 88 to 92 percent in 1993.
- 89 percent of indirect CSWs surveyed in 1996, 89 percent reported using a condom with every client, compared with 56 percent in 1993.
- 29 percent of indirect CSWs surveyed in 1996 reported using a condom with every nonpaying sexual partner, compared with 23 percent in 1993.
- 18 percent of single women (non-CSWs) reported using a condom during their last sexual contact in both 1993 and 1996.

Special Feature

A special feature of the AIDSCAP/Thailand program was the linkage of its subprojects through community mobilization and DACs and the creation of a project identity (Bangkok Fights AIDS) to establish a sense of indigenous partnership.

The community mobilization process employed in Bangkok can be described as follows: an implementing agency, such as a university, works through a local coordinating mechanism (the core members of the DAC) to identify and strengthen networks of individuals in high-risk groups. Technically skilled agencies arrange targeted BCC to these networks through a variety of channels to promote the social norms that support STI/HIV/AIDS prevention. Meanwhile, clinical service structures are created or strengthened to increase access to STI treatment, counseling, and condom supplies. Throughout this process, the community networks are identified or created, and reinforced to increase the opportunities for communication between them and for diffusion to other networks.

Initially, the network strengthening component of the community mobilization effort focused on community diagnosis that mapped out and highlighted the complexity of Bangkok's social networks. Approximately 117 DAC members were trained and 7,273 men and women were reached in six districts. In the remaining 32 districts, greater emphasis was placed on strengthening DAC performance, rather than creating social networks.

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Implementing Partners

Asean Institute for Health Development

Association for the Promotion of the Status of Women

Association for Voluntary Sterilization

Bangkok Metropolitan Administration

Chulalongkorn University

Department of Health, Bangkok Metropolitan Administration

Foundation for Thailand Rural Medical Practitioners Association

Johns Hopkins University

Mahidol University, Faculty of Public Health

Medical Society for the Study of Sexually Transmitted Diseases

Ministry of Public Health of Thailand

Office for Population and Technical Assistance (OPTA)

Planned Parenthood Association of Thailand

Program for Appropriate Technology in Health (PATH)

School of Public Health, Mahidol University

Thai Association for Voluntary Sterilization

Thai Medical Society for the Study of Sexually Transmitted Diseases

Thai Red Cross Society

Thailand Rural Reconstruction Movement

World Vision Relief and Development

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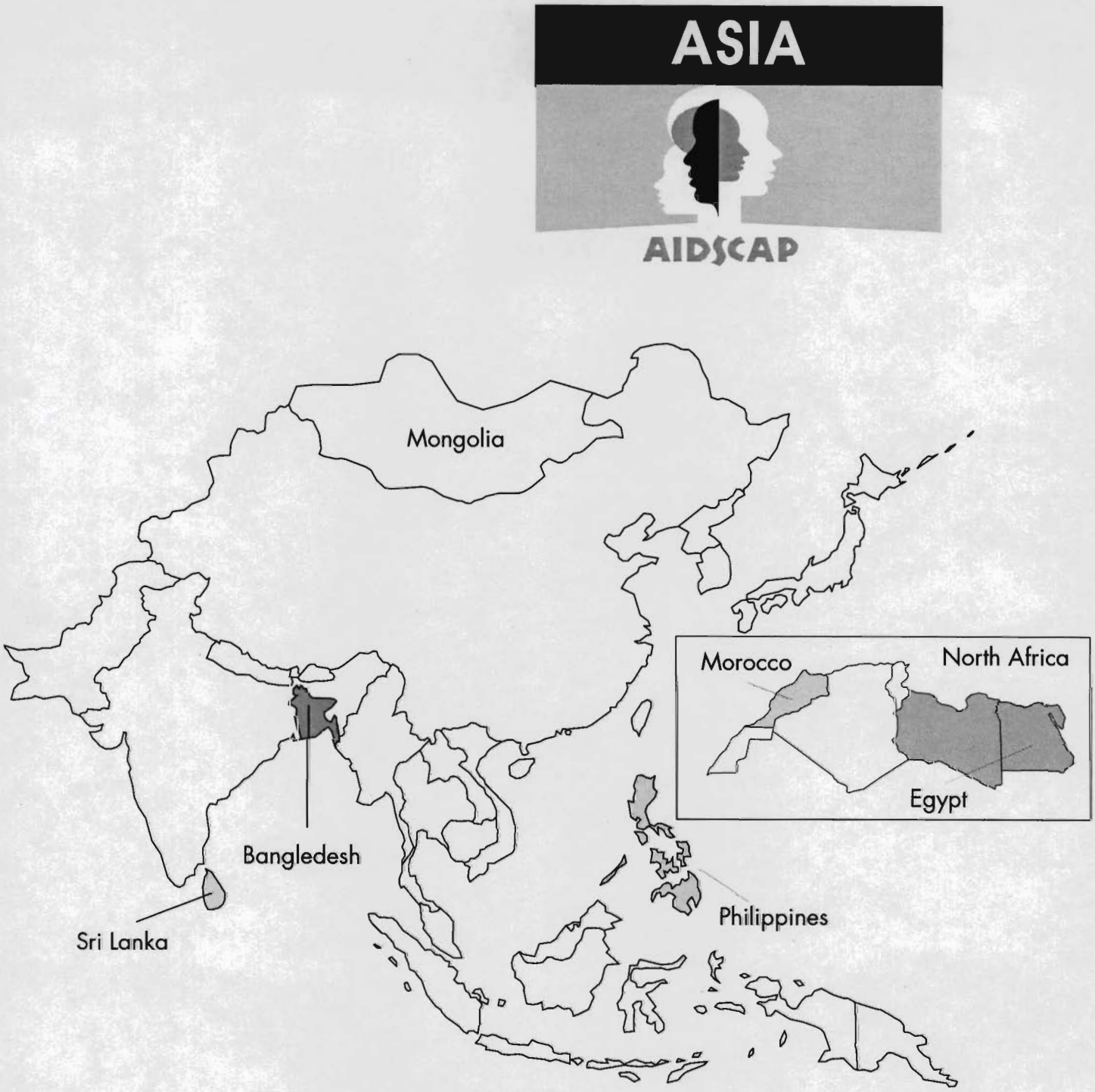

Associate Countries

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Bangladesh

AIDSCAP

Epidemiology

For reasons that are unclear, reported HIV prevalence rates are remarkably low in Bangladesh. In 1995, the national HIV prevalence rate was estimated to be 0.05 percent among sexually active adults. Other sexually transmitted infections (STIs), however, exist at high levels, particularly among groups with high-risk behaviors. Samples of commercial sex workers (CSWs) in Dhaka revealed 30 percent syphilis prevalence rates and 23 percent gonorrhea prevalence rates. A national prevalence study revealed that 6 percent of sexually active adults are serologically positive for syphilis. Bangladesh has many of the epidemiological and social factors that could produce a devastating epidemic: high-density population, low health standards, high rates of STIs, minimal sex education in schools or by families, an active commercial sex network, and a high degree of international migration and trade with countries where HIV is spreading rapidly. By the year 2000, the World Bank projects 300,000 cumulative HIV infections and over 30,000 cases of AIDS in Bangladesh.

Country Overview

Bangladesh, with a population of 117 million persons, is already the most densely populated country in the world, and its population is expected to double in 30 years. Bangladesh is also one of the poorest nations in the world. An estimated 70 million Bangladeshi live in absolute poverty. More than 80 percent of the population live in rural areas and have very little access to health care. All health problems are exacerbated by malnutrition; 67 percent of rural children suffer chronic malnutrition.

Because of this country's high population growth, the Bangladeshi government has made family planning a public health priority. As part of this effort, the Social Marketing Company (SMC) operates one of the largest condom social marketing programs in the world, with yearly sales of 120 million condoms.

In 1993, USAID/Bangladesh, concerned about the country's vulnerability to HIV and the lack of a formalized national HIV/AIDS prevention plan, requested that AIDSCAP assist the gov-

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ernment and other agencies in raising awareness about the epidemic and developing appropriate prevention programs. AIDSCAP's initial contact with in-country officials revealed a growing recognition of HIV/AIDS and desire on the part of nongovernmental organizations (NGOs) to become involved in prevention, even though these organizations lacked support and, in some cases, technical expertise in STI/HIV/AIDS prevention. Consequently, with USAID/Bangladesh support, AIDSCAP initiated a $200,000 program to strengthen NGOs' capacity to implement effective STI/HIV/AIDS prevention activities. AIDSCAP/Bangladesh activities initially focused on developing educational programs for NGO employees, but later expanded to include providing technical assistance in developing behavior change communication (BCC) materials for condom promotion and community-based peer education, and training family planning clinic staff in the syndromic approach and integration of STI services in family planning clinics.

Accomplishments

AIDSCAP worked to improve the capacity of indigenous NGOs to implement AIDS prevention activities and to speak with one voice to affect national policy. Accomplishments included the establishment of workplace STI/HIV/AIDS prevention education for NGOs operating in Bangladesh; improved STI case management through the use of the syndromic approach in family planning clinics; and facilitation of a conference on the development of a national consensus on the role of NGOs in HIV/AIDS prevention.

Behavior Change Communication

With AIDSCAP's assistance, 28 participants from 17 national and international NGOs received the knowledge and skills needed to develop effective HIV/AIDS staff education programs involving peer educator and counseling approaches. The training sessions, based on a curriculum successfully employed in similar sessions in Thailand, were adapted for Bangladesh and may be used by any local organization planning to implement HIV/AIDS prevention programs for its employees. AIDSCAP BCC activities also targeted groups at high risk of infection. Condom salespeople who participated in a training program developed by AIDSCAP/Bangladesh and the SMC now provide educational outreach to CSWs.

Condom Promotion and Distribution

With technical assistance from AIDSCAP, the SMC launched a new initiative called *Shurokha* to promote condoms for the prevention of HIV/AIDS among male and female CSWs and their clients. AIDSCAP's primary role was to provide technical assistance in the design of the intervention (target groups, sites, methods) and in pretesting BCC materials for condom promotion. Moreover, condom packaging now includes STI/HIV/AIDS protection messages in addition to standard messages about contraception.

Strengthening STI Services

Service providers from 20 NGO maternal-child health/family planning clinics now provide more effective STI case management for clients as a result of AIDSCAP-supported training in STI diagnosis and the syndromic management approach. Moreover, use of a training-of-trainers approach has enabled these NGOs to conduct their own STI diagnosis and management training sessions as needed.

Policy Dialogue

AIDSCAP/Bangladesh, at the request of USAID/Bangladesh, provided the necessary funding and technical assistance to conduct the 1995 NGO Conference for a National Consensus on HIV/AIDS, which drew representatives from 72 organizations providing primary health care and family planning services in Bangladesh. At this conference, participants identified activities that must be

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implemented to limit the HIV/AIDS epidemic in Bangladesh and clarified the collaborative role NGOs might play with the government in STI/HIV/AIDS prevention. Recommendations formulated by conference participants were presented to the Government of Bangladesh for inclusion in the country's Second Medium-Term Plan.

Implementing Partners

Access to Voluntary and Safe Contraception (AVSC) International

International Center for Diarrhea Disease Research

Program for Appropriate Technology in Health

Voluntary Health Services Society

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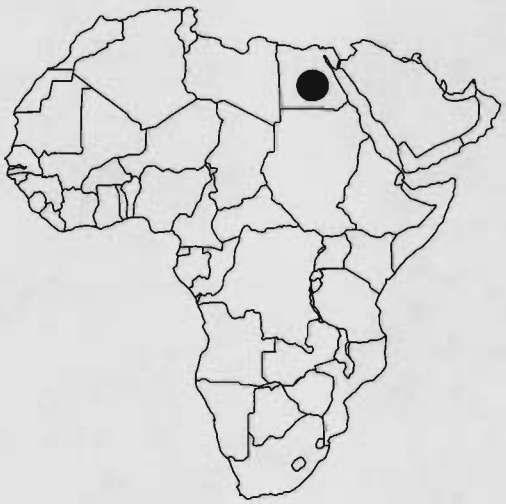
Egypt



Epidemiology

In 1996, of the 129 cumulative AIDS cases were reported to the National AIDS Control Program (NACP), heterosexual transmission accounted for 61 cases (47 percent); blood or blood products for 34 cases (26 percent); injecting drug use for 16 cases (12 percent); and homosexual transmission for 15 cases (12 percent). Three cases (2 percent) were of unknown origin. No AIDS cases were reported from prenatal transmission. Ten percent of the reported AIDS cases occurred in females, and no pediatric cases were reported. Egypt has no surveillance system, which makes reliable sexually transmitted infection (STI) estimates impossible. Male sexual dysfunction, infertility, and STI cases are reported together; the number recorded by the Ministry of Health and Population (MOHP) from 1992 to 1995 ranged from 41,740 to 42,849 cases.

Country Overview

Egypt has a population of more than 50 million, with more than 50 percent of the population living in rural areas in the Nile valley. Approximately 94 percent of Egyptians are Muslims, and Coptic Christians are the largest minority religious group. The political climate is dominated by debates of the role on Islam in Egyptian political and social institutions.

The MOHP established the NACP in 1986 under the auspices of the preventive care sector. The main objectives of the program are to educate the public about HIV/AIDS and to implement an HIV/AIDS prevention policy. STIs are part of the curative care sector. This makes coordination and integration of NACP activities with STI prevention and control very difficult.

AIDSCAP began communication and design work with USAID/Egypt in August 1995, following the merger of USAID's Asia and Near East Bureaus. Activities in Egypt then

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fell under the scope of work of the new Asia/Near East Bureau. The AIDSCAP scope of work in Egypt included conducting an STI/HIV/AIDS assessment to determine the areas of greatest need for donor assistance and a policy study tour to Thailand for Egyptian and Moroccan participants. In addition, USAID/Egypt requested that AIDSCAP to conduct a behavioral research among university youth in Cairo.

Accomplishments

During 18 months of implementation, AIDSCAP completed an STI/HIV needs assessment with recommendations for action and a 13-month behavioral research study of university students in Cairo. In addition, AIDSCAP organized the participation of three leading physicians in a policy study tour to observe the response to the epidemic by the Thai government, nongovernmental organizations, and the public health sector.

The needs assessment took place in April 1996 with a team of STI, behavior change communication (BCC), and program management specialists. Key recommendations from the assessment included (1) a review of HIV surveillance and testing in Egypt, (2) a study of STI prevalence, (3) the design of BCC training for Egyptian health care workers, (4) an assessment of the potential for promoting and marketing of condoms for disease prevention, (5) an assessment of the HIV/AIDS-related policy environment, and (6) the design of a plan for three new behavioral studies of groups at high risk of HIV infection.

Behavioral Research

Knowledge, attitudes, beliefs, and practices (KABP) research among university students in Cairo revealed relatively low levels of sexual intercourse (26 percent among males and 3.2 percent among females). Rates of condom use, however, were low. This study suggested that traditional Islamic culture may inhibit some young people from sexual risk taking, but high-risk behavior still occurs among university students. In addition, while knowledge of HIV/AIDS was high, students require additional, frequent, and more accessible information on prevention. The research team found that the students were much more willing to discuss sexual issues than had previously been assumed.

Capacity Building

AIDSCAP's primary capacity building role was raising awareness among policymakers and NGOs of the complexities of designing and managing STI/HIV/AIDS care and prevention programs. The initial assessment prompted the government and USAID/Egypt to reexamine the necessity for and process of collecting STI/HIV/AIDS data and to plan an STI prevalence study. The KABP survey went through a lengthy approval process, in part because university officials were concerned about the propriety of conducting a sexual behavior study among unmarried university students. Part of the institutional and cultural learning process in developing effective STI/HIV/AIDS prevention programs is recognizing and adapting to conventional mores and inhibitions about discussing and investigating sexual behavior.

Implementing Partner

International Medical Technology Ltd.

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Mongolia

Epidemiology

The HIV/AIDS epidemic in Mongolia is at an early stage compared with those in other countries in Asia. By the end of 1993, only one Mongolian living with HIV had been reported. In 1993, prevalence rates for other sexually transmitted infections (STIs) were generally less than 1 percent among various population groups—including soldiers, pregnant women, and truck drivers—but were significantly higher among samples of male and female commercial sex workers (CSWs) in Ulan Bator (1.7 to 3.7 percent for syphilis and 10.2 to 12.1 percent for gonorrhea). Based on this epidemiological picture of generally low STI/HIV prevalence, Mongolian and international public health specialists believe the country is in an excellent position to prevent HIV, especially with effective STI case management.

Country Overview

Mongolia is the seventh largest Asian country in area but, with 2 million inhabitants, is one of the smallest Asian countries in population. Approximately half of the country's residents live in urban areas. Nearly 500,000 people, or one-fourth of Mongolia's entire population, live in the capital city of Ulan Bator. Ethnically, the population is relatively homogenous, as almost 80 percent of the population belong to the Kalkha-speaking Mongol group. Most of the population is Buddhist, though a small percentage of the population, belonging mainly to the Turkic-speaking Kazak group, is Muslim.

Mongolia's Ministry of Health (MOH) has developed a relatively comprehensive health structure for treating STIs. In 1993, however, concern about antibiotic-resistant strains of gonorrhea and the effectiveness of certain diagnostic methods prompted the MOH and USAID to request AIDSCAP assistance in assessing the STI/HIV/AIDS situation in Mongolia and to strengthen the country's STI control measures. AIDSCAP developed a 1-year program, based on the result of its assessment to improve STI case management in Mongolia.

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Accomplishments

Strengthening STI Services

In collaboration with the National Dermatology and Venereology Center and the Dermatology and Venereology Hospital, AIDSCAP completed the first comprehensive assessment of STI data and services in Mongolia. With the Mongolia STI services assessment, AIDSCAP dispelled concern that STI prevalence rates among general population were rising rapidly; confirmed increasing resistance of certain STIs to commonly used antibiotics; revealed increasing public access to medication through drug vendors who were selling newly imported antibiotics, with little concern for indication or quality; and revealed the absence of STI treatment drugs on the national essential drug list.

Through a series of training workshops, AIDSCAP and Mongolia's National AIDS Program (NAP) augmented the abilities of 58 physicians working in STI reference centers and provincial clinics to diagnose STIs correctly and to use the syndromic approach to STI case management. AIDSCAP and the NAP also developed a list of recommended STI treatment drugs that was included in Mongolia's drug registration and essential drug list. Finally, AIDSCAP supported the translation into Kalkha of *The Handbook of STDs*, a guide for clinicians published by the Australian Department of Community Services and Health.

Behavior Change Communication

AIDSCAP provided technical assistance and financial support in the design and production of three different educational materials for STI patients. These materials were distributed to health care centers that provide STI services.

Capacity Building

With AIDSCAP assistance, Mongolia updated its STI services to correspond more closely with international standards, and improved its access to modern drugs for treatment of STIs. As a result, Mongolian health care providers are now better able to control STIs and, consequently, the spread of HIV.

Implementing Partner

Mongolian National AIDS Program

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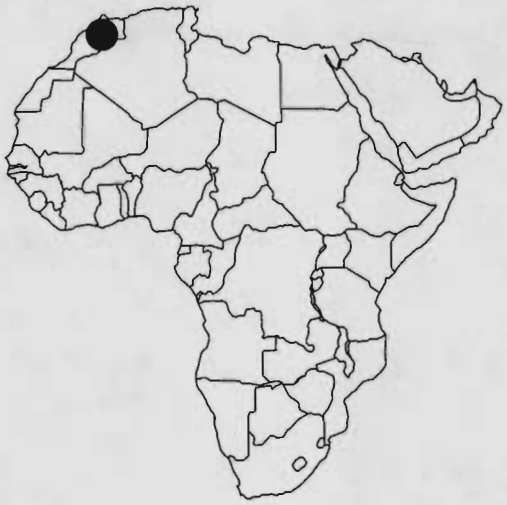
Morocco



Epidemiology

The first case of AIDS in Morocco was diagnosed in December of 1986. As of June 30, 1996, the cumulative number of declared AIDS cases had risen to 335. The distribution of these cases throughout the population has changed over time. In the early stage of the epidemic, heterosexual transmission was responsible for 20 percent of all infections. Currently, however, more than 50 percent of new infections are a result of heterosexual transmission.

In contrast to the relatively low number of AIDS cases, the Ministry of Health (MOH) reports high rates of other sexually transmitted infections (STIs)—mainly gonorrhea, chlamydial infection, trichomonas, syphilis, and chancroid. In 1995, the NACP reported 150,541 new cases of STIs. However, anecdotal information indicates significant underreporting of STIs, which may be attributable to the asymptomatic nature of many STIs, cultural taboos, self-medication, and health care professionals' failure to recognize STIs. The MOH estimates that the real number of new cases of STIs is closer to 400,000 per year.

Country Overview

STIs are an important cause of morbidity, disability, sterility, and loss of productivity, especially among women. One study in Tanzania found that a person infected with an STI is between two to five times more likely to contract HIV if exposed (Grosskurth, H., Mosha F., Todd, J., et al. in *The Lancet*, Vol. 346, August 26, 1995). The same study also found a 40 percent reduction in HIV incidence with the introduction of the syndromic approach to management. These findings and the rising number of cases in Morocco led the country's Ministry of Health (MOH) to adopt STI control as a primary strategy of its National AIDS Control Program (NACP).

AIDSCAP's objective was to strengthen the capacity of the Moroccan MOH to address reproductive and child health issues related to STIs and HIV/AIDS in Morocco. It did so by providing technical assistance to develop a pilot activity at three sites—Agadir, Marrakech, and Tangier—designed to address several key areas in STI service delivery

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at the primary health care level. This activity complemented concurrent activities of the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) that specifically addressed clients of family planning clinics. The project compared JHPIEGO's approach with other models of STI identification and management and provided equipment, training, and materials support to certain pilot JHPIEGO sites.

Accomplishments

AIDSCAP conducted an algorithm validation study to provide the information needed to test and adopt the recommended World Health Organization (WHO) algorithms for STI case management in Morocco. Morocco was the first Arab-Muslim country where the syndromic approach to STI case management was introduced. Prevalence data on STI etiology were made available to the Moroccan MOH, and risk factors for STI specific to Morocco were determined, also for the first time. In addition, pilot training workshops on the syndromic approach were conducted for private physicians, pharmacists, and vendors.

Laboratory capabilities to diagnose STIs were also reinforced, providing a model for sentinel surveillance of STIs. Techniques that proved successful in the pilot project are being used to establish a STI sentinel surveillance system. In addition, information from an ethnographic targeted intervention research (TIR) study conducted by AIDSCAP is being used to guide the development of future behavior change communication and training efforts.

AIDSCAP conducted an assessment of the quality of STI care in Morocco to provide a baseline for evaluation. It found that

- 24 percent of patients with specific STIs in public sector health facilities and 18 percent of STI patients in private sector health facilities were assessed and treated according to national standards (WHO prevention indicator 6).
- 6 percent of individuals seeking STI care in health facilities received appropriate advice on condom use and 15 percent received appropriate advice on partner notification (WHO prevention indicator 7).

Implementing Partners

Moroccan Ministry of Health

University of Washington

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Philippines

Epidemiology

The Epidemiology Unit of the Philippine Department of Health conducted HIV surveillance in six sites in 1996–97. It found unexpectedly low HIV prevalence, even among injecting drug users and commercial sex workers (CSWs) charging low fees. Epidemiologists have concluded that pockets of undetected HIV infection are unlikely and an epidemic has not yet materialized. AIDSCAP believes that if an epidemic did occur it would start with interactions between seafarers in the Celebes Sea and CSWs along sea traffic routes.

Country Overview

In the early 1990s, the political climate in the Philippines and the social practices of CSWs were similar to those found in Thailand, leading to predictions that an HIV/AIDS epidemic was imminent. The tolerant position of the government toward commercial sex had allowed the expansion of the industry into massage parlors, cocktail lounges, beer houses, and the streets.

The Philippines has a national network of sexually transmitted infection (STI) clinics (social hygiene clinics) that provide routine screening and treatment to registered CSWs. The number of STIs diagnosed by these social hygiene clinics showed an increase from 1988 (54,347) to 1991 (72,329), with a rapid decline in 1992 (32,968). This decline probably resulted from lapses in case reporting caused by the decentralization of the network rather than lower incidence of STIs. In addition, because these clinics serve mostly registered CSWs, the incidence of STIs among unregistered CSWs was expected to be higher.

In FY93, the Asia/Near East Bureau, through AIDSCAP, supported the implementation of an STI assessment to establish baseline data and guide future implementation decisions. AIDSCAP identified the health-seeking behavior of persons at increased risk of STIs, assessed the STI management practices of a cross section of STI care providers, and conducted baseline epidemiologic surveys of STIs for the development of standardized

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case management guidelines. Based on research findings, the USAID/Mission supported AIDSCAP activities that included developing behavior change communication (BCC) materials for social hygiene clinics, establishing a training course for STI practitioners, developing and disseminating national STI management guidelines, and hiring a full-time AIDSCAP program coordinator.

Accomplishments

Initially, the AIDSCAP/Philippines program supported research to establish areas for intervention. Based on these research findings, AIDSCAP recommended: concentrating STI control resources in urban areas with groups practicing high-risk behaviors; emphasizing the treatment of STIs during a patient's first encounter with the health system, and; standardizing STI case management to increase confidence in the national control program and to limit the emergence of resistant strains of pathogens.

STI and microbial resistance studies were conducted in Manila and Cebu City, the two largest urban areas in the Philippines. The three groups of women who voluntarily enrolled were registered CSWs, unregistered CSWs, and women attending antenatal clinics (ANC). These studies confirmed the higher STI vulnerability of unregistered CSWs, who experienced two to four times greater prevalence than registered CSWs. Also noteworthy was the higher than expected percentage of ANC attendees with chlamydial infection, suggesting that male partners form a bridge for infection from CSWs to their homes. Forty-six percent of the gonorrhea isolates showed resistance to ciprofloxacin treatment, which had been the national choice for gonorrhea treatment. These findings led to immediate action by the Department of Health to revise treatment protocols and give higher priority to reaching unregistered CSWs.

The targeted intervention research (TIR) methodology, developed by AIDSCAP in collaboration with Johns Hopkins University and the University of Washington, was used to identify health-seeking behaviors among CSWs and the determinants of such behaviors, including motivation; the quality, accessibility, and convenience of health services; and health care providers' attitudes toward STI clients. The findings were used by AIDSCAP to design behavior change communication (BCC) materials for STI clinics and a training program for STI clinic managers.

The findings of the prevalence study and the TIR emphasized the need for new national STI case management guidelines. AIDSCAP consequently supported STI consensus and advocacy workshops to promote understanding and acceptance of the research findings and to ratify revised national guidelines. A *National STI Management Guide* and a *Manual for Training in the Care and Prevention of STIs* were produced.

Implementing Partners

Art for Education and Communication Foundation, Inc.

Cebu City Health Department

Philippines General Hospital

Research Institute of Tropical Medicine

Training Institute for Managerial Excellence

University of the Philippines, College of Public Health Foundation

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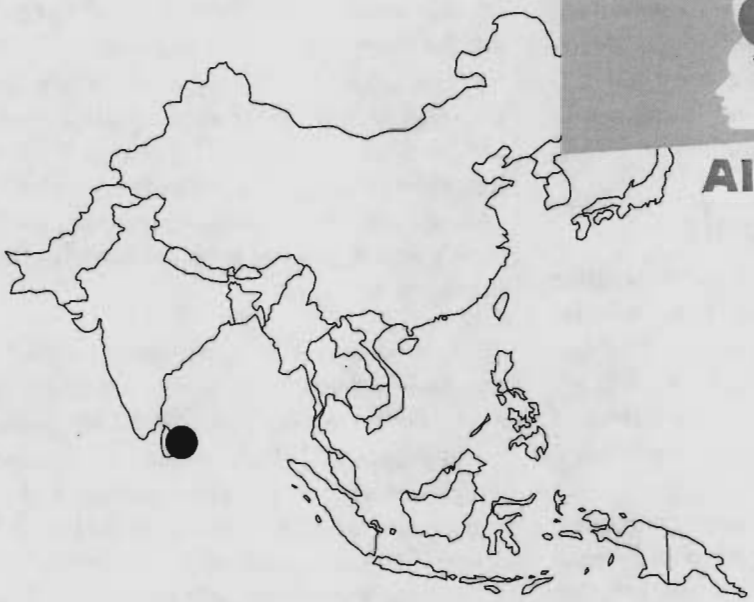
Sri Lanka



Epidemiology

The first case of HIV in Sri Lanka was identified in 1987. By 1993, the number of persons known to be infected with HIV had risen to 118, and 33 of them had developed AIDS. Estimates of the number of persons living with HIV rose from 3,500 in 1993 to 6,800 in 1996. Heterosexual contact is believed to be the major mode of transmission. In 1991, the World Health Organization estimated that more than 200,000 cases of sexually transmitted infection (STI) occurred yearly, but only a small proportion of these cases were treated in government clinics. Most persons sought treatment from private STI practitioners, general practitioners (GPs), or pharmacists. GPs, in particular, play a major role in STI control in Sri Lanka, because their accessibility and generally good rapport with clients frequently make them the preferred point of first contact with persons seeking treatment for an STI.

Country Overview

Sri Lanka is an island nation of approximately 18.3 million inhabitants. Three ethnic groups, the Sinhalese, Tamil, and Sri Lankan Moor, make up more than 99 percent of the population. The Sinhalese alone account for almost 83 percent of Sri Lanka's inhabitants. Buddhism is the predominant religion, followed by Hinduism, Islam, and Christianity. More than 78 percent of the population live in rural areas, and most Sri Lankans are agriculturists. While Sri Lanka's health and demographic indicators are considered good for a low-income country, it has a dearth of physicians. Moreover, armed conflict in the northern and eastern regions has led to a deterioration of health care services and increased levels of malnutrition and communicable disease.

Since the creation of Sri Lanka's National AIDS Control Program (NACP) and implementation of the Medium-Term Plan (1990–1993), USAID/Sri Lanka has supported several HIV/AIDS prevention programs to

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assist the NACP. In 1993, with support from USAID/Sri Lanka and the Asia/Near East Bureau, AIDSCAP and its partner, the Independent Medical Practitioners Association of Sri Lanka (IMPA), implemented a 1-year project to improve the capacity of Sri Lankan health care providers to manage STIs more effectively.

Accomplishments

With AIDSCAP technical assistance, the IMPA taught GPs how to manage STIs more effectively through two major activities. First, 126 GPs developed additional skills in STI diagnosis, management, and counseling techniques in a series of 12 regional workshops conducted in five provinces. Second, with input from these GPs, AIDSCAP and IMPA developed a continuing education program for 600 general practitioners throughout the country to acquire skills in STI management. The program consisted of a series of 10 STI training modules covering topics such as STI epidemiology, syndromic management approaches, laboratory confirmation procedures, counseling, partner management, and health education. The use of a long distance training approach proved effective and appropriate because most GPs have solo practices and are unable to take leave to attend training sessions.

Capacity Building

As a result of the AIDSCAP activities, standardized STI diagnosis and management procedures were developed and introduced to GPs for the first time in Sri Lanka. Coupled with the Ministry of Health's efforts to increase access to appropriate STI treatment drugs and to eliminate illegal distribution or sale of antibiotics, AIDSCAP's assistance made a major contribution to Sri Lanka's capability to control STIs.

Implementing Partner

Independent Medical Practitioners Association of Sri Lanka

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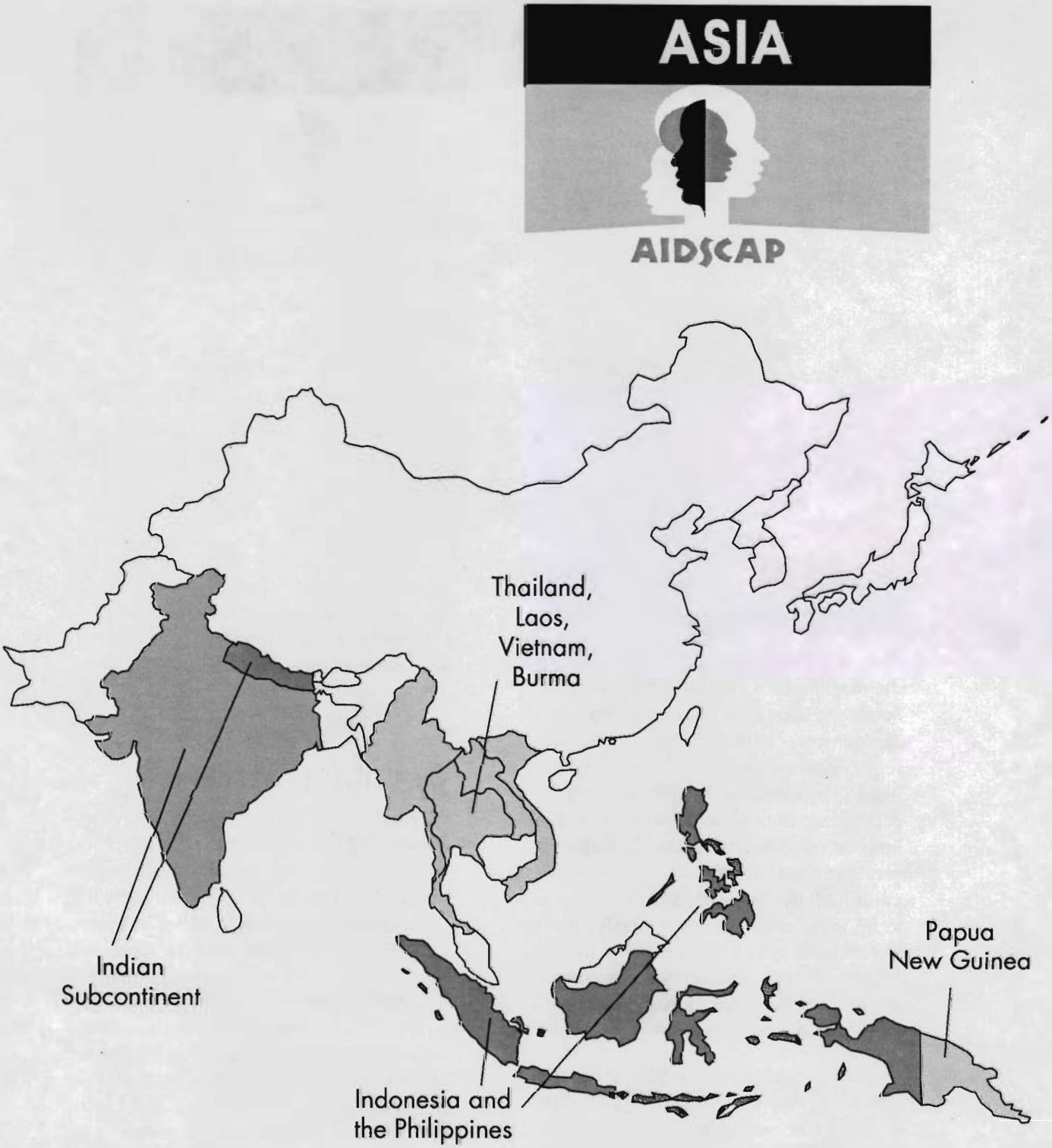

Areas of Affinity

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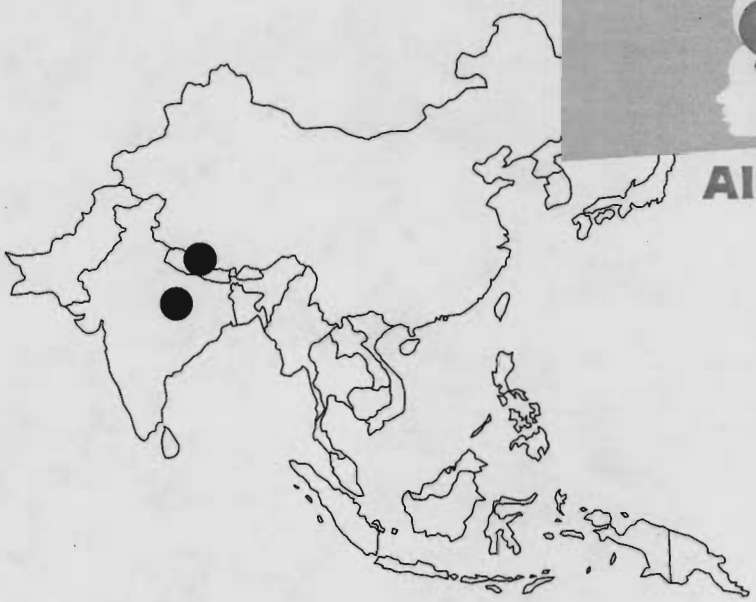
Indian Subcontinent



Epidemiology

Due to the region's large population base, the magnitude of the HIV/AIDS epidemic in South and Southeast Asia may be enormous. The number of persons living with HIV in this region increased from 1.5 million in 1993 to more than 5 million in 1997. In 1993, 312 AIDS cases in India and 18 cases in Nepal had been reported to the World Health Organization. By 1996, the number of reported cases had risen to nearly 3,000 in India and to 87 in Nepal. Currently, officials estimate that more than 2 million people in India are living with HIV. The number of persons living with HIV in Nepal is believed to be greater than 5,000.

In 1994, available seroprevalence data indicated that HIV prevalence among truck drivers in Bihar state was approximately 7 percent and increasing. These drivers were identified as a group that could play a significant role in the spread of HIV because of their mobility between countries, their tendency to seek commercial sex while away from home for extended periods of time, and a 25 percent sexually transmitted infection (STI) prevalence greater than among truck drivers in parts of India.

Country Overview

Although the Indian subcontinent area of affinity (AOA) included India, Bangladesh, Nepal, Pakistan, and Sri Lanka, the activities implemented under AIDSCAP primarily involved a cross-border intervention between India and Nepal. India, the world's second most populous nation, has a population of 953 million, with almost 75 percent living in rural areas. India has recently experienced high rates of urbanization, leading to urban concentrations such as Bombay (15 million), Calcutta (12 million), and Delhi (9.9 million). Although India contains a large number of ethnic and linguistic groups, approximately 80 percent of the population are Hindu. The largest religious minority, Muslim, constitutes slightly more than 10

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percent of the population. Approximately two-thirds of the labor force are involved in agriculture.

Nepal, one of the world's most isolated and least developed countries, has a rapidly growing population of approximately 21 million. Most of the population is very young; 42 percent of the population are younger than 15 years of age. Nearly 86 percent of the population live in rural areas, and 90 percent of the nation's work force are agriculturists. The urban population is concentrated in the capital city Kathmandu. Two ethnic groups, the Nepalese and the Bihari, make up 70 percent of the population; remaining ethnic groups constitute less than 5 percent each. About 90 percent of the population are Hindu.

In addition to sharing cultural and social similarities, India and Nepal have close economic ties and share major truck routes that are used by large numbers of transportation workers. Traffic at one border town alone can reach 1,400 trucks daily. AIDSCAP, with support from USAID's Asia/Near East Bureau, initiated a 22-month clinic-based AOA project in India's northern Bihar state to increase the capacity of both Indian and Nepali health care providers to prevent STI/HIV transmission among truck drivers and their assistants and sexual partners, as well as customs officials, owners of local shops, and tea/food/drink houses frequented by truckers. The Raxaul, India to Birgunj, Nepal border crossing, which was the primary implementation site, handles 90 percent of the commercial traffic between India and Nepal.

Accomplishments

After conducting a behavioral assessment of the target populations, AIDSCAP implemented a comprehensive, clinic-based STI/HIV/AIDS prevention project, the Bhoruka AIDS Project, that increased local clinicians' capacity to manage STIs, promoted the reduction of sexual risk taking among members of target populations, and developed a sustainable condom distribution system. In addition, AIDSCAP-sponsored workshops and advocacy meetings that sensitized local and national policymakers to the need for cross-border approaches to STI/HIV/AIDS prevention and bolstered support for the project. As a result, the project served as a model for future cross-border STI/HIV/AIDS prevention projects in the region.

Behavioral Research

In collaboration with local partners, AIDSCAP conducted a rapid assessment of the HIV/AIDS situation on trucking routes between Nepal, India, and Bangladesh. The assessment's key findings were that: (1) a large majority of trucks stop at major road junctions to eat, rest, or repair vehicles; (2) few local STI/HIV/AIDS education or prevention services exist; (3) truckers often preferred to seek treatment for STIs from unlicensed doctors or to self-treat; (4) condoms are not easily accessible; (5) almost all truck drivers work alone or with an apprentice; (6) single and married truckers engage in commercial sex along routes; (7) apprentices don't generally engage in commercial sex but may occasionally serve as sexual partners for truck drivers; and (8) commercial sex occurs in a variety of venues, including small, family-run brothels, large establishments, with hitchhikers along truck routes, and in pubs and bars.

Behavior Change Communication

Based on information obtained from the assessment, AIDSCAP developed a series of behavior change communication (BCC) activities to provide truck drivers with the knowledge and skills to protect themselves from STI/HIV/AIDS. Eighteen trained resource persons conducted both clinic- and community-based educational activities reaching over 9,100 men and women. To assist resource persons in their work, 9,339 STI/HIV/AIDS prevention education materials

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were produced and distributed to members of target populations.

Condom Promotion and Distribution

Distribution and sales outlets were established at the Bhoruka clinic in Raxaul, the border checkpoint, bars, and commercial sex establishments in Raxaul and Birgunj. Over 50,000 condoms were distributed or sold to target populations. By 1997, the project successfully weaned target populations from receiving free-of-charge condoms to buying condoms sold through a Nepal condom social marketing project.

Strengthening STI Services

With AIDSCAP technical assistance, the Bhoruka STI clinic was established in Raxaul. Clinic staff now provide effective STI case management through the use of the syndromic approach as well as STI/HIV/AIDS counseling to clinic attendees. Over the life of the project, the clinic averaged three new male STI patients per day. Moreover, initiation of an outreach program where female health care providers visited commercial sex workers at their workplaces increased sex workers' use of the clinic's STI services.

Policy Development

Through a series of workshops and seminars, local, national, and international policymakers were sensitized to the importance of STI/HIV/AIDS prevention and the need for cross-border collaboration. As a result of this effort, two advisory boards, consisting of government officials, community-based leaders, and trucking industry representatives from India, Nepal, and Bangladesh, were established to advocate and oversee future HIV/AIDS prevention activities along international borders.

Capacity Building

As a result of AIDSCAP efforts, the necessary clinic infrastructure, networks with other organizations, and material and human resources were put in place to stop the spread of STI/HIV in cross-border areas previously known for their inadequate STI services. The Bhoruka AIDS Project served as a model for the entire Indian subcontinent. Other international donors, such as the Joint United Nations Programme on HIV/AIDS and the U.K. Department for International Development, expressed interest in AIDSCAP's cross-border work and funded national expansion of project activities, thereby ensuring their continuation.

Implementing Partner

Bhoruka Research Center for Hematology and Blood Transfusion

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Indonesia/ Philippines

Epidemiology

The Philippines and Indonesia are countries with low rates of HIV infection. When epidemiologists from the Philippine Department of Health conducted HIV surveillance in six sites in 1996 and 1997, they found unexpectedly low HIV prevalence, even among injecting drug users and commercial sex workers (CSWs) charging low fees. Since the first publicly acknowledged case of AIDS in Indonesia was reported in Bali in 1987, 517 AIDS cases have been reported from 17 of the 27 provinces.

Country Overview

The Philippines and Indonesia are both archipelago nations with large, culturally heterogeneous populations. Both countries have major regional commercial shipping centers, thriving tourism and commercial sex industries, and large migrant worker populations. To the extent that the sexual networks of Filipino seafarers overlap with Indonesian networks, an epidemiologic bridge has been established among the two countries and their neighbors.

Through AIDSCAP, USAID supported behavioral research and interventions targeting transient populations, such as fishermen and CSWs in ports and border areas in Indonesia and the Philippines. In addition, multiple pilot interventions were implemented in Indonesia with diverse populations: CSWs in Riau province near Singapore and Batam; street children in Jakarta; sexually active youth in Bali; newspaper reporters and editors in Jakarta and Surabaya; and Islamic institutions for advocacy and research to define HIV/AIDS interventions for youth.

Accomplishments

From 1993 to 1996, the Asia/Near East Bureau supported AIDSCAP to conduct a needs assessment and to develop projects targeting mobile populations traveling between Indonesia and the Philippines. The results of formative research on the risk behaviors of fishermen and their sexual partners were used to develop a

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project that reached 1,500 fishermen through peer education. Activities were also targeted to reach the CSWs who serve the fishermen.

When an assessment of the shipping industry in the Indonesian port city of Merauke identified Thai fishermen as a link in the spread of HIV/AIDS, an intervention was developed and piloted to provide an example for AIDS committees and nongovernmental organizations (NGOs) in other Indonesian cities facing the problem of reaching foreign fishermen in international ports. Most of the fishermen said that the inability to negotiate in their own language and the unavailability of condoms increased their risk for HIV infection. The Thai fishing companies responded by agreeing to provide the Thai seafarers a bonus for completing a term of employment in good health, thus providing a short-term incentive for condom use.

In an attempt to obtain a more complete understanding of the context for HIV transmission and the resources available for prevention, AIDSCAP supported a rapid ethnographic assessment in five Indonesian cities in 1995. The assessment indicated that rapid development of transportation and industry in border and port cities in Indonesia had had a major impact on the growth of the sex industry. This, in turn, seemed to contribute to the high prevalence of sexually transmitted infections (STIs). In all sites, the provincial teams selected adolescents and CSWs for targeted HIV/AIDS prevention messages.

The Outreach Peer Intervention Model was developed in 1996 to decrease the spread of STI/HIV/AIDS among CSWs and their clients in Teluju, which is located in the Riau province of Sumatra. The development of the business growth triangle comprised of Singapore, Johor (Malaysia), and Riau (Indonesia) facilitates cross-border movement and provides potential pathways for HIV transmission. Riau province hosts several economic projects that employ large numbers of migrant workers, who have subsequently attracted a large population of CSWs. These CSWs were targeted with peer education, which was reinforced by community awareness campaigns, competitions between brothels for cleanliness, and improved access to condoms and behavior change communication (BCC) materials. According to an evaluation survey, condom use increased, but the decision to use a condom remained with the client.

AIDSCAP also supported projects targeting the youth of Indonesia through the two largest Islamic institutions in the country. In 1995, research was conducted with senior policymakers in Nahdlatul, Muhammadiyah, and with schoolteachers and students in Islamic schools to determine the most effective types of communication interventions to reach youth. Based on the finding that parents and adolescents lacked the communication skills to discuss reproductive and sexual issues, reproductive health modules were designed and used in Islamic religious and social institutions.

In Jakarta, where the number of street children ranges from 5,000 to 20,000, a pilot activity was designed to reduce sexual risk taking among youth. Based on research findings, outreach educators were trained, BCC materials were developed, and technical assistance was provided to NGOs who work with street children. Additional BCC materials for youth—a film, comic book, and puppet theater—were developed through the HIV/AIDS Arts and Media Project.

In Bali, a pilot intervention with sexually active youth aged 15 to 25, was implemented in three sites from 1996 to 1997. Through male and female peer outreach workers and volunteer peer educators, more than 2,856 youth were reached with STI/HIV/AIDS risk-reduction messages and more than 15,000 condoms were distributed. Pre- and post–knowledge, attitudes, beliefs, and practices surveys found that 71.6 percent of survey participants reported that they always or almost always used condoms, compared with a baseline of 22 percent.

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The Media Center, established with support from the Ford Foundation, implemented a one-week training in June 1995 for journalists and editors in writing responsibly and informatively about HIV/AIDS. Twenty journalists from Jakarta and Surabaya attended the workshop. Samples of their articles published after the workshop indicated increased sensitivity in reporting on the issues of HIV/AIDS and increased coverage of the topic.

Implementing Partners

Center for Health Research, University of Indonesia (CHR-UI)

Center for Multidisciplinary Studies and Health and Developments (CEMSHAD)

Private Agencies Collaborating Together (PACT)/Indonesia

Program for Appropriate Technology in Health (PATH)/Indonesia

Project Concern International (PCI)

Yayasan Citra Usadha Indonesia (YCUI)

The Media Center

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South Pacific Island Nations

Epidemiology

The first case of HIV infection in Papua New Guinea (PNG) was identified in 1987. By 1993, the reported number of persons living with HIV rose to 153 (including 57 persons living with AIDS), and estimates of the prevalence rate among the general population ranged from 0.25 to 0.75 percent. The male to female ratio among seropositive persons was 1:1, and heterosexual contact was considered the primary transmission mode. Syphilis prevalence among the general population was estimated to be 3 percent in 1993, and incidence of this STI has increased four-fold since 1971. The high mobility of transportation workers within PNG and among other nations of the South Pacific could play a critical role in the spread of the epidemic throughout the Pacific Rim.

Country Overview

Papua New Guinea is the largest and perhaps most complex of the Pacific island nations. In 1990, its primarily rural population was estimated at 3.9 million. Over 860 language groups are represented on the island. The country's economy is based primarily on mining, logging, and agricultural exports. Scarcity of local employment drives many villagers to PNG's two port cities, Port Moresby and Lae. Public and private medical services are generally inaccessible to PNG's rural population.

In 1993, AIDSCAP, in collaboration with the PNG Institute of Medical Research (IMR), assessed the country's STI/HIV/AIDS situation and reviewed the response of the Department of Health, international donor agencies, and nongovernmental organizations (NGOs) to the epidemic. Results of the assessment indicated that the epidemic was probably more advanced than initially expected and that interventions targeting specific groups, such as commercial sex workers (CSWs) and workers in the transport industry and fisheries, were needed. To this end, the $100,000, 1-year AIDSCAP program supported research on these groups' risk behaviors and, based on this research,

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designed comprehensive STI/HIV/AIDS interventions targeting these groups.

Accomplishments

With AIDSCAP support, the IMR successfully conducted ethnographic research that laid the groundwork for future HIV/AIDS prevention interventions. Moreover, AIDSCAP assisted in the development of educational materials designed for use with three at-risk populations.

Behavioral Research

The IMR conducted a 6-week rapid ethnographic assessment of six target populations: long-distance truck drivers, truck driver assistants, truck stop workers, public motor vehicle drivers, sailors, and dockside workers. The study obtained information about these populations' social networks and sexual behavior and the receptivity of the transportation industry to HIV/AIDS prevention programs. Results of this research confirmed the epidemiologic significance of these groups and provided information about their behaviors that was critical to the development of effective AIDS prevention activities. Study findings were presented at a series of three workshops attended by government officials, international donor organizations, NGOs, and worker and management representatives from the transportation industry.

Based on the ethnographic assessment, the IMR concluded that: (1) most men and women interviewed, including both managers and workers, needed more information about HIV/AIDS prevention; (2) sailors and truck drivers were frequent buyers of sex; (3) sailors frequently shared sexual partners among themselves; (4) because they receive only brief periods of shore leave, shipboard outreach was the most effective approach to educating sailors; (5) drivers were rarely at their bases for extended periods, indicating that roadside intercepts or trucker association meetings were the best sites for interventions; and (6) condom use was low, particularly among older truckers and sailors.

Program Design

Based on the results of the ethnographic research, AIDSCAP and the IMR designed a $3-million, comprehensive STI/HIV/AIDS prevention program targeting CSWs, truckers, and maritime workers. The IMR submitted a proposal for this program to the Australian International Development Assistance Bureau, which subsequently funded the program.

Behavior Change Communication

In collaboration with local artists, AIDSCAP developed three STI/HIV/AIDS prevention cartoon storybooks and accompanying laminated flip charts for use with CSWs, sailors, and truckers. The storybooks use easily understandable terminology and speak directly to the target groups.

Implementing Partner

Papua New Guinea Institute of Medical Research

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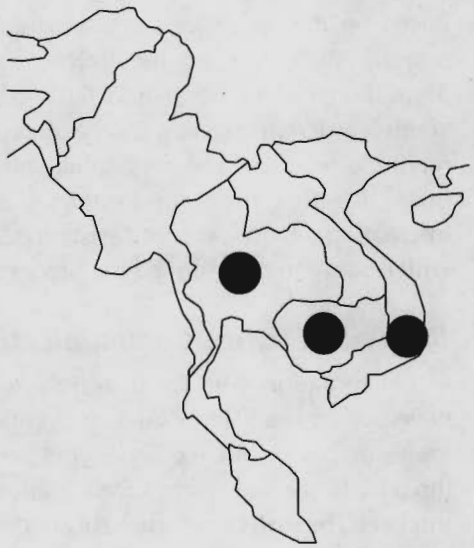
Thailand/Cambodia/Vietnam



Epidemiology

The first round of HIV sentinel surveillance (HSS), supported by AIDSCAP and completed in 1995, found that the average rate of HIV infection in target groups was among the highest in Asia. The second round in 1996 confirmed increases in HIV rates among commercial sex workers (CSWs) from 38 to 47 percent in the same nine provinces that participated in the 1995 HSS. HIV prevalence remained stable at approximately 8 percent for police and military personnel and at 2.6 percent among pregnant women. An additional nine provinces included in the 1996 HSS reported lower levels of HIV. This difference is more than likely because the nine provinces surveyed in the 1995 HSS have border crossings with Thailand and Vietnam.

Country Overview

Most of AIDSCAP's assistance in the Thailand/Cambodia/Vietnam area of affinity (AOA) was programmed to Cambodia because of the restrictions on USAID funding to Vietnam and Thailand and at the recommendation of USAID's Mission in Cambodia and its Regional Support Mission in Thailand. Both countries had no USAID presence for some or all of the duration of AIDSCAP.

As of 1997, Cambodia had 21 international border crossings with its three neighbors—Thailand, Laos, and Vietnam. Research funded by the Asia/Near East Bureau established that sexual networks connect Thai men with female Cambodian and Vietnamese commercial sex workers (CSWs), who in turn have extensive contact with local Cambodian men. Cambodia is a good example of how the AOA principle can explain the spread of an epidemic across borders. AIDSCAP research described the phenomenon of a high-risk environment existing near large border crossings and explained how domestic epidemics are ignited and perpetuated.

Through AIDSCAP, USAID supported a rapid assessment of two Cambodian/Thai border crossings to document the STI/HIV risk environment in 1994. In late 1995, a USAID/

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Cambodia assessment led to national program research and policy advocacy in the areas of STI/HIV prevalence surveys, HIV counseling and testing guidelines, behavioral surveillance, and capacity building.

Accomplishments

The accomplishments of AIDSCAP projects in Cambodia include revised national guidelines for the management of STIs and for HIV counseling and testing practices; wider global recognition of the severity of the HIV/AIDS epidemic in Cambodia; and increases in foreign assistance for HIV/AIDS prevention in Cambodia.

AIDSCAP support of the HSS allowed for expansion to all Cambodian provinces by 1997, thus documenting the pervasive spread of HIV in much less time than was needed for a comparable epidemic in Thailand. With AIDSCAP support, the methodology of the 1996 and 1997 rounds of the HSS was improved by addressing the problems of coercion and anonymity, refining the range of sentinel groups, and training personnel to maintain surveillance and data collection.

The results of AIDSCAP's STI prevalence and etiology survey led to the revision of Cambodia's national guidelines for the management of STIs. As a result of the University of Washington's finding of antibiotic-resistant *Neisseria gonorrhoeae*, the MOH and its STI advisory panel changed the recommended treatment for gonorrhea.

In order to preempt a possible witch-hunt mentality toward persons living with HIV, AIDSCAP hired a Thai consultant to work with the National AIDS Program on HIV counseling and testing. In addition to holding multiple advocacy meetings with government staff and training them in appropriate HIV testing and counseling, AIDSCAP assisted in the development and dissemination of national guidelines that can be used as a model for other countries in the region.

AIDSCAP focused on strengthening existing health care structures and building the capacity of health care personnel to enable them to develop their own research and educational activities. Technical assistance was provided in developing research protocols, analyzing data, and facilitating workshops. A behavioral surveillance survey has established the baseline for future evaluation of behavior change in response to the increasing level of prevention activity in Cambodia.

Implementing Partners

Family Planning International Assistance

National AIDS Program (NAP) of the Ministry of Health

Population Services International (PSI)

The Institute for Population and Social Research (IPSR), Mahidol University, Thailand

University of Washington

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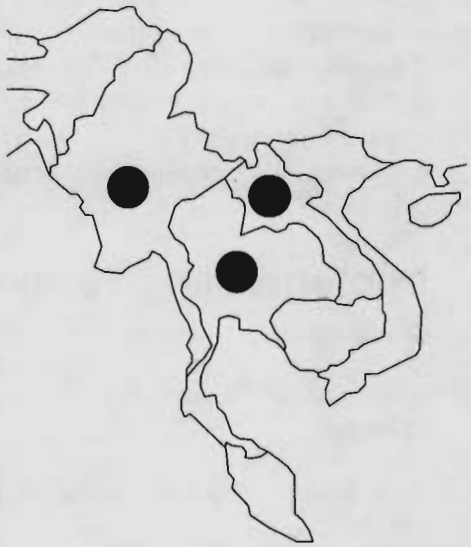
Thailand/Lao PDR/ Burma (Myanmar)



Epidemiology

The HIV/AIDS epidemic in Lao People's Democratic Republic (Lao PDR) is at a relatively early stage compared with those of many other countries. In 1989, the first case of HIV infection was identified, and in 1991, the first AIDS case was detected in Bokeo province adjacent to Chiang Rai, a province with one of the highest HIV prevalence levels in Thailand. As of 1993, only 38 persons had been identified as HIV-positive. Between January and June 1997, 4,743 samples were tested (including samples from blood donors) from all over the country and 47 were HIV-positive. Of those 47 HIV-positive persons, 18 had developed AIDS.

Despite the low levels of detected infection, the proximity of northern Lao PDR to one of the highest prevalence areas of the region (northern Thailand and Burma) creates an environment conducive to the transmission of HIV into Lao sexual networks. Every Lao province borders on another country, and travel is easy and frequent between Thailand, China, Vietnam, and Lao PDR.

The National Committee for the Control of AIDS (NCCA) oversees all HIV/AIDS programs. Lao PDR has no systematic reporting for HIV and no program to control sexually transmitted infections (STIs).

Country Overview

The common borders of Thailand, Lao PDR, and Burma, and the frequent movement of populations in this infamous "golden triangle" drug trade region, provided the rationale for its area of affinity (AOA) designation. The political differences of these countries, however, pose challenges to AOA implementation. Thailand is a free market, capitalist democracy; Lao PDR has a communist government that only opened its borders to the outside world at the start of this decade; and Burma has a repressive dictatorship. Although the countries share some common language, hilltribe and ethnic populations, and the predominance of Buddhism, their cultures are also distinct and different.

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AIDSCAP's initial scope of work noted the high rates of HIV infection in parts of Burma and northern Thailand and the absence of data in Lao PDR. As a result, AIDSCAP conducted an assessment in Lao PDR in 1994 along the Thai-Lao border and made recommendations for future interventions that included behavior change communication (BCC), STI prevention and care, and condom programming. An 18-month delay in approval of the assessment by the Lao government was an unanticipated reality of communist bureaucracy. Because of limitations in funding and at the recommendation of the USAID Regional Support Mission, AIDSCAP limited its pilot interventions to BCC activities along the Lao-Thai border. Ongoing fighting made interventions along the Burmese-Thai border impossible.

Accomplishments

As a communist country, Lao PDR has no indigenous nongovernmental organizations (NGOs). Therefore, AIDSCAP managed and implemented its activities through the international NGO, CARE, in direct consultation with the government. AIDSCAP supported three subprojects through CARE: the original Lao-Thai border assessment; further qualitative research with target populations to design interventions; and a BCC intervention at three key border crossing areas. In addition, AIDSCAP supported a workshop for journalists and an HIV and STI sentinel surveillance design workshop, and sponsored the attendance of numerous representatives of governmental organizations at regional conferences and workshops.

Behavior Change Communication

A 3-month formative research activity, involving focus group discussions with migrants, traders, border police, restaurant and bar owners, waitresses, and commercial sex workers provided the baseline data for the design of communication materials and intervention activities. The three border sites identified for interventions included Vientiane municipality, Bokeo province, and Champasak province.

Following approval of the assessment plan by the NCCA, AIDSCAP initiated a 22-month BCC activity in the three border sites. BCC messages and materials were tailored to the specific target populations in each site. A key implementation feature was the involvement and participation of government committees at each stage of the project, from pretesting BCC materials to participating in special events. The project working teams in each province included representatives from the Provincial Committee for the Control of AIDS (PCCA), the Lao Women's the Health Education Division of the Ministry of Health, the Lao Youth Union, representatives of ethnic minorities and the private sector, and CARE/Lao staff. Project activities included the development of BCC materials (e.g., stickers, pamphlets, posters, billboards, calendars), radio spots, and a radio soap opera series, special events, and distribution of materials at Lao festivals. At the end of the project, the target population, particularly women, reported increased knowledge about STI/HIV/AIDS.

STI/HIV Surveillance

Because of budget constraints and at the recommendation of the Regional Support Mission, AIDSCAP did not implement any direct STI interventions in Lao PDR. However, at the invitation of the NCCA in May 1997, the project sponsored a roundtable discussion at the Institute of Hygiene and Epidemiology in Vientiane on setting up an STD reporting system and HIV sentinel surveillance. At the seminar, 18 local representatives and five resource persons from Thailand and AIDSCAP identified specific sites for collecting HIV and STI data and developed an implementation plan.

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Media Workshop

At the request of the NCCA, AIDSCAP supported a media workshop for local journalists designed to improve the quality and increase the frequency of HIV/AIDS coverage in Lao PDR. The HIV/AIDS Workshop for Media Personnel in Lao took place in August 1996 with 15 participants. Experts on HIV/AIDS and senior journalists from both Thailand and Lao served as resource persons for the workshops.

Capacity Building

NCCA and PCCA staff who participated in the CARE interventions reported significant increases in skills and in knowledge of how to plan, manage, and implement an STI/HIV/AIDS prevention project. In addition, AIDSCAP supported the attendance of NCCA staff at a number of international conferences and regional workshops and seminars to share their own experiences and learn from neighboring countries. Given the past isolation of the Lao PDR, these activities were particularly meaningful.

Implementing Partner

CARE/Lao

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Latin America/ Caribbean

Major Countries

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Brazil

Epidemiology

Brazil has the largest HIV/AIDS epidemic in South America. The country is home to 50 percent of the population of South America but has 75 percent of the region's AIDS cases. The first AIDS case was reported to the Ministry of Health (MOH) in 1982; several earlier cases were retrospectively identified. By May 1997, 110,845 AIDS cases had been reported to the Pan American Health Organization. While many countries have higher per capita AIDS incidences, only the United States has reported more cumulative AIDS cases. The HIV/AIDS epidemic in Brazil is concentrated in highly populated urban areas, such as São Paulo, Rio de Janeiro, Pôrto Alegre, Santos, and Belo Horizonte.

Men who have sex with men (MWM) have experienced high rates of infection since the beginning of the Brazilian epidemic. In 1994, HIV seroprevalence among MWM was 24 percent in Rio de Janeiro and 28 percent in Pôrto Alegre. While seroprevalence remains high among MWM, the proportion of AIDS cases occurring among this population decreased from 50 percent in 1988 to 23 percent in 1996. The proportion of cases due to heterosexual transmission increased from 5 percent in 1988 to 31 percent in 1996. Consequently, the male to female case ratio has decreased from 9:1 in 1987 to 3:1 in 1996.

Sentinel surveillance has documented high HIV prevalence among other at-risk populations. Studies completed in the early 1990s show that 6 percent of commercial sex workers (CSWs) serving upper-income clients in São Paulo were infected with HIV. Among CSWs serving low-income clients, seroprevalence ranged from 12 percent in São Paulo to 27 percent in Santos, a major port. Sexually transmitted infection (STI) clinic attendees also have high rates of infection. Sero-prevalence among STI patients was 15 percent in São Paulo and 23 percent in Rio de Janeiro. Studies of STI patients in smaller cities have found lower rates of infection, ranging from 1 percent in Aracaju to 9 percent in Salvador. Injecting drug use also accounts for a substantial proportion of HIV

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infections in Brazil. Approximately 19 percent of cumulative AIDS cases have occurred among injecting drug users (IDUs). Sentinel surveillance has found HIV prevalence as high as 65 percent among IDUs in several cities.

While seroprevalence is higher among those groups considered at-risk, rates of HIV infection are increasing among the general population. Seroprevalence among pregnant women, often used as a proxy for seroprevalence among the general population, ranges from 0 percent in rural states to nearly 3 percent in the city of Pôrto Alegre. As the number of infected women has increased, the proportion of AIDS cases due to vertical transmission has also increased, from 0.5 percent in 1985 to more than 3 percent in 1996.The MOH estimates an HIV seroprevalence of 1 percent among men and women aged 15 to 49 in the states of São Paulo and Rio de Janeiro .

In Brazil, the only STIs subject to epidemiologic surveillance are congenital syphilis and AIDS. As a result, little is known about the prevalence of other STIs, such as gonorrhea, chlamydia, or primary and secondary syphilis. As in many settings, asymptomatic infection among women and self-treatment by men contribute to high STI prevalence in Brazil. Studies on STIs in CSWs found point prevalence of 66 percent in São Paulo and 69 percent in Santos. These rates are worrisome because they indicate high-risk behavior among CSWs and because concomitant STI infection can greatly increase HIV transmissibility.

Country Overview

Brazil is the largest and most populous country in Latin America and the fifth largest and most populous country in the world. Seventy-seven percent of Brazil's population of 160 million live in urban areas. The cities São Paulo and Rio de Janeiro rank third and ninth, respectively, among the world's largest cities. Since independence, Brazil has often experienced political instability and has been subject to several military dictatorships. Although Brazil has relatively low rates of unemployment, the disparity between the upper and lower socioeconomic groups is among the largest in the world.

Cultural factors influencing the HIV/AIDS epidemic include the extreme alienation of the gay community, which often leads to low self-esteem, fatalistic attitudes about HIV/AIDS, and sexual risk taking among this population; traditional gender roles that often limit communication about STI/HIV prevention and impede women's ability to negotiate condom use; the acceptance of multiple sexual partners for men; abuse of alcohol and other drugs; rapid urbanization; and the marginalization of Brazil's poor. In addition, economic necessity forces many women and girls into commercial sex work.

USAID identified Brazil as a priority country for HIV/AIDS prevention in 1992, after completion of the AIDSCOM and AIDSTECH projects. The goal of the AIDSCAP program was to reduce the incidence of sexually transmitted HIV infection in Brazil. AIDSCAP/Brazil identified three strategies to achieve this goal:

- reduce sexually transmitted infection prevalence by improving STI clinical services, expanding services to new clinics, and increasing use of new and existing STI clinics by creating a referral system.
- reduce high-risk sexual behavior among the target groups through behavior change communication (BCC).
- increase condom use by improving accessibility, availability, and affordability of condoms.

AIDSCAP/Brazil targeted male and female CSWs, MWM, STI patients and their partners, men away from home , women, and youth. The

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states of São Paulo and Rio de Janeiro were the geographic focus of the interventions; however, during the final year of the project, AIDSCAP expanded its interventions into the impoverished northeast, which has a rapidly growing HIV/AIDS epidemic.

Accomplishments

Strengthening STI Services

The STI component of AIDSCAP/Brazil employed several strategies to decrease STI prevalence. Recognizing the importance of surveillance to STI control efforts, AIDSCAP supported the development of a health information system in Santos and Rio de Janeiro. Second, AIDSCAP worked to improve STI diagnosis and treatment by training clinic staff in the syndromic management of STI. AIDSCAP/Brazil translated an STI manual entitled *Control of Sexually Transmitted Diseases: A Handbook for the Design and Management of Programs*, and published nearly 10,000 copies in Portuguese. This manual is intended for use in Portuguese-speaking Africa as well as in Brazil. In addition, AIDSCAP supported the development of a newsletter on STIs for health professionals.

Approximately 2,000 health care professionals from Rio de Janeiro, Santos, Ceará, and Bahia were trained in syndromic management and gender sensitivity. AIDSCAP also supported the decentralization of STI services and the creation of new clinics. In Santos, the number of STI treatment facilities increased from 1 to 22 over the life of the project. STI treatment is now available at every public health clinic in the city. BCC campaigns emphasized appropriate treatment-seeking behaviors among target audiences, increasing demand for STI services. Finally, AIDSCAP worked with the MOH to improve STI drug logistics.

Condom Promotion and Distribution

The condom promotion component of AIDSCAP/Brazil exceeded its goals for distribution and sales. During the life of the AIDSCAP program, 14.8 million condoms were given away free-of-charge and 72 million were sold through condom social marketing programs. AIDSCAP/Brazil contracted with DKT do Brazil to develop and market a new brand of condom, called Prudence. Prudence condoms were advertised on television, radio, and billboards and promoted by AIDSCAP's other implementing agencies. This affordably priced and well-advertised condom created competition in the condom market, which forced other condom manufacturers to aggressively market condoms. As a result, annual condom consumption increased from 50 million to 200 million between 1992 and 1996. Prudence is now the third largest brand in Brazil.

Behavior Change Communication

The BCC component of the AIDSCAP/Brazil was characterized by innovative approaches to educational interventions. BCC activities used a variety of media, such as videos, brochures, posters, radio programs, and street theater to communicate messages about STI/HIV/AIDS prevention to the target audiences. Behavior change messages included partner reduction, consistent and correct condom use, and appropriate and timely treatment for suspected STIs. During the life of the project more than 16,000 people were trained and more than 1.3 million people were educated. In addition, 7.8 million educational materials were distributed.

Capacity Building

AIDSCAP's provision of technical assistance and resources to implementing agencies engaged in HIV prevention in Brazil resulted in significant organizational and institutional development. Specifically, AIDSCAP noted the following trends in a study of organizational development conducted in December 1996:

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- Increased demand for technical services from AIDSCAP implementing agencies.
- Increased use of monitoring and evaluation information for project planning and implementation.
- More effective financial management and systems in implementing agencies.
- Improved coalitions, involving stakeholders and counterpart organizations, for program implementation and policy development.

Conclusions about the sustainability of initiatives is premature. However, the institutionalization of AIDSCAP's strategies and techniques, the scaling up of AIDSCAP pilot projects and reproduction and adaptation of its materials, and the improved funding environment for HIV/AIDS prevention in terms of both public and private sector support are promising for future interventions. Encouragingly, Associação Saúde da Família (ASF), the NGO that served as the AIDSCAP office in Brazil, has received funding from the Brazilian government, U.S.-based private foundations, and the private sector to continue its prevention activities. ASF has implemented a high-profile HIV/AIDS fundraising campaign targeting the Brazilian general population.

Key Outcome Data

In order to evaluate the effectiveness of AIDSCAP interventions, surveys on STI/HIV/AIDS knowledge, attitudes, beliefs, and practices (KABP) were conducted with several target groups before and after the interventions. In the preintervention surveys, awareness of HIV/AIDS was nearly universal among all target groups, but knowledge of specific means of prevention and perception of personal risk was much lower. Qualitative data from indepth interviews and focus group discussions were also collected.

Postintervention surveys showed improved KABP among the target groups. Among MWM in Rio, knowledge that condoms can prevent HIV transmission increased from 71 to 93 percent. While few MWM reported reducing their number of partners, many reported increased condom use or avoiding penetrative sex with casual partners. The proportion of MWM reporting consistent condom use increased from 60 percent in 1993 to 89 percent in 1995. Among CSWs, knowledge that HIV can be transmitted through vaginal intercourse increased from 79 to 95 percent, and reported consistent condom use with clients increased from 57 percent in 1991 to 93 percent in 1997. More than 96 percent of CSWs interviewed had condoms with them at the time of the interview. Reported condom use with regular partners also increased substantially, from 12 to 22 percent, though it remains low. Many CSWs reported that alcohol use sometimes interfered with their ability to enforce condom use with clients.

Adolescents reported fewer misconceptions about HIV/AIDS in the postintervention surveys. Awareness of the asymptomatic nature of HIV infection increased from 76 to 90 percent among this population, although knowledge that other STIs can be asymptomatic was much lower. Reported consistent condom use increased from 25 to 40 percent among adolescent females and from 40 to 77 percent among males in this age group. This is a significant increase over control areas: the most recent Demographic and Health Survey notes that only 20 percent of Brazilian women aged 15 to 19 use condoms. Men away from home reported a decrease in sex with casual partners, from 20 to 14 percent, and increased condom use with casual partners.

Special Features

The AIDSCAP/Brazil program was characterized by innovative approaches to potential constraints. A position paper written by DKT do Brazil is credited with the Brazilian president's

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decision to decree a year-long tax holiday on the 60 percent duty levied on imported condoms. The duty was reimposed after one year, but at a much lower rate of 10 percent.

AIDSCAP/Brazil leveraged approximately $4 million in private sector investments, which greatly increased the sustainability of project activities. DKT International provided nearly $2 million worth of condoms to condom promotion projects. A number of companies, including Levi-Strauss, Unilever, publicity agencies, and several fashion magazines, provided in-kind contributions that furthered prevention activities. With support from the Brazilian postal service and the MOH, an AIDS awareness postal stamp was created showing the red ribbon symbol superimposed on a condom. A T-shirt, "Wear for a Cure," also raised awareness of HIV/AIDS among the general population. The popular women's magazine *Claudia* collaborated with AIDSCAP by publishing a series of monthly articles about HIV/AIDS. This contribution allowed HIV prevention messages to reach *Claudia's* 700,000 readers.

Formative research and program evaluation were also key components of the AIDSCAP program in Brazil. An important study on the acceptability of the female condom concluded that this method increased the chances of successful condom negotiation and safer sex, and offered an alternative contraceptive option for women wishing to prevent pregnancy. Study participants were motivated not only to use the female condoms, which were provided free of charge during the study, but also to purchase the device after the study's completion.

Implementing Partners

Associação Brasileira Interdisciplinary de AIDS (ABIA)

Appropriate Health Resources and Technologies Action Group Ltd. (AHRTAG)

Association for the Prevention and Treatment of AIDS (APTA)

Center for AIDS Prevention Studies, University of California at San Francisco (CAPS)

Childhope

DKT do Brazil/Population Services International (PSI)

Implementing Agency for Cooperation and Training (IMPACT)

Instituto de Estudos da Religião (ISER)

John Snow, Inc. (JSI)

Organização de Apio ao Portador do Virus da AIDS (OASIS)

State University of New York (SUNY)

União Brasileira Contra as DST

Women, Children, Citizenship & Health

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Dominican Republic

Epidemiology

HIV/AIDS has been well established in the Dominican Republic since the mid-1980s. Between 1983 and 1996, 3,289 cases of AIDS were reported to the national AIDS control program, Programa de Control de Enfermedades de Transmisión Sexual y SIDA (PROCETS). PROCETS estimates the actual number of AIDS cases to be as much as 70 percent higher. While men who have sex with men (MWM) have experienced high rates of infection, heterosexual contact is the most common mode of transmission in the country, accounting for more than 80 percent of infections. Seroprevalence among pregnant women, often a harbinger of an epidemic in the general population, has increased steadily from 0.7 percent in 1991 to 2.2 percent in 1996. Certain areas of the country have been more affected than others; in 1996, the Puerto Plata region reported HIV seroprevalence of 8 percent among women seeking antenatal care. High rates of HIV infection have also been found among those groups traditionally considered at-risk, such as MWM (12 percent), commercial sex workers (CSWs) (7 percent), and sexually transmitted infection (STI) clinic attendees (7 percent) The male to female case ratio has dropped from 7:1 in 1984 to 2:1 in 1996, suggesting an increasingly heterosexual epidemic.

Country Overview

Located in the western Caribbean, Hispaniola is the second-largest island in the Antilles. The Dominican Republic (DR) occupies the eastern two-thirds of the island, while Haiti occupies the remainder. The country has 8.2 million inhabitants, most of whom are of mixed Spanish and African ancestry, although a minority predominantly of European descent comprises the country's political and economic elite. Tourism has become increasingly important to the Dominican economy, and agricultural production is reliant on Haitian labor, as large numbers of Dominicans move from rural to urban areas and to the United States.

Several structural factors contribute to the spread of HIV/AIDS in the Dominican Republic. Ur-

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banization, Haitian immigration, and seasonal migration to the United States have led to increased sexual risk taking and increased contact with high-prevalence populations. The marginalization of poor neighborhoods has also increased sexual risk taking, especially among youth. Alcohol abuse also plays an important role. Limited economic opportunities for women lead many to engage in commercial sex, and social and religious barriers to condom use hinder the widespread adoption of safer sex practice.

The Dominican Republic became an AIDSCAP associate country in 1992, following completion of the AIDSTECH and AIDSCOM projects. Epidemiological projections that year estimated that by the year 2000 as many as 5 percent of the adult population, or 300,000 persons, would be infected with HIV. In 1992, USAID changed the status of the Dominican Republic from an associate to a priority country, greatly increasing both funding and technical support for HIV/AIDS prevention.

The goal of the AIDSCAP program was to reduce the incidence of sexually transmitted HIV infection in the Dominican Republic. AIDSCAP/DR identified three strategies to achieve this goal:

- To decrease the prevalence of sexually transmitted infections (STIs) through improved diagnosis, treatment, and prevention.
- To increase condom use among target groups and the general population by expanding access, availability, and acceptability.
- To reduce sexual risk taking among target groups through behavior change communication (BCC).

AIDSCAP/DR targeted MWM, CSWs, adolescents and young adults, people in the workplace, and family planning clients as groups at risk of HIV infection.

Accomplishments

The AIDSCAP/DR program provided financial support and technical assistance to 15 nongovernmental organizations (NGOs). These NGOs conducted behavioral research, implemented educational interventions, promoted condom use, and worked to improve STI services. Support of governmental agencies, including the national laboratory and PROCETS, strengthened epidemiological surveillance, improved the government's ability to respond to the HIV/AIDS epidemic, and led to the promulgation of a national AIDS law.

AIDSCAP/DR implemented BCC subprojects ranging from person-to-person educational interventions to a mass media campaign targeting youth that aired on Dominican television and radio. These subprojects trained 21,000 people, educated nearly 930,000, and distributed approximately 1.5 million educational materials. The mass media campaign aired nearly 500,000 TV and radio spots.

The STI component of the AIDSCAP program worked to decrease the prevalence of STIs by upgrading clinic and laboratory facilities, improving drug logistics, and developing STI treatment protocols. Recognizing that the Dominican health system had limited resources, AIDSCAP/DR developed an algorithm for the syndromic management of STIs. Evaluation showed the algorithm to be effective, and 854 service providers were trained in syndromic management.

Six implementing agencies worked to develop condom distribution networks in the regions where educational interventions had been implemented. In an effort to improve quality and increase affordability, AIDSCAP developed and marketed a new condom, called Pantera. During the life of the program, over 2 million Pantera condoms were distributed free-of-charge and 4.6 million were sold.

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Key Outcome Data

Evaluation research shows that the AIDSCAP program helped reduce high-risk sexual behavior in the Dominican Republic. During the program, both awareness of HIV and knowledge of how to prevent the infection increased among all the target groups. Men from the general population reported reducing the number of partners, avoiding sex with CSWs, and using condoms more frequently. Both male and female youth in Santo Domingo reported delaying sexual debut and decreasing their involvement in commercial sex. Condom use increased, and self-reported STIs decreased across the target groups. Most significant, HIV seroprevalence appears to have remained stable in most of the sentinel populations.

Over the course of the program, sexual risk taking decreased among both target groups and the general population. In 1992, 73 percent of youth in poor neighborhoods of Santo Domingo reported that they were sexually active; in 1996, only 30 percent reported sexual activity. Among this same population the proportion reporting that they engaged in transactional sex decreased from 27 to 7 percent among males and from 9 to 6 percent among females. In the general population, 85 percent of men and 26 percent of women report having changed their sexual behavior to avoid HIV infection.

Condom use increased significantly during the AIDSCAP program. Condom use at last sexual encounter increased from 80 to 98 percent among brothel-based CSWs and from 38 to 63 percent among MWM. In the Puerto Plata region, the percentage of hotel employees who use condoms during sexual encounters with tourists increased from 86 to 95 percent.

Inconsistent reporting of STIs limits the conclusions that can be made about trends in STI prevalence. However, rates of self-reported STIs have decreased among the target groups. In Puerto Plata, self-reported STIs dropped from 11 to 7 percent among CSWs and from 15 to 1 percent among hotel employees. The proportion of CSWs reporting that brothel owners require regular gynecological exams increased from 89 to 98 percent. Knowledge of STI treatment locations increased strikingly among target groups.

Most significant, HIV seroprevalence appears to be stabilizing in several sentinel populations, including STI clinic attendees, where prevalence has averaged about 7.5 percent since 1992. Preliminary data suggest that the rate of HIV infection declined slightly among pregnant women from 1995 to 1996—from 2 to 1.2 percent in Santo Domingo and from 1.2 to 0.3 percent in San Francisco—although continued surveillance is necessary to confirm this trend. HIV appears to be spreading rapidly in the tourist region of Puerto Plata, where seroprevalence increased among pregnant women from 4.1 percent in 1995 to 7.9 percent in 1996.

Special Features

A highlight of the AIDSCAP/Dominican Republic program was the extraordinary success of its mass media campaign. The campaign received unprecedented private sector support from radio and television stations, which donated more than U.S. $9 million worth of free air time to broadcast HIV/AIDS prevention messages. Given the current climate of decreased donor funding, the private sector will be called on to play an increasingly prominent role in HIV/AIDS prevention efforts. The active involvement of the national media in HIV/AIDS prevention is an important example of private sector/NGO collaboration.

Building capacity and sustainability was a key focus of the AIDSCAP/Dominican Republic program. AIDSCAP conducted an institutional development workshop for representatives from NGOs working in HIV/AIDS prevention and worked to develop partnerships between these

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NGOs, which had previously seen themselves as competing for funding and recognition. As a result of this emphasis on collaboration, several subprojects were implemented by two Dominican NGOs working cooperatively. At the end of AIDSCAP funding, the five central NGOs had developed institutional sustainability plans, and all had secured funding from other donors for additional HIV/AIDS prevention projects.

Implementing Partners

Agencia Latinoamericana de Expertos en Planificación H. (ALEPH)

Amigos Siempre Amigos (ASA)

Coordinadora de Animación Socio Cultural (CASCO)

Centro de Enfermedades de Transmisión Sexual y SIDA (CETS)

Centro de Orientación e Investigación Integral (COIN)

Comité de Vigilancia y Control de SIDA (COVICOSIDA)

Fundación Cultural y Educativa (FUCES)

Instituto Dominicano de Desarrollo Integral (IDDI)

Instituto Nacional de Salud (INSALUD)

Laboroto Rio de Janeiro Nacional de Salud

Patronato de Lucha Contra el SIDA (PLUS)

Programa de Control de Enfermedades de Transmisión Sexual y SIDA (PROCETS)

Technicmarketing

University of Washington

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Haiti

Epidemiology

HIV prevalence in Haiti is estimated to be 10 percent in urban adult populations and 4 percent in rural areas. The female to male ratio of HIV/AIDS-infected persons is close to 1:1. Of all HIV infections reported in the country, 80 percent occur in young adults aged 20 to 44, many of whom contracted the infection during adolescence. The prevalence of non-HIV sexually transmitted infections (STIs) is also high. An AIDSCAP-funded study of 1,000 women attending an urban antenatal clinic in an impoverished area found that 46.9 percent of women in the sample were infected with at least one STI. Overall, STI/HIV/AIDS epidemiology in Haiti parallels high-prevalence patterns found in parts of sub-Saharan Africa.

Country Overview

USAID/Haiti began supporting HIV/AIDS prevention in Haiti in June 1989 through Family Health International's AIDSTECH Project. In April 1991, the USAID project was expanded and renamed Aba SIDA (Haitian Creole for "Down with AIDS"). Shortly after the initiation of the expanded Aba SIDA Project, a military coup deposed Haiti's democratically elected government and ignited a severe political and economic crisis that lasted almost 4 years. Although the United States withdrew development assistance to Haiti in protest of the military government, HIV/AIDS prevention in the private and nongovernmental sector was exempted, allowing for a continuation of Aba SIDA activities. The Aba SIDA Project was the only nationwide response to the HIV/AIDS epidemic during this period. Under a new cooperative agreement with Family Health International (FHI) that began in October 1992, technical assistance responsibility for Aba SIDA was transferred to FHI's AIDSCAP Project. Aba SIDA ended in June 1996.

AIDSCAP/Haiti was designed to respond to an advanced HIV/AIDS epidemic and pronounced prevalence rates for other STIs. Therefore, its target populations were broad: adolescents and sexually active adults. Other behavior change

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interventions were tailored to meet the particular needs and perspectives of smaller, well-defined target populations, including commercial sex workers and their clients, women and men in the workplace, adolescents in schools and communities, and patients with symptoms of sexually transmitted infections. The communication strategy for targeted interventions was based on a variety of behavior change messages to accommodate individual variability both within and among target audiences.

AIDSCAP/Haiti's behavior change interventions with specific target audiences were multifaceted projects. While behavior change communication (BCC) was the centerpiece of the interventions, distributing condoms, facilitating access to STI care, and engaging the support of influential persons in target communities were also important components.

Accomplishments

Twenty Haitian institutions received technical and financial assistance to conduct key interventions to reduce the sexual transmission of HIV/AIDS and STIs. During the life of AIDSCAP, Haitian communities and grassroots organizations made remarkable progress in raising awareness about STI/HIV/AIDS and encouraging behavior change. More than 800,000 people were educated on how to protect themselves from HIV/AIDS, and more than 400,000 educational materials were distributed. More than 6,000 health workers, nongovernmental organization (NGO) personnel, and community volunteers were trained in the skills needed to sustain HIV/AIDS prevention programs, and more than 16 million condoms were sold or distributed through condom social marketing activities.

Strengthening STI Services

After an elected government was installed in Haiti, national guidelines for STI case management were developed and adopted by the new Haitian Ministry of Health. These national STI management guidelines were disseminated in June 1996 after extensive research, training, and institutional development had built a consensus with public and private sector practitioners on STI diagnosis and treatment. Although no measurement of STI treatment according to the national guidelines was feasible, a measurement of the percentage of clinicians in an AIDSCAP-funded project correctly treating the most common STI syndrome increased from 10 percent in 1993 to 69 percent in 1995.

Policy Dialogue

In addition to the development of national STI policy, other activities were undertaken to improve the policy environment in support of HIV/AIDS prevention. The first forums on women and HIV/AIDS in Haiti were sponsored, and a dialogue was initiated to ensure that women's concerns were addressed in Haiti's new plan of action for HIV/AIDS prevention. AIDSCAP also sponsored a mass media campaign, with special events aimed at increasing the awareness of the public of the HIV/AIDS epidemic and increasing social support of prevention projects.

Improving Care and Management

Through the AIDSCAP AIDS Care and Management Small Grants Initiative, three hospitals in Haiti received financial support to improve hospital and home-based care for AIDS patients and social support for people living with HIV/AIDS and their families, to provide economic assistance to affected families through income-generation activities, and to integrate prevention services into their care activities.

Capacity Building

Evidence of increased managerial and technical capacity of the AIDSCAP/Haiti implementing agencies was documented through a rapid assessment survey and indepth interviews. Program managers reported in-

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creased staff skills in a range of technical areas, including BCC, condom social marketing, evaluation research, and STIs. Improvements in program management were reported in the areas of report writing, financial management, and strategic planning. In addition to improved staff skills, program managers reported improved management systems for finance, monitoring, and evaluation. Finally, all program managers cited improved networking with private and public sector organizations and developing coalitions.

Key Outcome Data

AIDSCAP/Haiti programs led to a significantly increased understanding of HIV/AIDS transmission and prevention methods in both high-risk target populations and the Haitian population in general. Behavioral changes were also reported. Three significant outcomes of the AIDSCAP program, evident from an analysis of baseline and postintervention research in AIDSCAP target audiences, are that the knowledge of HIV/AIDS has substantially increased, personal risk assessment skills have improved, and a high percentage of the population report behaviorial change to reduce the risk of HIV/AIDS infection

Special Features

During the period of the AIDSCAP program, Haiti endured major political and economic crises. A coup d'état in 1991 paralyzed the National AIDS Control Program (NACP). The economy was also severely impaired, and violence was widespread. Donor agencies withdrew their development assistance to Haiti to protest the coup. Through AIDSCAP, however, USAID continued to support NGO-based HIV/AIDS prevention in Haiti. During this time, as the only major HIV/AIDS prevention activity in the country, AIDSCAP assumed many of the responsibilities of the NACP, including coordinating and funding activities, providing technical assistance to specific intervention projects, and conducting high visibility HIV/AIDS awareness and advocacy campaigns. The current level of prevention and control efforts in Haiti is due to USAID's commitment to HIV/AIDS interventions in the country despite the political circumstances, as well as the dedication of AIDSCAP and its NGO partners to carry on despite the upheavals.

Documented Outcomes for the General Population in Haiti

Aware of the sexual transmission of HIV

	1990	1995
	60%	90%

Knew of at least one prevention method

	1995
	95%

Unable to assess personal risk for HIV/AIDS

	1990	1995
	18%	1%

Knew of condoms

	1990	1995
men	69%	95%
women	54%	95%

Knew of one or more sources for condoms

	1995
	>90%

Ever used condoms

	1990	1995
men	16%	32%
women	6%	12%

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Implementing Partners

Alliance des Femmes Haïtiennes

Centre de Promotion des Femme Ouvrières

Centre Haïtien de Service Social

Centres pour le Développement et la Santé

Comité d'Action des Jeunes Contre le SIDA

Grace Children's Hospital

Groupe de Lutte Anti-SIDA

Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infection Opportunistes

Haitian Association of Public Health

Haitian Institute for Community Health

Hôpital Albert Schweitzer

Hôpital de Fermathe

Implementing Agency for Coorperation and Training/Inter-Aide

Institut Haïtien de L'Enfance

Miraj Productions

Population Services International/DOBACO

Producteurs Haïtiens Reunis

Professional Management Services

Save the Children

Volontariat pour le Développement d'Haïti

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Honduras

Epidemiology

Honduras has the highest AIDS prevalence in Central America. While only 17 percent of the population of Central America lives in Honduras, the country has 48 percent of the region's AIDS cases. By April 1997, 9,376 persons with HIV infection had been registered, although public health authorities estimate that the actual number of cases is 30 to 50 percent higher. Ninety-three percent of cases are a result of sexual transmission. Men who have sex with men (MWM) represent approximately 13 percent of reported cases. Approximately 83 percent of the cases are among heterosexuals, and the ratio of men to women is 1.8:1, although young women are disproportionately overrepresented. The increasing number of infected women has led to increased vertical transmission: children under the age of five now account for 4 percent of cases.

The city of San Pedro Sula is the center of the Honduran HIV/AIDS epidemic. Sentinel surveillance of pregnant women in San Pedro Sula has documented HIV prevalence of up to 4 percent. The capital, Tegucigalpa, has a relatively lower prevalence. While urban areas have the highest rates of infection, every department in the country has reported cases of HIV or AIDS. According to projections made in 1993, AIDS may affect between 10 and 17 percent of adults in San Pedro Sula and between 4 and 12 percent of adults in Tegucigalpa by the year 2000. The largest number of new HIV infections are expected to occur among the 20- to 24-year-old age group.

Country Overview

Honduras borders Nicaragua, El Salvador, and Guatemala, and has coastline on both the Pacific Ocean and the Caribbean Sea. Approximately 90 percent of its population of 4.8 million are Mestizo (a mix of indigenous and Spanish heritage). The remainder of the population is of African, indigenous, or Spanish descent. Honduras is one of the poorest countries in Latin America, and an estimated 40 percent of the population is either unemployed or underemployed. The majority of Hondurans live in rural

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areas, although rural-to-urban migration has led to high rates of growth in cities such as San Pedro Sula and Tegucigalpa. Many women and youth from rural areas migrate to the garment factories near San Pedro Sula. The country's major exports include bananas and textiles.

Structural factors that fuel the Honduran HIV/AIDS epidemic include poverty and the social disruption caused by civil wars in Central America. Lack of economic opportunities force many women into the commercial sex industry. Alcohol abuse also plays an important role in sexual risk taking.

Following an AIDSCAP-funded socioeconomic impact study, Honduras became an AIDSCAP priority country in 1995. Prior to the AIDSCAP program, there had been a minimal response to the epidemic on the part of both governmental and nongovernmental organizations (NGOs).

The goal of the AIDSCAP program was to reduce the incidence of sexually transmitted HIV infection in Honduras. AIDSCAP/Honduras employed the following four strategies to achieve this goal:

- Reduce sexual risk taking among the target groups through behavior change communication (BCC).
- Decrease the prevalence of sexually transmitted infections (STIs) through improved diagnosis, treatment, and prevention.
- Increase condom use among both target groups and the general population by expanding access to, and availability and acceptability of condoms.
- Strengthen the capacity of Honduran institutions to respond to the HIV/AIDS epidemic with appropriate and effective prevention activities.

AIDSCAP/Honduras targeted commercial sex workers (CSWs) and their clients, MWM, people in the workplace (PWP), and the Garífuna (an ethnic minority) as groups at risk of HIV infection.

Accomplishments

During the 2 years of the program, AIDSCAP/Honduras reached 557,659 Hondurans with HIV/AIDS prevention messages. The program supported BCC interventions among groups with high levels of risk behavior, such as CSWs and MWM. In addition, interventions were conducted among groups who currently have low HIV prevalence but who may be at high risk of acquiring HIV, such as PWP and the Garífuna. The AIDSCAP interventions among PWP and the Garífuna represent the largest-scale HIV/AIDS interventions ever conducted among these populations.

Strengthening STI Services

The AIDSCAP/Honduras program achieved its goal of improving STI diagnosis and treatment services. In a joint collaboration with the Ministry of Health (MOH), the Units for the Integrated Management of STI (UMIETS) were strengthened. AIDSCAP improved STI diagnosis and treatment services by training 306 MOH clinic staff in syndromic management and providing funding to remodel and upgrade clinics. The UMIETS sought to destigmatize STI services by creating a separate clinic for CSWs. NGOs funded by AIDSCAP made STI services more accessible by creating a system for referring individuals suspected of having STI to the UMIETS. In addition, AIDSCAP supported a study on antibiotic-resistant gonorrhea conducted by the MOH and the Institute of Tropical Medicine. The study found that 60 percent of the gonococcal isolates that were tested were resistant to penicillin and 89 percent were resistant to tetracycline. As a result of this study, MOH authorities changed the national protocol for the treatment of gonorrhea and updated the national guidelines for STI management.

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Condom Promotion and Distribution

The condom promotion component of AIDSCAP/Honduras surpassed its goals. In an effort to increase condom use in Honduras, the program developed a distribution system in the four health regions where STIs and HIV/AIDS were most prevalent. Central storage centers were created to protect the condoms from excessive heat. Condoms were made available at 756 distribution posts, which included MOH clinics, social security offices, factories, brothels, and bars. In rural areas, condoms were available in the homes of peer educators. By the end of the project, more than 5.7 million condoms had been distributed, surpassing the goal of 4 million. This achievement is particularly impressive because condom promotion activities in Honduras coincided with a mass media campaign against condoms conducted by a group called Pro Life. In addition, the Catholic Church in Honduras rigorously opposed the promotion of condoms.

Capacity Building

Significantly increased capacity among all of AIDSCAP's implementing partners was an important outcome the program's efforts. AIDSCAP worked with a range of NGOs and governmental organizations who had little previous experience in HIV/AIDS prevention and improved their management capacity and accountability by strengthening their administrative and accounting systems. Technical assistance in evaluation techniques, including the design, implementation, and analysis of behavioral data relevant for the design and evaluation of interventions, was provided to every organization.

Organizations reported increased capacity in BCC, conceptual development, and materials design. Another area of technical improvement was in the management of STIs. Physical resources provided to each organization improved the effectiveness of organizational management, communications, and presentations. AIDSCAP also facilitated institutional development through workshops, conferences, and training sessions, which allowed for better networking and the exchange of lessons learned by program managers involved in HIV/AIDS prevention efforts in different target populations throughout Honduras.

Key Outcome Data

At the beginning of the AIDSCAP program, several implementing agencies conducted surveys to assess their target audiences' knowledge, attitudes, beliefs, and practices (KABP) with regard to HIV/AIDS. As AIDSCAP did not begin activities in Honduras until 1995, follow-up KABP studies will be conducted in 1999. Several agencies also conducted qualitative research that was used to develop targeted interventions.

Baseline KABP data indicated that while most Hondurans had heard of HIV/AIDS, few knew how to prevent transmission and fewer still were acting on that knowledge. For example, 100 percent of CSWs interviewed had heard of HIV/AIDS, but only 70 percent reported consistent condom use with clients. While 87 percent of MWM reported condom use, few reported condom use in every sexual encounter. Awareness of HIV/AIDS among the general population was much lower. Among men and women in the workplace, only 19 percent of men and 22 percent of women could cite two or more ways to prevent HIV/AIDS infection. More than 76 percent of men reported having sex with partners other than their permanent regular partner, and 8 percent reported having sex with other men. Only 62 percent of men and 20 percent of women reported having ever used a condom. Of those who reported condom use, 11 percent reported using them for every sex act. Only 47 percent of those interviewed knew how to use condoms correctly.

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Special Features

One of the successes of AIDSCAP/ Honduras was the design of a protocol for rapid program implementation. The idea behind rapid program implementation was to jump-start national HIV/AIDS prevention efforts by bringing representatives from collaborating agencies together for intensive training. Representatives from 26 public and private sector organizations participated in a week-long training workshop on project design. Ten of these organizations participated in a second workshop that emphasized project development. As a result of this intensive effort, AIDSCAP and its partners were able to complete most of the project subagreements within 2 weeks, and the Honduran HIV/AIDS prevention effort was underway within a month of the initial training workshop.

Implementing Partners

Asociación de Municipalidades de Honduras (AMHON)

Centro de Estudios para el Desarrollo y la Participación Social (CEDEPS)

Comunidad Gay Sampedrana (CGS)

Centro de Orientación y Capacitación en SIDA (COCSIDA)

Comunicación y Vida (COMVIDA)

Fraternidad Sampedrana de Lucha Contra el SIDA (FSLS)

Instituto Hondureño de Seguridad Social (IHSS)

Ministry of Health (MOH)

Institute of Tropical Medicine (ITM)

Organización de Desarrollo Étnico Comunitario (ODECO)

Oficina Gubermental de la Mujer (OGM)
Programas para el Desarrollo de la Infancia y la Mujer (PRODIM)

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Jamaica

Epidemiology

The first case of AIDS in Jamaica was diagnosed in 1982, and by 1993 there were more than 500 known cases. One year later, there were more than 800 cases, 64 percent male and 36 percent female, with all parishes reporting incidence. As of December 1996, data showed a total of 2,060 cases. According to the sentinel surveillance data of the Ministry of Health (MOH), the number of individuals infected with HIV is currently estimated to be between 5,000 and 10,000, 80 percent of whom are heterosexual. The majority (59 percent) of AIDS cases occurs in young adults, aged 20 and 39, with 8 percent pediatric cases.

In 1993, HIV prevalence was estimated at 0.1 percent in the general population and 0.3 percent in urban areas, and in 1996 prevalence was an estimated 0.3 and 0.4 percent. Sexually transmitted infection (STI) clinic attendees in Kingston and Montego Bay had a rate of 4 percent in 1994. While HIV prevalence is relatively low in comparison with other Caribbean countries, the large commercial sex industry, high rates of alcohol and drug abuse, the sizable number of migrant laborers, and high rates of STIs indicate the potential for the epidemic to have a devastating impact in Jamaica. Homophobia in Jamaica is a difficult barrier to reaching men who have sex with men (MWM).

Country Overview

Jamaica has a population of approximately 2.5 million persons of primarily African, European, East Indian, and Chinese origin. Nearly half reside in urban areas, with half of these urban residents living in metropolitan Kingston and St. Andrews. Literacy rates are 80 percent for women and 76 percent for men. More than 40 percent of Jamaican households are headed by women. Life expectancy is 69 years for men and 73 years for women. About one-third of the population lives in poverty.

In 1988, USAID/Jamaica expanded upon its previous prevention activities with the implementation of an AIDS/STI prevention and control

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project, which was designed to address the growth in AIDS cases and the dramatic increase in STIs. In 1992, this project was extended for 4 additional years, as USAID/Washington selected Jamaica as one of the 15 priority countries worldwide to receive technical assistance under the AIDSCAP Project. At that time in Jamaica, the epidemic was not yet believed to be overwhelming and prevention activities were considered to have the potential for significant impact.

The goals of the AIDSCAP program were to

- reduce the rate of sexually transmitted HIV/AIDS.
- decrease STIs through improved diagnosis and treatment.
- increase condom use by expanding and improving access.
- reduce the number of sexual partners through behavior change communication (BCC) among the target groups.

The primary target groups for the program were STI clinic attendees, commercial sex workers (CSWs), adolescents, adults with multiple sex partners, MWM, and people living with HIV/AIDS. Intermediate target groups included policymakers and opinion leaders, medical professionals, and commercial sector retailers. Geographically, the program covered the entire island, with some subprojects focusing on particular target populations and some focusing on urban areas.

Accomplishments

Behavior Change Communication

In the 4 years of the AIDSCAP/Jamaica project, a wide range of print material and mass media communication was produced and distributed to all of the targeted risk groups. To ensure consistency within the campaigns, the MOH communication team formed a BCC team of all AIDSCAP subproject managers that worked to guarantee uniform messages countrywide. A total of 6,017 people were trained and over 760,000 were educated by the Jamaican subprojects. More than 1.3 million copies of program materials were distributed.

Strengthening STI Services

When the program started, Jamaica had a well-developed STI diagnosis and treatment system, including infrastructure in both public and private sectors. Not only were public STI clinics operating, but the country also had national case management guidelines. In addition to reducing HIV transmission, the goal of the national program was to reduce the economic and psychosocial burden of STIs and their complications by decreasing overall morbidity and mortality. As a result of the AIDSCAP/Jamaica program, syphilis screening was decentralized, STI case management was strengthened, private practitioners were trained, and studies on vaginal discharge and genital ulcer disease were conducted.

During the AIDSCAP program, guidelines for STI case management and counseling were revised. Some 2,000 copies were distributed to service providers, including all 13 public STI and 13 antenatal clinics. More than 100 clinics were following manual guidelines by the end of the project. The reporting of clinic data was improved, and a new STI software database was developed and implemented. In addition, more than 500 public and 1,200 private sector health care workers received STI training. The program was also responsible for training and deploying peer counselors in 16 clinics.

Condom Promotion and Distribution

The purpose of the condom component of the AIDSCAP/Jamaica program was to decrease the rate of STI/HIV/AIDS infection by increasing the accessibility of condoms to specific target populations through nontradi-

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tional outlets. The goal was increased acceptability of consistent, correct use of condoms by these groups. The primary target populations for this component were young, sexually active adults (aged 15 to 30) and persons with multiple partners, including CSWs and STI clinic attendees. In general, Jamaicans were more likely to use condoms in 1996 than before the AIDSCAP program began. Since 1985, when condom use was estimated at about 2 million per year, annual consumption has increased to more than 10 million. In the past 3 years alone, consumption doubled. AIDSCAP subprojects distributed more than 5.1 million condoms over the life of the project.

Key Outcome Data

Data reported by the MOH at the end of the AIDSCAP program showed that primary and secondary syphilis prevalence decreased from 39 to 23.3 per 100,000. Incidence was down among both men and women. The number of cases of congenital syphilis declined from 62 in 1991 to 19 in 1996. In addition, the public sector reported that 100 percent of STI clinic attendees were treated for syphilis and gonorrhea according to national guidelines. A survey conducted of private sector physicians indicated that an estimated 61 percent were treating STI patients properly.

Evaluation research has shown substantial increases in knowledge and risk prevention behaviors among the majority of the Jamaican population, despite a minority who continue to believe in myths of HIV transmission and continue to engage in high-risk behaviors.

Knowledge levels, already high in 1992, continued to rise as belief in the myths of HIV transmission declined. More than 95 percent of the general population correctly cited two methods of HIV/AIDS prevention in 1996, an increase from 91 percent 4 years earlier. Increased knowledge of HIV/AIDS prevention methods was most striking among 12 to 14 year olds. Only 70 percent of boys and girls could cite two or more prevention methods in 1994, while 96 percent could in 1996.

In terms of modifying risk behaviors to avoid HIV infection, risk reduction strategies varied considerably among men and women and among different age groups. In general, men reported fewer partners and longer relationships, while women reported increased triple partners and condom use.

Adolescent boys reported decreased levels of sexual activity and delayed sexual debut, while younger adult men reported fewer multiple regular and nonregular partnerships. The percentage of boys aged 12 to 14 who became sexually active by age 15 declined from 58 percent in 1994 to 41 percent in 1996. The percentage of men aged 15 to 29 reporting nonregular partnerships declined from 42 to 25 percent. Men aged 20 to 49 dramatically decreased their rate of multiple regular partners as well, from approximately 60 to 30 percent.

Only 37 percent of women reported using condoms during their last sexual intercourse with a nonregular partner in 1992, compared with 73 percent in 1996, with 30 percent reporting every-time use in 1992 compared with 64 percent in 1996.

Special Features

The use of a public relations firm to promote behavior change and leverage media support in Jamaica sets this program apart from other AIDSCAP country programs. The public relations firm worked closely with the MOH's epidemiology unit and nongovernmental organizations to implement subprojects. The coordinated BCC strategy creatively used local culture, music, drama, celebrity endorsements, and humor to communicate safer sex messages to a broad cross section of the island's population. Some of the most successful BCC slogans were, "You can't tell by looking," "Only you

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can stop AIDS," "Using a condom is the way to live," and "Keep on keepin' it on." The public relations project was able to leverage over U.S. $1 million in sponsorship and in-kind contributions for the program's activities from the private sector and the media.

Implementing Partners

American National Red Cross (ANRC)

Association for the Control of Sexually Transmitted Infections (ACOSTRAD)

Berl Francis and Company, Limited

Futures Group, Inc.

Hope Enterprises

Jamaica AIDS Society (JAS)

Little People & Teen Players Club

Medical Association of Jamaica (MAJ)

Ministry of Health, Epidemiology Unit (EPI Unit)

Nurse Practitioner Association (NPA)

Statistical Institute of Jamaica (STATIN)

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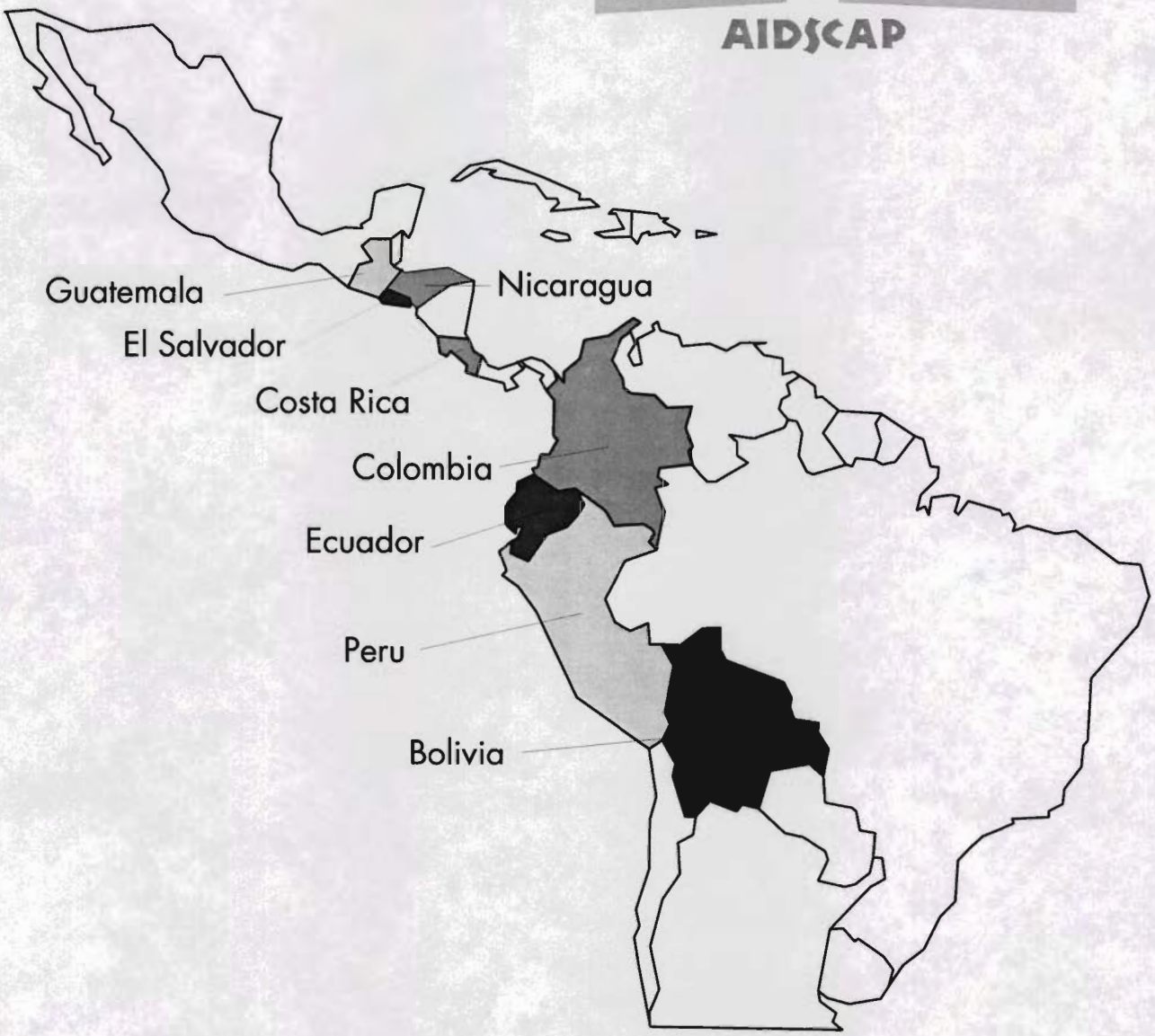
Latin America/ Caribbean



Associate Countries

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Bolivia

Epidemiology

Bolivia has a low incidence of HIV/AIDS and is in an excellent position to institute a sustainable STI/HIV/AIDS prevention program that will ensure continued low incidence. The reviewed project had established an ambitious program, using baseline research, the integration of sexually transmitted infection (STI) case management, a behavior change communication (BCC) component, and condom promotion and distribution. A strong basis for expansion of the program is now in place.

Country Overview

In 1991, a comprehensive effort was initiated by USAID/Bolivia to control and prevent the spread of STI/HIV/AIDS. Project activities were originally focused on targeted interventions with high-risk behavior groups in selected cities in the country. In October 1993, an AIDSCAP team conducted a midterm evaluation of this project. The evaluation team interviewed staff of the project, the USAID Mission, the former Secretariat of Health, and nongovernmental organizations to assess the issues and challenges of each component of the project. General findings and recommendations were issued in a final report, which was used to improve the project during its last 15 months.

Accomplishments

The team visited the project sites and conducted extensive interviews with local and international staff from the Ministry of Health, the Centers for Disease Control and Prevention, and the USAID Mission, among others.

The specific areas reviewed included

- STI case management and prevention practices,
- STI and HIV/AIDS sentinel surveillance systems,
- information, education, and counseling components,

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- project management and institutionalization,
- condom promotion and distribution, and
- financial management.

The team concluded that the project's strength was in its STI services to registered commercial sex workers. It also concluded, however, that the project lacked a strong communication component, had limited condom promotion coverage, and was reaching a small percentage of the target population. There were also concerns regarding the financial management system and the sustainability of the project due to its limited integration with local institutions. The team produced a report with recommendations to improve the project's different program areas.

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Colombia

Epidemiology

Of all South American countries, Colombia ranks third behind Brazil and Argentina in the number of cumulative AIDS cases. The capital, Bogotá, is the geographic center of the Colombian epidemic and home to 39 percent of the country's reported AIDS cases. Nearly two-thirds of cases are among people aged 25 to 44, and more than 90 percent of infections are sexually transmitted. Early in the epidemic, the majority of AIDS cases occurred in men who have sex with men (MWM). In 1990, the male to female ratio of cumulative AIDS cases was 11:1. However, the increasing number of AIDS cases among women indicates that heterosexual transmission is increasing rapidly. By 1995, the male to female ratio among new AIDS cases had decreased to 3.8:1.

Seroprevalence studies in Colombia suggest that the HIV/AIDS epidemic is well-established, particularly among groups engaging in high-risk behaviors. By the year 2000, the number of people living with HIV could reach between 65,000 and 190,000. There may be between 9,000 and 26,000 new AIDS cases by 2000, with as many as 170 AIDS deaths a week.

While core groups such as MWM's and commercial sex workers continue to be at high risk of infection, many female members of the general population are at risk because of the behavior of their regular partners. Of the 13 female AIDS cases treated at one Bogotá hospital in 1996, nine attributed their HIV infection to their husbands (Fundación Forjar, 1996).

Country Overview

At the request of the USAID/Colombia, a team of behavior change communication experts from AIDSCAP traveled to Colombia in May 1992 to conduct an HIV/AIDS needs assessment in order to program USAID mission funds set aside to support HIV prevention activities.

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Accomplishments

AIDSCAP conducted an analysis of the national response to HIV/AIDS in order to develop a prevention and control strategy for Colombia. The needs assessment suggested that Colombian decision makers have insufficient knowledge about AIDS, and the knowledge of the general population is often medically inaccurate. Despite public education campaigns, the creation of a National AIDS Program in the Ministry of Health, and the passage of appropriate legislation to protect the rights of people living with HIV/AIDS, there was little awareness of the gravity of the epidemic among policymakers. The lack of public sector commitment was reflected in the minimal resources allocated to prevent the spread of HIV. AIDSCAP determined that a stronger commitment from decision makers in the public and private sectors was crucial to control the rapidly growing HIV/AIDS epidemic in Colombia.

As a result of these findings, AIDSCAP recommended a two-part strategy to initiate HIV/AIDS control and prevention efforts in Colombia. The first component was to develop an AIDS Impact Model to provide key decision makers with accurate information on the extent of the epidemic and the potential socioeconomic impact on Colombia. The second component was to design and implement a public opinion awareness campaign to create an environment conducive to increased funding for HIV prevention on the part of both the private and public sectors.

The public opinion campaign began in October 1992 and continued until March 1993. The campaign published 205,000 newspaper supplements, each with a condom attached, which were included in the December 1 issue of *El Espectador*, a national daily newspaper. A publicity launch on the eve of the supplement's appearance drew prominent political and journalistic personalities and received extensive media coverage. Other activities included the creation of posters targeting both policymakers and groups at high risk of infection, as well as a Human Rights Day program promoting the rights of people living with HIV/AIDS. It is estimated that 16 million people were reached either directly or indirectly as a result of the campaign.

In 1996, AIDSCAP, in collaboration with the consulting firm *Consultores Internacionales en Seguridad Social y Salud,* conducted an assessment of the socioeconomic impact of the HIV/AIDS epidemic in Colombia. A team of experts developed and implemented the study. Local staff were trained in modeling techniques and computer programs to obtain economic and epidemiologic projections of the impact of the epidemic. The socioeconomic impact assessment is being used to raise awareness of the need for HIV prevention among public and private sector policymakers.

In addition to these projects, AIDSCAP sponsored the participation of three Colombians at the 1995 USAID HIV/AIDS Prevention Conference in Washington, D.C.

Implementing Partners

Apoyemonos

Consultores Internacionales en Seguridad Social y Salud Ltd. (CINSSA)

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Costa Rica

Epidemiology

A national study of reproductive health conducted among youth aged 15 to 24 indicated that 31.4 percent of the males and 15 percent of the females aged 15 to 17 engaged in premarital sexual relationships. The first national AIDS survey, prepared in 1991, reported that 94.9 percent of the males interviewed (n=1,671) and 74.6 percent of the females (n=1,584) had initiated sexual activity before they were 20. In their first sexual act, 76.7 percent of the males and 81.6 percent of the females did not use any contraception. While more than 70 percent of the males aged 15 to 19 reported having between 2 and 10 sexual partners, less than 20 percent of the female respondents reported more than one partner.

Country Overview

The Costa Rican government began its National Adolescent Program (NAP) in 1989. NAP's goal is to respond to the needs of Costa Rican adolescents and to help protect them from biological and psychosocial trauma through the efforts of interdisciplinary teams. Despite the high level of knowledge of HIV/AIDS among the adolescent population, further programs are required to change attitudes toward HIV/AIDS as a necessary phase in the adoption of recommended prevention behaviors.

AIDSCAP collaborated with NAP to contribute to the long-term reduction in the incidence of sexually transmitted infection (STI) and HIV/AIDS among this population. The project enabled NAP to develop a model for training and supervising a network of adolescent peer health educators in selected regions of Costa Rica.

Accomplishments

Four workshops were conducted with the goal of increasing knowledge and changing attitudes, beliefs, and practices that place youth at risk of infection. In turn, some of the participants became peer health educators in their communities. A total of 128 adolescents between the ages of 15 and 19 (65 females and 63 males; 60 students and 68 employed) received educa-

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tional training during the three-day workshops. Approximately 2,060 informative pamphlets on STI/HIV/AIDS, condoms, and self-esteem were distributed directly to adolescents and 6,735 were distributed by peer health educators. A total of 289 activities (video presentations, lectures, group meetings, plays, and one-to-one dialogue) reached 2,970 adolescents during the project.

Two methodological guides were developed, one targeting adolescents and the other targeting adults. The guides stress the importance of a participatory methodology, or a combination of lecture and small-group discussion, in training. A total of 3,000 condoms were distributed through the Adolescent Clinics of Programa Integral del Adolescente. A postworkshop questionnaire was completed by 253 adolescents (50 percent male and 50 percent female). The questionnaire revealed an increased level of knowledge of STI/HIV/AIDS and correct condom use and increased tolerance of people living with HIV/AIDS and of homosexuality.

The experience gained in this project formed the basis for a nationwide program to be undertaken by NAP.

Implementing Partner

FUNDESIDA/MOH (Departamento de Control de SIDA, Ministerio de Salud)

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Ecuador

Epidemiology

Ecuador, like many countries in the region, lacks adequate epidemiologic HIV/AIDS surveillance. As of 1991, only 141 AIDS cases had been reported to the Ministry of Health (MOH), but public health authorities estimate that the actual number of AIDS cases is at least 10 times higher. While the majority of early cases were among men who have sex with men, increasing numbers of female AIDS cases suggest that heterosexual transmission is increasing, in large part because of unprotected commercial sex.

The MOH requires that commercial sex workers (CSWs) be tested for sexually transmitted infections (STIs) and HIV bimonthly in order to obtain and retain legal status. Data obtained from the MOH STI Prevention Unit in Guayas Province indicate that 12 percent of CSWs test positive for syphilis and 60 to 70 percent test positive for gonorrhea. Although HIV seroprevalence has been relatively low, the high prevalence of STIs indicates the potential for a rapid spread of HIV among CSWs and their clients. Many CSWs are unregistered and are not tested for STI/HIV on a regular basis. These unregistered CSWs are at high risk of HIV infection.

Country Overview

As of September 1996, the Pan American Health Organization had recorded 569 cases of AIDS in Ecuador, placing the country in the low-to-middle range of South American nations affected by the HIV/AIDS epidemic. AIDSCAP's aim in Ecuador, therefore, was to maintain the country's relatively low prevalence of HIV/AIDS. With this goal in mind, AIDSCAP assisted the Ecuadorian Red Cross to improve laboratory procedures to improve blood screening and worked with Fundación Futura on a behavior change communication (BCC) project that targeted CSWs. AIDSCAP's most recent intervention in Ecuador consisted of an educational program for CSWs implemented by a family planning association that operates in Guayaquil, the country's commercial center.

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Accomplishments

AIDSCAP supported the Asociación Pro-Bienestar de la Familia Ecuatoriana (APROFE), a private, nonprofit affiliate of the International Planned Parenthood Federation (IPPF), Western Hemisphere Region, to implement a project focused on BCC for CSWs and brothel owners. The strategy was to recruit CSWs as peer educators and to obtain support for condom use from brothel owners. A technical team comprised of STI and BCC specialists, a nurse, and an evaluator, conducted 24 risk-reduction workshops with groups of CSWs. The brothel owners also participated in four workshops on STI/HIV/AIDS. In addition, APROFE trained five CSWs as peer educators and 48 CSWs to provide follow-up in the field. APROFE worked closely with the CSW union Primero de Agosto, which represents 3,000 legally registered CSWs, to identify workshop participants and peer educators. An estimated 15,000 unregistered or clandestine CSWs are working in Guayas Province. The project activities took place in three cities where commercial sex is prevalent—Guayaquil, which is Ecuador's main commercial center and largest port, and Milagros and Naranjal, which are cities located in the sugar cane, pineapple, and rice producing regions. These cities are centers of seasonal migration and transport.

APROFE developed a team of peer health educators who held weekly meetings with CSWs and recruited volunteer promoters. The Hermanas Adoratrices, an order of Catholic nuns, supported the project by arranging meetings between APROFE and the CSWs and by providing space for the meetings. The project has trained at least 100 educators; produced and distributed 12,000 printed materials; and reached more than 1,800 CSWs, brothel owners, and clients.

AIDSCAP also supported a project targeting CSWs, their clients, and brothel owners in Quito. The project, titled AIDS Prevention Pilot Program with High-Risk Groups, was implemented by Fundación Futura. This Ecuadorian nongovernmental organization promotes family planning and STI prevention, and has considerable experience in condom social marketing. With backing from the National AIDS Control Program and USAID/Ecuador, Fundación Futura had previously established a pilot project in Guayaquil targeting female CSWs and their clients, brothel owners, and pharmacy workers. The project, based in an MOH clinic serving CSWs, provided BCC and promoted and marketed condoms. With AIDSCAP support, it was replicated at two MOH clinics in Quito and at MOH clinics in Santo Domingo de los Colorados, Milagro, and Quevedo. At least 800 peer educators and bar and brothel owners were trained. During the project, 4,400 CSWs were reached with HIV/AIDS awareness and prevention messages, 10,000 educational materials were distributed, and 74,000 condoms were sold.

The Red Cross of Ecuador implemented a project under AIDSCAP to develop a long-term national program for quality assurance in HIV testing, and the Red Cross worked with every laboratory performing HIV testing in Ecuador. The project established ongoing laboratory inspection and proficiency testing programs, improved data management and reporting capabilities, and trained laboratory inspectors in identifying the technical needs of laboratories.

AIDSCAP also funded activities that developed materials for World AIDS Day.

Implementing Partners

Asociación Pro-Bienestar de la Familia Ecuatoriana (APROFE)

Fundación Futura

Ecuadorian Red Cross

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El Salvador

Epidemiology

The first case of AIDS in El Salvador was identified in 1984. By 1996, nearly 1,800 cases of AIDS had been reported to the Ministry of Health (MOH), although it is believed that the actual number of cases is significantly higher. El Salvador has many of the social conditions conducive to a serious epidemic, such as widespread commercial sex, significant migration, and post–civil war social disruption. Inaccurate knowledge of transmission and discrimination against people living with HIV/AIDS impede prevention efforts. In 1995, a socioeconomic impact study conducted by AIDSCAP found that, in the absence of interventions, El Salvador would soon experience a substantial number of infections, which would have a negative impact on both the health sector and the national economy. With sexual transmission the predominant mode of transmission, the epidemic was expected to affect the young, the working population, and housewives.

Country Overview

In 1995, USAID/El Salvador requested the assistance of AIDSCAP to support the Educational Program in AIDS Prevention strategy developed by the Pan American Health Organization. The AIDSCAP project, implemented by the nongovernmental organization Fundación Nacional de Prevención, Educación y Control del VIH/SIDA, developed materials and trained health educators from the Instituto Salvadoreño de Seguro Social (ISSS) and the MOH to conduct behavior change communication interventions in the workplace. The goal of this project was to increase knowledge of HIV/AIDS and reduce high-risk behavior among factory workers in San Salvador.

Accomplishments

AIDSCAP/El Salvador trained 25 health educators from the ISSS in data collection, interviewing techniques, group and participatory education techniques, and in the use of the new educational materials. In addition, a baseline study was conducted with 499 participants from 50

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factories, as well as a qualitative study with 47 focus groups, to develop messages and educational materials.

Based on the findings of these studies, the project produced 500,000 pamphlets, 600,000 flyers, 20,000 posters, 500 flipcharts with instruction manuals, 500 copies of a manual on educational methodology, 5,000 copies of a promotional calendar, 25,000 notebooks, and 500 T-shirts for the facilitators.

Key Outcome Data

Knowledge, attitudes, beliefs, and practices surveys conducted at the beginning and end of the project indicated that

- knowledge of means of infection increased from 70 to 94 percent.
- knowledge of two means of protection increased from 24 to 37 percent.
- knowledge that healthy looking people can be carriers of HIV/AIDS increased from 62 to 81 percent.
- condom use increased from 18 to 30 percent.

Implementing Partner

Fundación Nacional de Prevención, Educación y Control del VIH/SIDA (FUNDASIDA)

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Guatemala

Epidemiology

HIV/AIDS prevalence in Guatemala has increased dramatically since the first AIDS case was reported in 1984. As of July 1994, 1,280 cases had been reported to the National AIDS Prevention and Control Program of the Ministry of Health. As in many developing countries, underreporting by physicians and a deficient surveillance system make existing data unreliable. Conservative figures estimate that there are between 4,000 and 7,000 AIDS cases in Guatemala. The first cases were reported among men who have sex with men (MWM). While MWM continue to experience high rates of infection, more recent data suggest that heterosexual transmission is increasing rapidly, as heterosexuals now account for approximately 65 percent of cases. As the epidemic has evolved, a greater number of cases have been reported among women. Women aged 15 to 19 now account for more cases than men in that age group. As greater numbers of women of reproductive age have become infected, the number of cases of vertical transmission have also increased.

Country Overview

HIV/AIDS is not perceived as a serious threat to the overall well-being of Guatemala because its spread there has been much slower than in other countries. As the epidemic is still at an early stage, prompt action can help avoid an escalation in prevalence. Therefore, using a rapid assessment approach, an exploration of the demographic, sociocultural, political, and economic effects of the epidemic in Guatemala was undertaken to mobilize policymakers to make informed decisions about preventing HIV/AIDS.

Accomplishments

The assessment identified many weaknesses in the current response to the epidemic. In the area of epidemiology, Guatemala lacks national guidelines for the diagnosis of HIV/AIDS, standards for the diagnosis and treatment of sexually transmitted infections (STIs), and a national STI control program. In addition, the health system's list of essential drugs is outdated and does not include many basic STI treatment drugs. To

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date, HIV/AIDS education efforts have been inadequate. Behavior change communication activities have emphasized information dissemination rather than behavior change, and existing educational materials are inappropriate for illiterate audiences.

Based on the results of this assessment, AIDSCAP recommended the development of a multidisciplinary and multisectoral national strategy. An important component of this strategy is integrating HIV/AIDS prevention messages into secondary school curricula, as well as integrating HIV/AIDS and STI control and prevention with maternal and child health services. AIDSCAP recommended the development of a surveillance system based on anonymous case reporting and sentinel surveillance. The study's authors hope that Guatemala's HIV/AIDS strategy will employ prevention and control activities that have proven effective in curbing sexual transmission of HIV.

In February 1995, USAID and AIDSCAP conducted a 3-week workshop for epidemiologists, physicians, and economists from Guatemala, El Salvador, and Nicaragua. The workshop trained participants in the use of computer models and indirect costing methodologies to estimate the impact of the epidemic. Workshop participants were also trained in techniques of effective presentation of study findings to policymakers in both the public and private sectors.

Implementing Partner

PANOS Institute

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Nicaragua

Epidemiology

The first AIDS case in Nicaragua was reported in 1987. To date, with approximately 300 cumulative AIDS cases recorded, Nicaragua's epidemic may seem minor. However, like many other countries in Central America, Nicaraguan records suggest considerable underreporting of cases. A 1993 Pan American Health Organization report estimates that the number of HIV/AIDS cases in Nicaragua may be as high as 5,000. A more recent assessment by the Ministry of Health (MOH) estimated the potential number of infected individuals closer to 15,000.

The HIV/AIDS epidemic in Nicaragua is comparable to the epidemic in other Central American nations. Eighty percent of the reported cases are contracted through sexual transmission, 19 percent through the exchange of infected syringes between drug addicts, and 1 percent through the transfusion of infected blood. Fifty-four percent of the people affected were heterosexual, 40 percent were men who have sex with men, and the remaining 6 percent were children. The male to female ratio for these cases was 6:1. However, it should be noted that the ratio was 2:1 for the 30 cases reported during the first semester of 1995.

Country Overview

Nicaragua is located between Costa Rica and Honduras, and has a population of 4.2 million. Approximately 45 percent of the population are under 15 years of age. The country and its economy were devastated by civil war and mismanagement in the late 1970s and early 1980s. Recovery has been slow, and unemployment is a continuing problem. Although reported AIDS cases in Nicaragua are low, many factors, including migration, poverty, and increasing levels of commercial sex, could lead to an explosive epidemic by the end of the century. Public reaction to HIV/AIDS is often discriminatory or indifferent.

At the beginning of 1995, the USAID Mission in Nicaragua requested AIDSCAP to develop HIV/AIDS prevention and control activities in the

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country. The first stage of the activities was a qualitative study to support a national strategy for the prevention of HIV/AIDS. The results of the investigation indicated that misinformation about transmission and prevention was a major problem. In general, condom use was very low. The ineffectiveness of the traditional epidemiological focus on high-risk groups was also revealed by the study; therefore, a greater range of groups should have been considered to be at high risk of HIV/AIDS infection and included in education and prevention interventions. Based on this study, a behavior change communication (BCC) strategy was initiated.

AIDSCAP/Nicaragua consisted of four program components, each one designed to reach specific audiences. The objectives of the components were the following:

- Influence the social environment through BCC in order to create the necessary support for changes in high-risk sexual behavior leading to the prevention of HIV/AIDS.
- Develop, organize, and support local HIV/AIDS prevention programs.
- Build the capacity of local institutions to develop and implement HIV/AIDS control and prevention activities.
- Establish, through BCC, the concept of vulnerability to HIV/AIDS among targeted audiences, eventually changing attitudes and practices to reducing sexual risk taking.

Accomplishments

The major accomplishments of AIDSCAP were in the areas of research, policy, and BCC. The project supported sentinel surveillance and qualitative behavioral research, which were the foundation for the national strategy. The BCC activities conducted by the project included rallies, a music video, seminars, beachfront education, video drama, and cultural events to raise awareness and promote the human rights of people living with HIV/AIDS.

AIDSCAP also contracted a nongovernmental organization (NGO) owned by professional songwriters, singers, and musicians widely recognized in the Hispanic world, to develop a music video aimed at counteracting the stigma against people living with HIV/AIDS.

The AIDSCAP-supported projects trained more than 1,000 persons, educated approximately 900,000 persons, and distributed nearly 60,000 pieces of BCC material in approximately 6 months. AIDSCAP supported efforts to promulgate a new law relating to the human rights of people living with AIDS. More than 60,000 condoms were distributed during the project.

AIDSCAP also supported a coalition of NGOs working to pass a law that would protect the human rights of people living with HIV/AIDS. The law was approved by a majority of the Senate and signed into law by the president of Nicaragua in December 1996.

Implementing Partners

Casa de la Mujer "Mercedes Rosales" AMNLAE-Estelí

Casa de la Mujer "Sonia Bello" AMNLAE-Rivas

Centro de Asesorías y Servicios Mujer y Familia

Centro de Intercambio Cultural y Técnico (CICUTEC)

Cruz Roja Nicaragüense

Fundación Mejía Godoy

Fundación Nimehuatzín

Pro-bienestar de la Familia Nicaragüense (PROFAMILIA)

Socio-Medical Research Associates, Inc.

Peru

Epidemiology

The first case of AIDS in Peru was identified in 1983. Since 1983, cases have been reported in all regions of the country, and the number of AIDS cases reported is increasing exponentially. The cumulative number of cases reported increased from 878 in 1993 to 3,697 in 1995, a four-fold increase. While this increase reflects an improved case reporting system, it also indicates that the number of AIDS cases is considerable and that the epidemic is growing steadily. Seroprevalence studies suggest that the HIV epidemic is well-established in Peru, particularly among high-risk populations. Although only 3,697 AIDS cases had been reported as of 1995, there may be as many as 7,000 persons living with AIDS and up to 77,000 people living with HIV in the country. In other words, for every reported AIDS case in Peru, there may be one unreported AIDS case and up to 21 unreported HIV infections.

Data gathered by the Sexually Transmitted Disease and AIDS Control Program (PROCETS) of the Ministry of Health indicate that metropolitan Lima-Callao is home to 86 percent of the country's reported AIDS cases. The vast majority (83 percent) of Peru's AIDS cases have occurred among the economically active 20-to-49 age group. The prevalence of AIDS cases among people in this group suggests that many Peruvians are infected during adolescence. Almost 95 percent of HIV/AIDS infections are due to sexual transmission; blood transfusions or perinatal transmission account for the remainder. While men who have sex with men have experienced high rates of infection, increasing numbers of AIDS cases among women suggest that heterosexual transmission is becoming more common. The current male to female ratio of HIV/AIDS cases, based on cumulative reported HIV/AIDS cases, is 6:1.

Country Overview

Peru has one of the weakest public health infrastructures in Latin America. Access to health care is extremely limited and the health report-

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ing system is poor. Reliable epidemiologic and economic data are also limited. Despite the limitations of available data, however, Peru's HIV/AIDS epidemic is rising steadily and has become established among a cross section of Peruvian society.

As part of an effort to contain the growth of the HIV/AIDS epidemic in Peru, USAID/Peru is designing the SIDAYUDA results package. The goal of the package is to raise the awareness and commitment of Peruvian political leadership to encourage a coordinated, multisectoral response to the epidemic. AIDSCAP was requested to assist in the design of this prevention effort.

Accomplishments

AIDSCAP completed an epidemiological computer modeling of the HIV/AIDS epidemic, as well as a rapid assessment of its socioeconomic impact of the epidemic. This assessment was based on a review of existing epidemiologic, demographic, and economic data.

The projections of the study estimate that between 50,000 and 77,000 Peruvians were infected with HIV as of 1995. By the year 2000, this number could reach 180,000, and there may be as many as 230 new AIDS cases and 144 AIDS deaths per week in the country. By the year 2005, projections suggest that a total of 65,000 to 100,000 individuals will have died of HIV/AIDS. Because the epidemic is prevalent among individuals aged 20 to 49, many of whom have young children, the impact on the work force will be devastating both to the national economy and to individual families. Growing numbers of AIDS orphans will need to be cared for by grandparents or other family members. Orphans without families will place a burden on already strained public services.

The AIDSCAP report's primary recommendation is to strengthen Peru's national HIV/AIDS prevention effort by developing and increasing awareness of the magnitude and impact of the epidemic, in order to generate more support and resources for HIV/AIDS programming. The socioeconomic impact study data can be an effective tool for raising policymakers' awareness of HIV/AIDS and to develop and sustain support for comprehensive prevention interventions. This approach relies on the strategic dissemination of study findings and the presentation of reliable data. Using the HIV/AIDS impact assessment to develop a short- and long-term policy strategy can strengthen the commitment of policymakers and others who influence policy to increase resources for HIV/AIDS prevention and control.

Coordinated and comprehensive HIV/AIDS prevention interventions provide an opportunity to slow the growth of Peru's epidemic. The material and political commitment of Peruvian leaders to a comprehensive and multisectoral prevention strategy will contribute not only to slowing the growth of the epidemic, but also to reducing the negative impact of HIV/AIDS on families and communities throughout the country.

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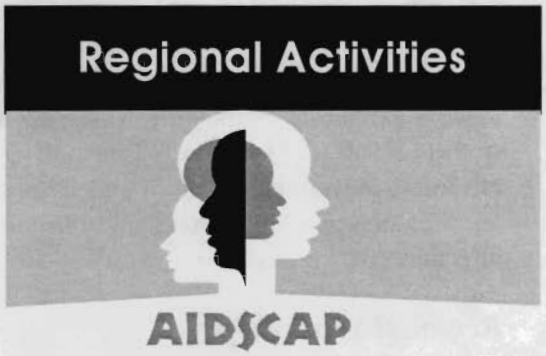
Regional Activities



Epidemiology

El Salvador, Nicaragua, and Costa Rica all share a border with Honduras, one of the countries with the highest incidence of HIV/AIDS in Latin America. Rapid increases in commercial traffic traveling the regional highways has resulted in a sharp rise in commercial sex work in towns close to the highways. This situation has, in turn, increased the risk of the epidemic spreading from Honduras into the other countries' border towns, then continuing on to the inner cities. Therefore, it was of utmost importance to raise awareness among policymakers of the possible consequences of an unchecked and ignored epidemic in order to stimulate the development of national policies in support of HIV/AIDS prevention programs.

Accomplishments

Socioeconomic Impact Studies

At the request of the USAID missions in the three countries, AIDSCAP conducted a series of socioeconomic impact studies in El Salvador, Guatemala, Honduras, and Nicaragua in collaboration with representatives from governmental and nongovernmental organizations (NGOs). The main purpose of the assessments was to prepare an overview of findings on the epidemiological profile of HIV/AIDS in the region. They also analyzed the response of the public and private sectors, NGOs, and international donors in confronting the epidemic. The results provided policymakers with concrete information about the potential impact of an HIV/AIDS epidemic in the region.

AIDSCAP's impact analyses raised awareness of HIV/AIDS as a multisectoral development issue, rather than merely a health issue. As a result of the impact assessment, USAID decided to make Honduras a priority country for prevention and control efforts under the AIDSCAP Project and

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secured commitment from the Government of Honduras. In addition, a video production in Honduras was used to initiate workplace prevention programs in the private sector. The study in El Salvador led to increased funding for HIV/AIDS prevention programs and to the creation of new workplace sexually transmitted infection (STI) clinics.

Regional Workshops

AIDSCAP sponsored several satellite meetings of the X Latin American Congress on STIs and the IV Pan-American Conference on AIDS in Santiago, Chile, during November 1995. These included an international media seminar implemented by the PANOS Institute and the Corporación Chilena de Prevención del SIDA (CChPS) and two workshops conducted by the Civil-Military Alliance to Combat HIV/AIDS and AIDS.

Journalists' Training

The objective of the one-day media seminar held by the PANOS Institute/CChPS was to promote accurate reporting of HIV/AIDS issues and to facilitate future contacts between the media and key individuals attending the conference. Twenty-three journalists from print and broadcast media representing 11 countries participated in the seminar.

Civil-Military Collaboration

The Civil-Military Alliance implemented two workshops in connection with the STD/AIDS conference. The first session's objective was to disseminate information on regional models that demonstrate the types of prevention activities possible through civil-military collaboration. The second meeting, Planning Session for Latin America and the Caribbean: Military and Civil-Military Possibilities, was attended by high-ranking representatives from seven nations' military and for civil institutions. The purpose of this session was to develop a strategy and work agenda for civil-military collaboration on HIV/AIDS prevention in Latin America and the Caribbean.

As a sequel to the Chile conference, the Civil-Military Alliance drafted a policy and strategy paper, titled "HIV/AIDS Strategy in Latin America and Africa: Military and Civil-Military Policies and Issues," to develop a framework for a collaborative civil-military HIV/AIDS agenda and to improve strategies for the operationalization of this agenda. The paper, which also examined the important role women play in the civil-military collaboration, was presented in Honduras at a July 1997 regional policy and strategy seminar on gender issues. It was disseminated to all participants in the Chile conference, all ministries of health and defense in the region, and leading NGOs, and was published in the Civil-Military Alliance newsletter.

Gender Initiatives

Perhaps the most significant step taken toward institutionalizing gender in AIDSCAP programs was the regional gender and STI strategy. In this three-tiered strategy, each AIDSCAP program in the region developed and implemented a high-impact STI research, intervention, or training pilot project, participated in gender training for senior managers to enhance gender analysis skills building, and ultimately participated in a 2-day regional conference for partner countries. This workshop was attended by 25 participants, including AIDSCAP senior management and implementing agency officials from the Dominican Republic, Honduras, Brazil, Bolivia, Peru, and Nicaragua. As a result, AIDSCAP staff who were establishing their own indigenous NGOs drafted gender value statements for these nascent organizations that communicated their organizational beliefs about gender. Regional guidelines were also developed for the implementation of gender-oriented STI/HIV/AIDS prevention activities. Finally, partnerships were established between Brazil and Bolivia, and between Honduras and Nicaragua to share lessons learned in gender-sensitive HIV/AIDS programming.

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Gender and STIs

As a part of the AIDSCAP Women's Initiative, the Centre for Development and Population Activities (CEDPA) trained the project's senior managers in the region with the knowledge and skills needed to facilitate incorporation of gender into STI/HIV/AIDS prevention activities. The three AIDSCAP resident advisors and three senior program officers participated in the 2-day gender and STI training in January 1997. The training focused on gender sensitization, analysis, and skill building, and on increasing technical knowledge, with particular emphasis placed on the implications of gender on STI awareness, treatment, and care.

Gender and STIs: A Participatory Approach

The principal goal of the AIDSCAP-supported project implemented by the Asociación de Municipios de Honduras (AMHON) was to increase women's power to make decisions about their reproductive health, especially with regard to STI/HIV/AIDS prevention, by training 50 women in leadership and reproductive health. A central component of this empowerment was to strengthen women's knowledge, attitudes, beliefs, and practices (KABP) surrounding STI/HIV/AIDS. Projecto Mujer also sought to raise awareness of gender issues in STI/HIV/AIDS prevention among the staff at nearby health clinics.

This project succeeded in integrating STI/HIV/AIDS education with AMHON's other leadership and training activities. In order to design the training, AMHON carried out a qualitative study examining sexual decision making, access to and perceptions of reproductive health services, and KABP regarding STI/HIV/AIDS. The researchers conducted focus groups with a total of 55 women. Seven indepth interviews with key informants provided more detailed information on these issues. In addition, AMHON conducted a survey of 260 women attending MOH clinics.

The qualitative data provided valuable insights into some of the constraints facing women as they seek access to reproductive health care services and try to protect themselves from STI/HIV/AIDS. Data indicated a relatively low level of knowledge regarding many reproductive health issues. Participants and their male partners had little knowledge, not only of STI/HIV/AIDS, but also of reproductive events such as the menstrual cycle, contraception, pregnancy, and menopause. The survey data also provided feedback on the perceived quality of local reproductive health services and suggested ways to improve them. Many women surveyed felt that obstetrical care was particularly inadequate.

Workplace Prevention

AIDSCAP supported the Mexican Federation of Private Health and Community Development Associations (FEMAP) to improve HIV/AIDS prevention services for *maquiladora* workers in the Mexican border city of Juárez. In a previous phase of the project, peer health educators had been trained in five *maquiladoras*. At the end of the first year, labor problems required FEMAP to withdraw activities from one of these *maquiladoras* and initiated activities in another *maquiladora*. The renewal of the project focused on consolidating the network of 60 peer health educators, which reached 3,515 workers at any one time. Activities were aimed at increasing peer health educators condom sales and prevention communication skills. During the project, 19,930 condoms were distributed.

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