

HIV/AIDS

FHI/UNAIDS BEST PRACTICES IN

PREVENTION COLLECTION

EDITED BY BUNMI MAKINWA AND MARY O'GRADY

Fhi



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Authors may be reached by contacting Family Health International for the current contact information.

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Family Health International HIV/AIDS Prevention and Care Department, 2101 Wilson Boulevard, Arlington, VA, 22201, USA
Telephone: 1-703-516-9779 Fax: 1-703-516-9781 E-mail: mogrady@fhi.org Internet: <http://www.fhi.org>

UNAIDS 20 Avenue Appia, 1211 Geneva 27, Switzerland
Telephone: 4122-791-4651 Fax: 4122-791-4165 E-mail: unaids@unaids.org Internet: <http://www.fhi.org>

Designed by Gensler, Washington, DC

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THE CALL TO PREVENTION ACTION

The spread of HIV continues unabated in all regions of the world.

We have seen the epidemic shattering individual lives and devastating communities. More and more, we realize that HIV/AIDS threatens the security, stability and development of whole regions, destabilizing already fragile economic and social systems.

Despite the devastating impact of this epidemic, the beacon of hope remains. For we have seen that prevention efforts, applied with collective resolve and boldness, can and do stop the spread of HIV infection. National governments and civil society must become increasingly and zealously engaged in HIV prevention and care, because sustained and comprehensive actions are needed, both to care for the 36 million people now living with HIV and to minimize those joining their number in the future.

To this end, prevention must remain a priority—prevention that goes beyond individual behavior change. Our prevention programmes must address the root causes of the epidemic—the social and economic factors that make women, men, and children vulnerable. Reducing obstacles to basic education, information on reproductive and sexual health, access to primary health care, and economic opportunities are central elements in HIV/AIDS prevention programmes.

We can and we must focus much greater attention on reaching out urgently to increase HIV prevention awareness and knowledge, introduce and support risk reduction behavioural and social change, foment positive and safe sociocultural norms, build solid national and transnational infrastructures, as well as share resources worldwide to reduce poverty as a driver of the epidemic.

In recognition of the vital role of prevention, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Family Health International (FHI) are publishing the Family Health International/UNAIDS Best

Practices in HIV/AIDS Prevention Collection. Encompassing a broad body of knowledge and expertise, this book is centered on HIV/AIDS prevention in the non-industrialized world. This collection is based on the six years of work performed by FHI's international and local partners in the world's largest single international HIV prevention initiative to date, the AIDS Control and Prevention (AIDSCAP) Project. It offers a substantial number of models that may be replicated around the world.

During its years of operation, from 1991 to 1997, AIDSCAP managed and supported more than 800 HIV/AIDS and other sexually transmitted infection (STI) prevention programmes in 50 countries through funding by the United States Agency for International Development (USAID). From this group of interventions, 20 initiatives have been chosen that are considered to be of global importance for dissemination through a case study approach. These case studies will be useful to individuals, communities, municipalities, non-governmental organizations, businesses and governments. And, these 20 state-of-the-art "best practices" from the

1990s still represent in the year 2000 some of the most innovative, effective and comprehensive approaches to HIV prevention that have been implemented in non-industrialized countries to date.

The case studies in this collection cover a range of different issues that includes training in the management of sexually transmitted disease (STD) syndromes for health workers treating STIs, refining the communication skills of outreach workers, and training business managers in cost-effective HIV prevention programming. These local initiatives have a proven track record as catalysts for change and offer global lessons, expanding our knowledge of what does and also does not work in HIV/AIDS and sexually transmitted infection prevention programming.

The hallmark of these programmes is that individuals have made a difference. We trust that you will distill the lessons for yourselves and carry the banner of prevention forward.

A handwritten signature in black ink, appearing to read "Robert Baughman". The signature is written in a cursive style with a horizontal line above it.A handwritten signature in black ink, appearing to read "Niall". The signature is written in a cursive style.

HIV/STI interventions in a refugee camp should begin with an unwavering commitment to the principle that it is unethical not to provide protection against disease transmission, especially in cases where the population is already known to have a high HIV prevalence, as was the case in Rwanda.



HOWARD J. DAVIES/PANOS PICTURES

RWANDAN REFUGEES RETURN HOME IN 1996 FROM CAMPS IN TANZANIA, THEIR TEMPORARY HOME SINCE 1994.

HIV/AIDS PREVENTION AND EDUCATION FOR REFUGEES: IMPLEMENTING EFFECTIVE EMERGENCY PROJECTS

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HIV/AIDS PREVENTION AND EDUCATION FOR REFUGEES: IMPLEMENTING EFFECTIVE EMERGENCY PROJECTS

INTRODUCTION

This case study seeks to provide a step-by-step approach to instituting an emergency HIV/AIDS intervention programme for refugees, using available best practices. The approach reflects the experience gained from the AIDS Control and Prevention (AIDSCAP) Project intervention for Rwandan refugees in the Ngara district's refugee camps in northwestern Tanzania, which ran from mid-1994 until December 1996.

The rapid onset of the Rwandan refugee crisis and its vast scope, violent ethnic origin, degree of global attention and other factors combined to form a unique situation that set this project apart from previous HIV/AIDS interventions. The project evolved over time as circumstances changed, but its flexibility and design make it replicable in most refugee situations.

The “best practices” discussed in this case study pertain to the practical considerations in mounting a quality programme—one that satisfies the needs of a refugee population—during an emergency. By their very nature, emergency situations do not afford project managers the luxury of time to design and implement programmes. Project managers need guidance in preparing for the basic elements and situations they are likely to encounter so they can take necessary steps

expeditiously, in a logical order, and to an extent appropriate to each situation.

This case study recounts the project's context, the challenges of instituting an effective HIV/AIDS intervention, and the results of the programme. It then recommends 20 specific steps for launching an emergency HIV/AIDS intervention, in the approximate order in which they should be taken, and ends by discussing sustainability, ethical considerations and lessons learned.

BACKGROUND

When civil war broke out in the spring of 1994, hundreds of thousands of Rwandans fled to neighbouring countries and over half the population became internally displaced. Refugees streamed into hastily constructed camps, and diseases—including HIV/AIDS—inevitably followed them. It is estimated that at the peak of the exodus, more than two million Rwandans were living in refugee camps neighbouring their country.

With the continuation of hostilities and no immediate sight of a resolution to the Rwandan crisis, the United States Agency for International Development (USAID) requested that Family Health International's AIDSCAP

Project support HIV/AIDS-prevention programming for the Rwandan refugee population in Tanzania. Funds were shifted from the AIDSCAP's programme in Rwanda to respond to the newly created needs of the Rwandan population in exile. AIDSCAP selected CARE International as the lead agency to manage the intervention and subcontractors John Snow International (JSI) and Population Services International (PSI) to provide additional assistance in needs assessment/evaluation and condom distribution and promotion respectively.

Four months after the exodus began, CARE launched the HIV-prevention project, staffed almost entirely by refugees. The conditions of refugee life in the Ngara camps, 18 kilometres from the Rwandan border, greatly increased the risk of exposure to HIV and other sexually transmitted infections (STIs). The demise of social structures and mores, loss of homes and jobs, overburdened health care resources, instant urbanization, overcrowding and a burgeoning commercial sex trade all led to increased risk-taking behaviour among the refugees. Women and adolescent refugees, vulnerable to violence, rape and coercive sex, were at especially high risk.

IMPLEMENTING THE PROGRAMME

When the intervention project team—consisting of the CARE project director and the PSI project manager—arrived, the project's target population in the Ngara camps was estimated at 100,000. This number grew to 165,000 in just a few months. Given the high estimates of HIV prevalence in Rwanda and the knowledge that the results of an ongoing KABP (knowledge, attitudes, beliefs and practices) survey would not be available for several months, the team

decided to begin work immediately without the benefit of accurate baseline data.

Lacking structural facilities, the team set up an office in a tent and hired a furniture maker to construct tables and benches. The project design called for the employment and training of refugees as community outreach workers, later known as AIDS Community Educators (ACEs). The ACEs were meant to cover the camp at a ratio of one educator to every 1,000 adults. PSI's condom promotion and distribution segment called for approximately 25 “promoters.”

The team posted a ‘help-wanted’ notice outside the CARE/PSI tent and at the food distribution centre—the fastest way to attract refugee workers. Anticipating a large turnout, the team was prepared to handle around 300 to 400 people with staff borrowed from the food distribution team. The next day more than 2,000 refugees showed up to apply for the positions, but the food distribution staff's experience in handling and processing large crowds eased the tension.

Identifying qualified and trustworthy staff turned into a major challenge because of the refugees' lack of income opportunities and consequent desire for employment. No matter what qualifications the posted jobs required, it seemed each applicant had them. Often the résumés were identical other than they bore different names. (It was later discovered that an enterprising teacher ran a résumé service in the camp.) Within a week the project had selected three trainers, four condom promoter supervisor/trainers, one counsellor trainer and five counsellor trainees.

The project director and project manager provided the training for the supervisors and

trainers over a two-week period. The lack of training materials and educational information in the Kinyarwanda language, however, presented several difficulties. The project hired a team of refugee artists to draw posters and illustrations for the training manuals, and a wood carver produced 150 wooden penis models for condom instruction. The trainers and supervisors assisted the project director and manager in writing the training manuals for the ACEs and promoters.

The next task was to identify candidates for the ACE and condom distribution training classes. This proved to be a tedious and lengthy process of elimination. First, résumés were reviewed, sorted and ranked. The trainers recalled the top choices and selected twice the number of applicants as positions were available. The trainers administered a brief ten-question test, and the questions eliminated those who lacked minimal knowledge of anatomy and could not identify three signs of HIV and STIs and three routes of transmission. The trainers agreed on acceptable scores for trainees. Candidates were told that those who received the highest test scores would be given the jobs. This method turned out to be acceptable to the applicants, and those who passed were eligible for the two-week training course.

The training programme was divided into three sections to keep the classes a manageable size. The ten-question test results provided useful insights into the level of knowledge about HIV and STIs. At the end of the course the trainers administered a 20-question examination to ensure the competence of all ACEs and condom promoters.

During the training period the project director prepared the refugee community for the programme by holding small meetings with the

community leaders, religious and women's leaders and other refugee outreach workers. Interestingly, all of these groups readily accepted the need for the intervention, as Rwanda's HIV/AIDS control programme had raised community awareness of HIV/AIDS prior to the refugee crisis.

After the refugee community had been informed, the project director met with each relief organization to explain the objectives and activities of the project. In the close confines of a refugee camp, good coordination and cooperation with other implementing agencies is essential for a successful outcome. More than 40 international agencies were implementing programmes in the huge Rwandan camps. Programme activities overlapped into several sectors—health, maternal/child care, community services, water and sanitation—which enabled different programmers to cross-train outreach workers.

The project also partnered with other nongovernmental organizations (NGOs) to address rape, a major problem exacerbated by the need for women and girls to leave the camps to search for firewood. The collaboration resulted in the formation of crisis intervention teams (CITs) made up of refugee volunteers trained by the NGOs to provide support for victims. CIT members acted as mediators for the victims and became the first line of response in rape cases.

Once the programme was up and running and coordination was established with other agencies, the project director and manager turned their attention to overseeing the day-to-day activities of the project. The AIDSCAP CARE team grew to 100 ACEs, 14 counsellors, one community service staff member and three trainer-supervisors. The AIDSCAP PSI team consisted of 25 promoters, one manager, one

supervisor/trainer, a sports events manager and an audiovisual technician. Handling logistics and monitoring and evaluation proved to be the most difficult tasks in the daily management of the large refugee programme staff.

Midway into the project, ACEs on home visits discovered a large number of people with AIDS symptoms who were too ill to care for themselves. This led the project to set up a home-based care service using refugee volunteers supervised by a refugee social worker to provide water and cooked food and to take patients to the hospital when needed.

The refugees sometimes took advantage of the organizations for which they worked by making unreasonable demands, such as refusing to work unless they were picked up and driven to and from their assigned territories. The project distributed bicycles to the supervisors, counsellors and promoters whose jobs required them to travel regularly among the three camps. During the rainy seasons the refugees refused to carry out their work visiting individual families unless they were provided with raincoats, umbrellas and rain boots. The project paid the staff on a scale established by the United Nations High Commissioner for Refugees (UNHCR); the rules stipulated that a refugee could hold only one job, but a number of workers were receiving salaries from several different agencies.

Keeping trained staff also proved challenging. Other agencies readily recruited workers—especially those who had already been trained. Sometimes agencies violated UNHCR rules by offering higher salaries. This practice was especially prevalent among agencies with short-term projects, and this issue dominated discussions at a number of coordination meetings. Mostly,

however, the agencies coordinated their activities well, sharing data and survey findings freely and scheduling events to avoid conflicting agendas.

Other agencies also participated in numerous AIDSCAP-sponsored sporting events and community entertainment activities at which promoters and ACEs brought their messages and materials to large crowds. The weekly soccer games and inter-camp tournaments drew crowds as large as 10,000 and involved participants from all agencies. Using enjoyable and popular activities as vehicles for promoting messages about safer sex, the project turned a sensitive topic into a familiar, if not comfortable, issue.

HIV/STI-PREVENTION RESULTS

Limitations of Data Overwhelming controversy (not to mention logistical problems) prevented the AIDSCAP Project in Ngara from taking direct measurements of HIV prevalence within the camp populations. Baseline statistics on HIV prevalence consisted of data taken from the Rwandan population before the crisis erupted in 1994. Quantitative data recorded during the project measured process indicators of project achievements. These included: knowledge, attitudes, the number of condoms and IEC (information, education and communication) materials distributed, the number of educational and counselling sessions held, and how many persons were trained. Data regarding behaviour change for preventing HIV infection relied on self-reports, as recorded by JSI in a baseline KABP survey conducted in August and September 1994. A follow-up survey was conducted almost a year later, in July 1995. Plans for a final survey in early 1997 were cancelled when the Tanzanian Army

evacuated the camps in December 1996 and forced the refugees to return to Rwanda.

Throughout the project, focus group discussions and in-depth interviews were used to provide a rich and detailed understanding of situations in the camp. Such qualitative information proved more valuable and informative than the quantitative results from the surveys. Survey data in the camps suffered from numerous problems, including: over-counting of refugees to exaggerate food and service needs; deliberate misrepresentations, sometimes owing to suspicions of the surveyors' motives or disagreement with perceived programme objectives; improper or incomplete administration of the survey instrument; and, organized interference with the conducting of the survey. The quantitative survey data, therefore, provide a less rigorous indication than their levels of statistical significance indicate, but are useful for a rough quantitative analysis.

It should be noted that the total population of the Ngara camps numbered more than 300,000 refugees. To establish baseline data for refugees under the project's management, 559 refugees (aged 15-49) were sampled from among the 165,000 refugees within the project implementation areas. After 12 months, the study team conducted a follow-up survey among the same population of 165,000 refugees. The follow-up survey carried out in June 1995 sampled 484 people using the same questionnaire and methods as in the baseline survey: this slightly smaller sample was well within acceptable statistical standards to produce a valid comparison. Teams of trained refugee surveyors solicited verbal responses during house-to-house visits. Although the population

within the project's implementation areas changed as more refugees arrived in the camps, baseline and follow-up residents remained comparable with respect to age, sex, education level and religion.

Programme Effects A comparison between baseline and follow-up surveys reveals effects that could well be attributed to the project. Knowledge of HIV/AIDS prevention was already at a high level before the intervention, which may explain why no significant changes resulted. At the time of the baseline measurement, 87 per cent of the respondents could mention at least two effective ways to prevent HIV infection. This figure changed to 85 per cent at follow-up, which was not a statistically significant difference. All categories of incorrect beliefs about HIV transmission declined, however, during the intervention period. These categories included misconceptions about contracting the disease from touching or sharing utensils with people with AIDS, using public latrines, or being bitten by mosquitoes. In addition, the proportion of respondents who were aware that healthy-looking people could carry HIV showed a statistically significant increase (from 81 to 87 per cent).

Despite the apparently high levels of knowledge and awareness, however, risky behaviour changed relatively little. No statistically significant changes were observed in the proportion of respondents answering that they had "ever used" condoms, which remained low at 37 per cent for men (from a baseline of 35 per cent) and 17 per cent for women (from a baseline of 13 per cent). Reported use of condoms during the most recent intercourse

remained at the same low level of 16 per cent for men, but increased from 5 per cent to 17 per cent for women. The condom use reported by the refugees was comparable to that reported by KABP surveys done in Rwanda prior to the refugee crisis.

The low rate of condom use cannot be explained in this case by a lack of condoms. Within a 12-month period, the project distributed 1.4 million condoms, and the surveys indicate that condom accessibility increased from 52 per cent to 95 per cent for men and from 42 per cent to 85 per cent for women, exceeding the targets set for the intervention. A total of 95 per cent of sexually active men and 85 per cent of sexually active women reported having access to condoms. The surveys revealed one alarming finding, however: attitudes towards condoms became more negative during the intervention period. Among those who did not use condoms, as many as 82 per cent did not propose the use of condoms to their partners because they felt condoms were associated with promiscuous behaviour. This figure contrasts with 29 per cent who held this attitude at the time of the baseline study.

Concurrent with findings of low condom use, the study also revealed increases in sexual activity, especially with multiple partners. More women were found to be sexually active at the time of the follow-up study (87 per cent, versus 79 per cent at baseline), and the proportion of women who had had more than one partner during the previous two months increased to 16 per cent (from 2 per cent at baseline). The proportion of men who had had more than one partner during the previous two months increased from 12 per cent to 23 per cent.

Perhaps more significantly, changes in sexual partnerships increased during the intervention period: 38 per cent of the sample reported having changed sexual partners during the course of the last year, compared to 23 per cent the year before (figures significant at the 95 per cent confidence level).

One can interpret these results in a number of ways. New patterns of dependency and distribution of wealth occurred in the refugee camps, especially during periods in which food distribution was insufficient for some groups. These patterns may have had an impact on sexual networking. In the many households headed by females, women engaged in frequent risk-taking behaviour, such as exchanging sex for food and protection. The heavy consumption of alcohol by the refugees may have contributed to short-term pairing and increased sexual activity. Moreover, a widespread propaganda campaign instigated by young Hutu men to increase the population of Hutus (even though the genocide by Hutus decreased the population of Tutsis) influenced refugee leaders to pressure men to impregnate as many women as possible. Condom use was discouraged as being counterproductive to their goal of increasing births.

Several marked differences in the demographic variables at baseline and at follow-up may provide clues to changes in sexual behaviour. Data supporting anecdotal information in this area are scant, and additional research would add to the knowledge of how all these factors influence behaviour that puts people at risk of HIV and other STIs. The net result of the intervention, therefore, can easily become confused, exaggerated or otherwise misperceived among the tangle of variables inherent in an

emergency refugee situation. Causality is beyond the means of anything short of a fully controlled study, which this refugee HIV/AIDS-intervention efforts could not provide.

EMERGENCY REFUGEE HIV/AIDS

INTERVENTION: 20 ESSENTIAL STEPS

The following 20 steps are designed to guide programme managers in planning and delivering HIV/AIDS prevention and education in the context of an emergency refugee relief project. Depending on the exigencies and circumstances particular to a given case, these steps or the order in which they occur may need to be modified. Time and circumstances permitting, many of the steps can and should be taken simultaneously, to advance with all possible speed.

1. **Review relevant literature and demographic and epidemiological data** to determine the extent of problems. The literature will help you design a preliminary strategy that will later be sharpened by first-hand knowledge gained from personal observations, focus group discussions and in-depth interviews. Understand the culture of the people you intend to help: there may be certain practices that conflict with your HIV/AIDS-intervention programme.
2. **Assess community health.** The refugee population you are dealing with is not the only population that concerns you: the local residents of the host country will be affected by the influx of refugees. Benchmarks are necessary for both refugee and local populations in order to know how your project is affecting people inside and outside the refugee camps. Assess the capacity of existing local health services and identify opportuni-

ties to tie into or coordinate with them. Also, make appropriate arrangements for local hospitals and clinics to be used as referral facilities for complicated and emergency procedures for the refugees.

3. **Inform other agencies** of your programme and enlist their cooperation and support. This step is crucial to the success of your programme. In the Ngara camps, the UNHCR medical coordinator reviewed and approved the STI treatment protocol. The UNHCR also held regular coordination meetings, during which project managers from all agencies discussed their programmes and arranged their events to avoid conflict. In a large refugee relief programme, you are likely to encounter many people from whose ideas and experiences you can benefit. The perspectives you gain from managers of other projects are vital to helping you determine what is likely to be successful (or possible) in your own project. Roads, electricity and other infrastructure and support can accommodate your project best if you let people know as early as possible what your needs are and what you plan to do.
4. **Identify refugee leaders** and influential community members, inform them of your project and enlist their help and support. The initial chaos of refugee influx into the camps may make this step difficult. Coordinate with other agencies to find out what information they have about the refugee population and meet with community leaders as soon as possible. Special efforts are needed to identify and meet with women leaders in the community.

Influential members of the refugee community can determine the success or failure of your project; stress that your organization is working in partnership with them for the health of their community.

5. **Obtain necessary supplies** (e.g., condoms, poster board for signage) and training materials from headquarters. Sometimes this will not be possible; modification of materials/supplies/methods is inevitable. It is also vital to establish appropriate storage/warehousing facilities and an inventory system for all project materials and supplies, as well as a method for regular delivery of products and services.
6. **Conduct focus group discussions and in-depth interviews** to clarify terms and deepen your understanding of important issues and social dynamics within the camp. This information will be vital when formulating an effective survey instrument and method of administering the survey. The information you get from the initial focus groups and interviews should have a definite purpose: to design the initial baseline survey to achieve meaningful results. Anticipate problems in reaching certain groups with your information and health materials. Concentrate particularly on unaccompanied minors and adolescent refugees, who are especially susceptible to HIV and often fail to receive attention in refugee relief programmes.
7. **Recruit and train refugees** to work as project surveyors and community educators. Your education efforts in the camp will need to branch out, so you should do a “training of trainers”—select trainers and translators to train a team of community educators. Conducting a baseline survey, however, should be their first project. In addition to collecting baseline data, your team should do periodic informal evaluations of the project’s effectiveness.
8. **Analyze results of baseline surveys.** When the analysis is completed, disseminate and discuss the findings with your project staff to, among other things, identify vulnerable groups, such as single women, women without husbands, adolescents and sex workers.
9. **Equip your team with the necessary materials and supplies.** Have a ready budget for emergency supplies, incentives, salaries and promotional events to begin your project. Devise a distribution system that is efficient and that concentrates not only on output but also on outcome. Handing out hundreds of thousands of condoms and leaflets—or even increasing knowledge—is not the final goal; deliberate and purposeful behaviour change is.
10. **Develop an ongoing calendar of activities** for your community educators to encourage innovative approaches to education and timely dissemination of materials and messages. Devise motivational techniques (e.g., poster contests, T-shirt and project logo design contests, painting of wall murals) for your team of educators, health workers and distributors to maintain morale and momentum in the face of inevitable (and probably mounting) challenges.
11. **Implement community activities** (soccer games, sport events, dances, inter-community competitions) to familiarize

all sectors of the refugee community with your messages in the context of enjoyable events. Associate your project with positive aspects of life in the camps, and if there are not many, create them.

12. **Establish monitoring indicators** such as an increase in distribution or demand, numbers of people seeking treatment for STIs or even prevailing attitudes in the camp regarding rape and sexual violence. Discuss with your team and with other agencies how to respond to rape, sexual violence and coercion that can put victims directly or indirectly at higher risk of HIV infection and other STIs.
13. **Set time-linked objectives** regarding your project goals as well as team members' individual performance. Make sure worker objectives are consonant with project objectives.
14. **Provide—or coordinate with agencies to provide—clinical and curative treatment** concurrently with education. Collaborate with health and sanitation workers, and cross-train workers so that they know how health, sanitation and education concerns inter-relate.
15. **Establish a home-based care programme for the terminally ill.** You may find an apparently rapid onset of AIDS cases after the programme has operated for a while. Many of those already sick with AIDS may have been too weak to flee to the refugee camps, artificially lowering the prevalence of the disease. Prepare for this eventuality as early as possible.
16. **Find and train counsellors** from the refugee community to deal with the trauma of STIs and decimation of the community from AIDS.
17. **Conduct periodic follow-up surveys** as needed to steer the project towards more effective operation based on quantitative indicators. Periodic surveys can show changes in the population over time. Always complement quantitative data with information gained from qualitative methods (focus group discussions, interviews); quantitative analysis may miss vital aspects of the situation.
18. **Continually conduct focus group discussions** to address needs and concerns within the community on issues pertaining to health. Intervention projects are dynamic, and as situations change, so do information requirements. Remember that focus groups not only help you to learn about the refugee community but also allow the refugees to think and talk about issues that affect them. Focus groups may sometimes be the only forum in which refugees can openly discuss sensitive issues in a comfortable, non-threatening atmosphere.
19. **Report findings to other agencies** and to the host government when appropriate to maintain good working relations and permit efficient collaboration. The best HIV/AIDS prevention project is a holistic one, because the disease affects nearly every aspect of life. A cooperative spirit and collaborative approach with agencies operating in other sectors of the relief effort will enhance your project.
20. **Get external evaluation** (formal 12-month reviews) to validate practices; share evaluation results with your team of workers. Positive evaluations can motivate your team, as can avoiding the prospect of a negative evaluation. Base incentives partly, but not entirely, on external evaluations.

DISCUSSION

Sustainability Are projects that are implemented in refugee camps sustainable? By definition, refugees are populations in motion, unstable and with uncertain futures. Their three main options are repatriation to their home countries, resettlement in the country of asylum, or resettlement in a third country. For many refugees, the period of limbo may span a generation or more, as in the case of Afghan refugees living in camps in Pakistan.

When “sustainability” is discussed in the context of development, it connotes a degree of ownership, a “buy in” by the governing agents or those holding authority in a community. Such a sense of ownership, however, seldom occurs in a refugee setting. Terms must be redefined for refugees. The “community” becomes the refugee camp, although some researchers reject this notion. Since refugee camps are not intended to be permanent, sustainability of HIV/STI interventions in the refugee setting is often defined in the context of individuals changing their behaviours towards safer sexual behaviour. Thus, sustainability is far from an absolute.

Social disruption, including war and internal displacement, brings dynamic change, not only in the structure of the community but also in gender roles. The so-called ‘governors’ of social behaviour, who keep people following established rules and norms, fall by the wayside in refugee camps. The disrupted social order may actually be conducive to positive behaviour change because people are more susceptible to change when they have been shocked or jolted. It may, however, have the opposite effect; sometimes only an educated guess can be made as to the outcome of such disruption.

In the case study of Benaco and Musahura Hill camps in Ngara, Tanzania, efforts were made to engage the communities’ ownership of the HIV/STI-prevention project by involving people of multiple age cohorts—adolescents, young men, young women, older adults—as well as church leaders, merchants, teachers and farmers. Over the two-year life of the AIDSCAP Ngara project, the refugees constituted a ready and “captive” audience. The sustainability of the project relied on the “captive” nature of the audience, but the sustainability of the project’s ultimate objective—behaviour change—did not. Project managers should therefore plan for and discuss with their team how the project’s objectives can continue, even after refugees leave the unnatural context of the camp or when relief agencies eventually terminate their programmes.

One such way to promote sustainability is to provide whatever materials may be necessary for the desired behaviour change, such as condoms for safer sex, or to work with the intended population to develop a variety of motivations for adopting the desired behaviour. The project also had to consider its own sustainability—its ability to continue providing condoms and other supplies for the refugees. PSI, an organization known for its social marketing of health products around the world, has contemplated instituting a phased-in social marketing of condoms as a market economy establishes itself in camps. However, in the Ngara camps, the intervention programme did not get around to social marketing condoms for a variety of reasons, including an early lack of income-earning potential among the refugees. Andreasen (1995) defines social marketing as “...the application of commercial marketing technologies to the analysis, planning, execution

and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society.”

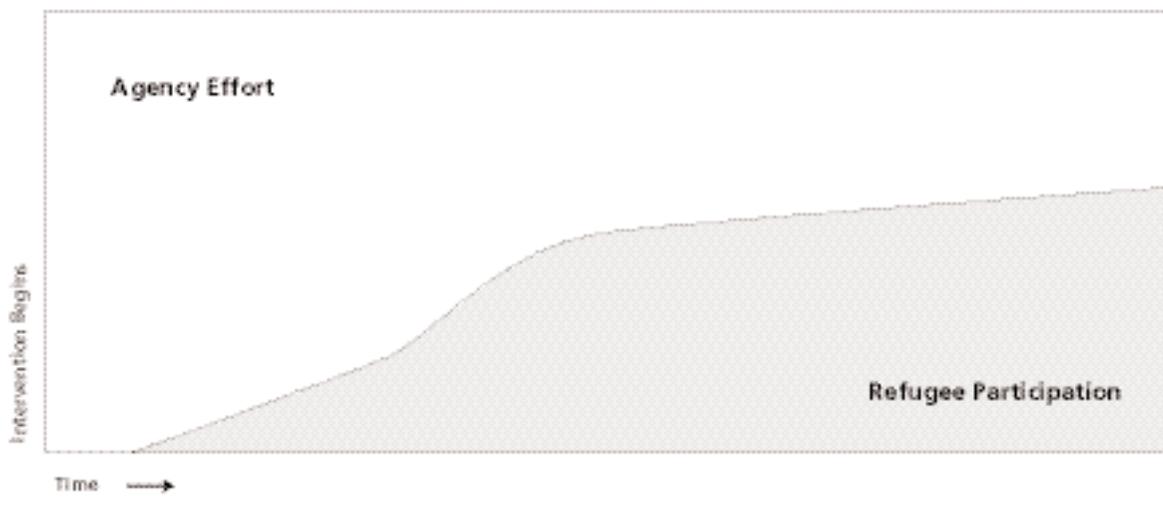
The programme for condom distribution had to rely entirely on donated materials and the continuing support of the PSI supply system, which was not sustainable in the long run. Moreover, the absence of even a nominal price for the condoms given to the refugees led to extensive waste, which arguably would not have happened if people had had to buy them. Free distribution of condoms also gave a much less accurate indication of actual condom use than marketing would have. In later months, the continuation of the condom distribution project was in perpetual jeopardy due to questionable supply and the total reliance on PSI and CARE.

Sustainability thus speaks directly to the division of responsibility and effort between

the agencies and the refugee community. How much should each contribute in order to maximize the motivation of the refugees to participate in and pursue the project’s objectives: controlling or reducing the spread of HIV/STIs through behaviour change? The answer to this question is unique to the refugee situation at hand, although the Ngara camps’ experience shows that the division of responsibility changes over time. The figure below represents graphically the experience of the Benaco and Musahara Hill camps within Ngara, in which the refugees’ participation in the project grew from essentially none at the onset to a good deal in mid-project, but then levelled off. The rectangle represents the sum of project efforts and how this was shared over time (see Sidebar 1, below).

SIDEBAR 1

Key findings of new ERA’s simulated client survey



In one aspect of the project, however, the refugees did take responsible and almost complete ownership: the sports events at which promotion and distribution of condoms took place. The project team members worked with the refugee community and created a very popular sports league that held regular soccer and volleyball games at which the health workers and condom distributors worked the crowds, handing out materials. Half-time events at the games (which drew crowds estimated at 10,000) incorporated messages about HIV/STI prevention and treatment, cleverly worked into popular skits and musical performances. The sports league clearly showed a resurgence of community pride, and the intervention project was able to associate itself with a positive aspect of camp life—one the refugees had made their own. Sustainable HIV/AIDS intervention projects need to be associated with a sense of community, hope and pride, and nothing illustrated this better than the sports league and the dances and skits held at half-time during the games.

Ethical Considerations HIV/STI intervention in a refugee camp should begin with an unwavering commitment to the principle that it is unethical not to provide protection against disease transmission, especially in cases where the population is already known to have a high HIV prevalence, as was the case in Rwanda.

Frequently during the course of the intervention, the continuation of the project—and the whole relief programme for the refugees—was in jeopardy. During these times, the decision was made not to divulge this information to the refugees. Such a lack of “open communication” does not accord with

a typical conception of partnership, which is what the intervention project tried to establish with the refugee community to encourage its participation. Openly discussing the relief programme’s tenuous status, however, may well have led to riots in the camps. This example shows just one aspect of the need to balance opposing objectives in the best interests of the community. It also shows that the locus of control lies invariably in the hands of the agencies implementing the intervention project, no matter how desirable refugee community participation may be.

Although condoms were not marketed, there were plans to institute a pricing structure to do so. Before any such steps can be taken, however, one must ensure that even the most nominal of prices would not prevent some people without incomes from purchasing a condom, which—given the assumed prevalence of HIV and STIs in the camp—could have terrible consequences.

LESSONS LEARNED

Many lessons were learned during the two-and-a-half-year Ngara project. For example, latrines were first built far from dwellings, and a number of women and girls were attacked and raped inside or on their way to the latrines. This problem demanded a structural solution, and latrines were relocated closer to dwellings. Camp management instituted a system of four-family latrines, giving the families responsibility for their maintenance. Reports of attacks subsequently declined.

Focus group discussions with male community leaders and with young men increased sensitivity to gender violence and sexual abuse, and the refugee community

began to take more responsibility for preventing such abuse. The HIV/STI intervention used focus groups extensively, not only to gather information about the refugees but also to give participants opportunities to discuss issues and gain a greater understanding of their own community.

The intervention project also found that there are limits to the goal of increasing refugee participation. At the start of the project, the implementing agencies must move the project forward as quickly as possible, which may mean postponing efforts to gain maximum refugee participation. The chaotic circumstances at the onset of a refugee crisis require an orderly, agency-driven effort for a period of time before the refugees can begin to make a meaningful contribution and start to assume “ownership” of various project activities.

Refugee participation is linked to greater programme self-sufficiency, but there may be limits to how much self-sufficiency the refugees can achieve. In the Ngara camps, the Tanzanian government’s rules initially did not allow refugees to plant vegetable gardens (because planting implies land ownership and permanency). Food, health services and supplies were all donated, and the relief programme was constantly in danger of having this vital supply line interrupted.

Programmes to create self-sufficiency of the refugee population and to institute social marketing of condoms could relieve the dependency on external donations and make projects more sustainable. Supplies of condoms might be given free at first (for ethical reasons) until a market economy forms within the camps, and this takes a surprisingly short time to happen. A programme for instituting even the most

nominal price structure might lead to equitable and more efficient distribution of condoms and other materials, with measurable results in use and with less waste. Free goods are often thrown away or squandered. Adequate supplies of condoms and other health aids must also be accompanied by appropriate behaviour change messages, especially with the support of influential leaders among the refugees.

Agencies also encountered limits to what they could accomplish. In the Ngara camps, rules required that all relief agency workers exit the camps by sundown. Efforts to use video within the camp thus had to be adjusted because the rear-projection screens CARE and PSI had received for their video project could not be used in the bright daylight. Instead, the video project had to wait until mud buildings could be constructed to provide enough darkness during the day for viewing a screen. Instead of showing a video to thousands at a time, the project had to show videos on a television screen to a small room of people. Agencies should defer to the hands-on knowledge of field staff working in trying conditions, support them with appropriate materials and respond with flexibility to changing demands.

Intervention projects must work hard at maintaining high morale among agencies and in the refugee camp in order to achieve effective results. To this end, special events, sports, drama and the use of video for education and entertainment should form a major part of any health communication strategy in refugee camps. Above all, the health intervention project should associate itself with positive aspects of camp life and be a source of pride and hope for the refugee community.

AUTHORS

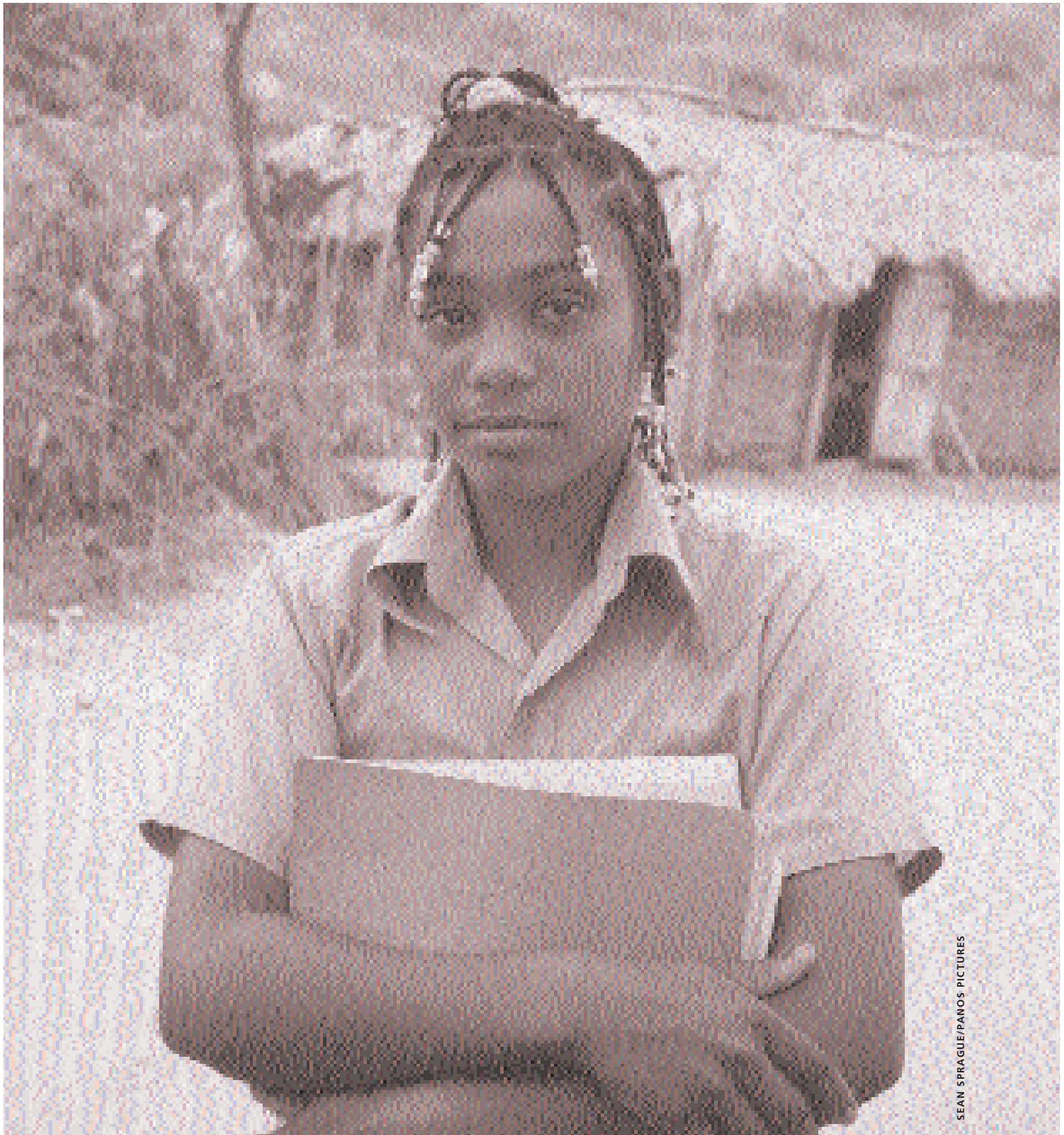
Judy Benjamin, CARE, Atlanta, Georgia, USA
Rose De Buysscher, Family Health International,
Research Triangle Park, North Carolina, USA
David Engel, Cornell University, Department
of Communication, Ithaca, New York, USA

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The campaign attained unprecedented multisectoral involvement and support: for the first time in the history of HIV/AIDS prevention in the Dominican Republic, NGOs, government agencies, international organizations and the private sector worked together for a common cause.



SEAN SPRAGUE/PANOS PICTURES

A DOMINICAN TEEN-AGED SCHOOLGIRL REPRESENTS ONE OF THE TARGET AUDIENCES FOR AIDSCAP'S YOUTH AND HIV/AIDS NATIONAL MEDIA OUTREACH CAMPAIGN.

HIV/AIDS PREVENTION MASS MEDIA CAMPAIGN FOR YOUNG PEOPLE IN THE DOMINICAN REPUBLIC

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HIV/AIDS PREVENTION MASS MEDIA CAMPAIGN FOR YOUNG PEOPLE IN THE DOMINICAN REPUBLIC

INTRODUCTION

A young man is shown embracing a woman on a couch in a dimly lit room. The sofa revolves, and the same man appears, holding another woman. With another turn, that woman is seen in the arms of a different man. In the background, a singer croons the opening lyrics of a romantic ballad: “Just one time I have loved in my life, just one time and never again.”

A final turn of the sofa reveals the last couple. The young woman looks up with a grim expression and stares directly at the camera. The word “SIDA” (AIDS) appears in bold red letters across the TV screen, and the narrator takes the sweet love song and turns its meaning on its head. “AIDS. Just one time and never again,” he warns. “Protect yourself. Don’t change partners. Use condoms. Because just one time is enough, and never again.”

This forceful TV advertisement was one of four produced for a mass media campaign launched in September 1995 by the AIDS Control and Prevention (AIDSCAP) Project in the Dominican Republic. Designed to increase young people’s perception of their own risk of contracting HIV, the two-and-

a-half-year campaign was supported by the United States Agency for International Development (USAID), which funded technical assistance, project management and materials production, and by Dominican media outlets, which contributed free air time and press coverage. The campaign also received support from many individuals, organizations and companies who provided their time and expertise free of charge or at very low cost.

More than a dozen governmental and nongovernmental organizations (NGOs) participated in developing the strategy that sustains the campaign and in distributing related printed materials. These organizations also worked with AIDSCAP to improve sexually transmitted infection (STI) and HIV/AIDS education and counselling services for Dominican young people between the ages of 13 and 19.

This case study focuses on the lessons learned from AIDSCAP’s mass media campaign. It also documents how the campaign was used to mount a broader effort to provide more consistent, high-quality HIV/AIDS/STI services to young people in the Dominican Republic.

HIV/AIDS AND DOMINICAN YOUNG PEOPLE

In 1993, projections developed from epidemiological surveillance data revealed that 5 per cent of the Dominican population could be infected with HIV by 2000. That same year the Information, Education and Communication (IEC) Committee of the National AIDS Commission (CONASIDA) designed a national HIV/AIDS prevention IEC strategy that identified young people as a key target audience.

Most reported AIDS cases were occurring among people aged 25 to 35. Since it can take ten years or more for people living with HIV to develop AIDS symptoms, it was assumed that the majority of people with AIDS had contracted the virus during their teens and early twenties. Thus, preventing HIV transmission among young people became an urgent priority.

At the time, young people had few places to turn to for accurate information and sound guidance on HIV/AIDS/STIs. Some organizations were trying to provide such services, but their efforts were not coordinated, and the quality of the services varied widely.

Despite the broad reach of the mass media in the Dominican Republic and its strong impact on youth culture and social norms, television and radio had never been used to disseminate HIV/AIDS messages designed specifically for young people. A previous media campaign to educate Dominicans about HIV and STI prevention, aired during 1989 and 1990, had targeted the general population. In 1994 the AIDSCAP programme in the Dominican Republic decided to explore the untapped potential of mass media advertising to reach and influence large numbers of young people.

Working Together In early 1994 AIDSCAP invited organizations working with young people to participate in developing a national HIV/AIDS IEC strategy. A working group was formed with representatives from 15 governmental and international organizations, NGOs and the church.

A programme strategy was developed during the second quarter of 1994, combining mass media and interpersonal communication. AIDSCAP recognized that mass media efforts would be more effective if they were reinforced with consistent messages from other sources and supported by services that enabled young people to act on the messages. Furthermore, some highly sensitive behaviours and issues can only be addressed and discussed at the interpersonal level. Therefore, AIDSCAP staff made a concerted effort to coordinate mass media efforts with organizations already implementing HIV/AIDS interventions targeting young people.

The working group was multisectoral, with representatives from the fields of education, family planning, youth services and development, health and research.

The participation of Programa de Control de Enfermedades de Transmisión Sexual y SIDA (PROCETS), the national AIDS and sexually transmitted infection control programme of the Dominican Republic, was particularly important, not only for its technical contributions, but also for its official endorsement of the campaign.

Considering its rigid positions on sexuality issues and condom use, the Catholic Church's participation and endorsement, through the

SIDEBAR 1

Participating organizations

Government

National AIDS and STD Control Programme (PROCETS)
Integral Health for Adolescents Programme (PRONAISA)
National Council for Family and Population (CONAPOFA)
General Directory for Young People Promotion (DGPJ)
Ministry of Education (SEEC)

NGOs

Coordinadora de Animación Socio-cultural (CASCO)
Instituto Dominicano de Desarrollo Integral (IDDI)
Asociación Dominicana Pro Bienestar de la Familia (PROFAMILIA)
APEC Institute for Sexual Education (INSAPEC)
Centro Nacional de Investigaciones Materno Infantiles (CENISMI)
Institute of Human Sexuality (ISH)

Church

Pastoral Juvenil

International Organizations

Pan American Health Organization (PAHO)
United Nations Population Fund (UNFPA)
Development Associates

Pastoral Juvenil, was also important. The Pastoral Juvenil, whose members include all organized Catholic youth groups, participated throughout the process and officially represented the Catholic Church in the campaign launch event.

Family Health International's AIDSCAP office in the Dominican Republic already had strong ties with many of the participating organizations. For example, two NGOs, Coordinadora de Animación Socio-Cultural

(CASCO) and Instituto Dominicano de Desarrollo Integral (IDDI), were implementing the Acuario Project with AIDSCAP support. This intervention targeted 13- to 24-year-olds in disadvantaged communities in Santo Domingo. It integrated HIV/AIDS prevention with efforts to help communities address many other threats to young people's health through intensive outreach and peer education.

All group members had experience with HIV/AIDS programmes for young people

and were able to offer valuable insights throughout the process of developing, implementing and evaluating the campaign. Many of the participating organizations were involved in pretesting and distributing materials at their project sites.

AIDSCAP provided the campaign with technical leadership through its Dominican Republic office staff and a number of international experts who served as consultants. AIDSCAP also brought all the sectors and organizations together to work collaboratively.

The working group met regularly to discuss progress and review materials. Decisions were made based on agreement by a majority of the members. At times, AIDSCAP had to assume a mediating role among organizations or individuals with different opinions or approaches. The involvement of a few highly respected local experts on working with youth facilitated this decision-making process.

Understanding Risk Data from recent studies was used to identify the target audience, goals and objectives of the strategy. AIDSCAP and its partners collected as much information as possible on young people's knowledge of and attitudes toward HIV/AIDS, sources of information about HIV/AIDS and sex, sexual behaviour at different ages, education levels, media preferences and use of various prevention methods.

Among the most important sources of information were two studies carried out in 1992 among young people. According to a knowledge, attitudes, beliefs and practices (KABP) survey conducted by the CASCO among 13- to 24-year-olds and the 1992

National Young People Survey (ENJOVEN 92), conducted among 15- to 24-year-olds, the average age of sexual initiation in the Dominican Republic was 14 to 15. Thirty-eight per cent of all young people surveyed reported that they had had sex before age 15. Further, more than three-quarters of those who had continued to have sex were not doing so with their initial partner.

Despite these high rates of sexual partner change, condom use was low among young people. A 1994 study of sexual behaviour conducted by the Institute of Human Sexuality (ISH) revealed that only 47 per cent of young people had used condoms in their sexual encounters. This study also showed that only 50 per cent of young people in schools had received sex education.

The ENJOVEN 92 indicated that 31 per cent of sexually active young women and 75 per cent of young men had used or were using condoms. However, half of these young people said they were not willing to use condoms in all their sexual relations.

The CASCO and ENJOVEN studies also showed that half of the young men and 15 per cent of the young women reported having changed their sexual behaviour (by having fewer partners or using condoms) since becoming aware of HIV/AIDS. Of those who had not changed their behaviour, more than half of the young women and one-fifth of the young men said they did not need to because they trusted their partners. Another reason they cited was having sex only with a regular partner and not with a sex worker.

Target Audience After reviewing the research results, the working group characterized the target audience of the strategy as young people who:

- are single
- live with one or both parents in urban and periurban areas of the country (58 per cent of Dominican young people live in urban areas)
- have completed part of secondary studies
- have received very little formal sex education
- do not talk about sexual issues with parents (parents do not try to discuss these issues with them either)
- initiate sexual activity at age 15 to 16
- do not like to use or have not used condoms for HIV/AIDS prevention
- occasionally use condoms as a birth control method.

Research results also helped working group members determine the key risk factors for HIV and STI transmission among Dominican young people:

- early initiation of sexual activity among both sexes, with frequent change of partners
- lack of formal sexual education
- low perception of personal HIV risk
- negative attitudes towards condom use and low use of condoms to prevent STIs.

Goals and Objectives The overall goals of the strategy were to promote behaviour change among 13- to 19-year-olds toward safe sex practices and to promote the demand for services in support of these behaviour changes.

The specific objectives were to:

1. Increase awareness and risk perception of STI and HIV/AIDS among 65 per cent of 13- to 19-year-olds and encourage them to adopt preventive measures.
2. Standardize criteria for HIV/AIDS and STI services among organizations delivering education and counselling to young people.
3. Increase to 20 per cent the number of 13- to 19-year-olds who seek HIV/AIDS and STI education and counselling services.

The strategy aimed to encourage behaviour change at two levels: individual and societal. At the individual level, messages were designed to target young people who were not sexually active as well as those who were sexually active. They addressed the following issues: risk awareness, abstinence, delaying initiation of sexual intercourse, having fewer sexual partners, non-penetrative sexual practices, condom use, monogamy and other alternatives to high-risk behaviour.

To attain changes at the societal level, the strategy also sought to: gain parents' and teachers' support for and involvement in prevention strategies and activities; reduce the stigma associated with HIV/AIDS; and, promote the adoption of supportive policies among government agencies, NGOs, religious groups and the media.

DEVELOPING AN IMPLEMENTATION PLAN FOR THE MASS MEDIA CAMPAIGN

In June 1995, AIDSCAP defined a three-phase implementation plan for the mass media component of the strategy, in collaboration with the working group. Each phase addressed one specific objective of the strategy. The first

and third phases targeted young people with communication messages for HIV/AIDS prevention. The second phase targeted organizations working with young people to standardize criteria on providing HIV/AIDS and STI services to ensure that the mass media campaign would be supported by consistent, high-quality interpersonal interventions.

The campaign addressed the 13- to 19-year-olds as one group. Further segmentation of this audience was not possible due to budget limitations. Some of the printed materials produced to complement the mass media efforts, however, address specific issues for subgroups within this age group. For example, a manual on providing HIV/AIDS and STI services to young people gives specific guidance on working with young Dominicans in early, middle and late adolescence.

AIDSCAP also developed a communication profile of the target audience, including young people's favourite music, television programmes, publications, products and hours for watching television and listening to the radio. This information helped programme designers develop messages and identify the best channels and times for airing them. Information about viewing and listening times later became irrelevant, however, because the media broadcast the spots throughout the day.

Choosing an Advertising Agency

Social and health projects in the Dominican Republic usually produce their own mass media materials. Because most project staff have little technical knowledge or expertise in materials production, the quality of the materials has suffered, and media campaigns

on social and health issues have had little impact on their target audiences.

To ensure professional quality in campaign materials, AIDSCAP decided to request proposals from advertising agencies. These were graded on experience in designing campaigns for social issues, production costs, proven quality of creative staff, production equipment and years of service. Based on these criteria, AIDSCAP selected and contracted with the local office of Nazca Saatchi & Saatchi, Cumbre. This agency is widely recognized in the Dominican Republic for producing creative social campaigns. AIDSCAP staff met with the creative staff of this agency to brief them on the goals and objectives of the project and to discuss cultural, social and religious issues unique to the diffusion of HIV/AIDS prevention messages. Cumbre also received a briefing document describing the target audience, including information on sexual and social behaviours, the communication profile and the sociocultural environment. This proved to be a pleasant surprise for agency staff members, who were not accustomed to receiving this kind of input from their clients. They said that starting with such detailed information on the audience saved time and effort and gave them a better understanding of the project.

The working group selected several people with communication experience, including AIDSCAP's IEC officer, to work closely with the agency and to monitor the production process. These people were involved in every aspect of the design and production process and held regular coordination meetings with Cumbre staff.

Disseminating the Messages Although Dominican law requires the media to donate a percentage of air time to social causes, the Ministry of Health had paid media outlets on several occasions to broadcast health promotion messages. Therefore, strong negotiation skills were required to persuade broadcasters to air the TV and radio spots for free.

AIDSCAP's IEC officer in the Dominican Republic, who had broad experience in the communication field and was well known among local media professionals, visited each of the TV and radio stations to introduce the campaign and increase awareness about HIV/AIDS. During these visits, she conveyed information about the epidemic, including statistics on HIV/AIDS among young people, and emphasized the need for all sectors to collaborate in prevention efforts.

Throughout the life of the campaign, media representatives were contacted regularly and encouraged to continue airing the spots. This follow-up, along with the quality of the materials, helped the campaign gain even greater support than expected from the TV and radio stations.

First Phase: Challenging Young People

The objective of the first phase of the campaign was to increase awareness of HIV/AIDS/STIs and improve risk perception among 13- to 19-year-olds. Two TV spots and two radio spots produced for this campaign questioned young people's knowledge of HIV/AIDS/STIs, their perception of personal risk and their behaviour. The messages were hard-hitting, designed to challenge young people's sense of invulnerability.

The first TV spot, entitled "Viejo, Si Te Da no Llegas" ("Hey Man, If You Get It, You Won't Make It"), was the first on Dominican television to use an "interactive" style, with actors staring directly at the camera and questioning viewers. This approach engaged viewers' interest and promoted dialogue on hard-to-discuss issues such as sex and STIs.

The spot was first aired in September 1995 at the official campaign launch. AIDSCAP organized this event to introduce the campaign, begin disseminating its key messages and seek the support and collaboration of government authorities and religious groups. During the event, 900 young people wearing T-shirts and caps printed with the slogan of the first TV spot walked through the colonial zone of the capital city of Santo Domingo to meet representatives from the government, USAID, different religious groups, NGOs, AIDSCAP and the media. This event was broadcast nationwide on television and radio.

The second spot, "Fiesta" ("Party"), began airing in December 1995. It showed young people dancing, talking and looking for partners in a situation where intimacy, alcohol and lack of parental supervision all played a part in placing them at risk. This spot also used a questioning approach, challenging the widely held misperception that a person with HIV/AIDS can be identified by his or her appearance. "You can't guess who has AIDS," it concluded.

Both spots and all other materials produced for the three phases of the campaign included the telephone number for an existing hotline for people suffering from depression, abuse or using drugs or alcohol, run by the Instituto de Desarrollo y Salud Integral (INDESUI).

Broadcasters continued to air both the first and second spots until June 1996. In support of these spots, campaign messages were posted on seven billboards in strategic parts of the capital city of Santo Domingo, and tens of thousands of printed materials (40,000 pamphlets, 10,000 posters and 15,000 stickers) were distributed nationwide. All these materials contained the same messages, logo, slogan and colours as the TV spots, and some included photos of the actors, ensuring complete identification with the campaign.

During this first phase of the campaign, the largest newspaper in the country published an HIV/AIDS question-and-answer contest in a special issue of *Listin 2000*, its weekly youth supplement. A campaign poster appeared on the cover of the supplement, which included several educational articles. The first 2,000 young people to respond correctly to the questions won a campaign T-shirt and a cap. In just a few days, all the prizes were gone—evidence of young people's interest and motivation to seek information about HIV/AIDS. Some even showed up with their parents at AIDSCAP's offices to claim their prizes.

Second Phase: Improving Services The second phase of the campaign, which began in November 1995, partially overlapped with the first phase. Its purpose was to promote consensus and coordination among all organizations working on HIV/AIDS prevention for young people through the delivery of education and counselling services.

To achieve this goal, AIDSCAP held three workshops with representatives from all these

organizations. Points of discussions during the workshops were young people's stages of development, characteristics of these stages, risk factors and alternatives for intervention. All discussions were based on an integrated health approach for adolescents. Results were compiled into a manual to guide organizations in the delivery of HIV/AIDS/STI education and counselling services to young people.

The manual contains a scheme that includes conceptual definitions of each stage of development and its characteristics, risk factors that should be addressed during each stage and ideas and examples of interventions designed to address those risk factors. It was developed as an initial working instrument that would later be revised and enriched by the experience of those using it.

Subsequently, educators, health promoters and teachers from approximately 100 youth organizations working throughout the country were trained in how to use the manual during four regional workshops, each three days long. Workshops included a theoretical component as well as a practical component on how to use the manual.

A service referral guide developed by AIDSCAP was also delivered to the youth organizations. Containing a list of noted health professionals who have received training in HIV/AIDS/STI, the guide facilitates referral to appropriate and high-quality services nationwide.

To ensure that the hotline advertised in the campaign materials provided accurate information on HIV/AIDS/STI services, AIDSCAP's staff in the Dominican Republic trained hotline personnel in HIV/AIDS

prevention methods and issues. AIDSCAP also gave INDESUI the computer equipment needed for a computerized database of HIV/AIDS information and a listing of HIV/AIDS service providers for referrals.

Third Phase: Only Once The third phase of the campaign began in June 1996 and concluded in December of that year. This phase consolidated messages for young people on prevention and referral to HIV/AIDS/STI education and counselling services through the TV and radio spot “Solamente una Vez” (“Only Once”).

Based on the lyrics of a classic song made popular again by a young Mexican artist, this spot linked the romantic message, “You only find true love once,” with the idea that just one exposure can result in HIV infection. Using the image of the revolving couch, the spot brought home the dangers of the serial monogamy and partner exchange so common among Dominican young people.

The original design of the campaign had included two spots for young people in its third phase. During focus group discussions conducted to assess target audience reaction to the first phase, however, young people had identified a need for messages addressing parental responsibility for providing sex education to their children. As a result, the third phase of the campaign was modified to include messages for parents.

The fourth spot, “Interactivo para Padres,” directly confronted parents with the fact that their children could be at risk of HIV and other STIs. It encouraged them to discuss love, sexual issues and STIs—including HIV/AIDS—with their children.

Although these two spots were programmed to be broadcast over six months, the media continued airing them through February 1997. During this phase, 100,000 pamphlets, 150,000 stickers and 80,000 posters were produced and distributed. New messages linked to the TV and radio spots were also posted on the seven billboards.

EVALUATION METHODS AND RESULTS

The scarce resources allocated for evaluation were mainly used to validate materials and monitor their dissemination, rather than for a more costly evaluation of their impact. As the campaign developed, however, AIDSCAP allocated more funding for evaluation and pursued opportunities to dovetail its research questions with other research agendas.

In an attempt to measure the impact of the campaign, a few questions about HIV/AIDS prevention and campaign message recall were included in the HIV/AIDS module developed for the 1996 Demographic Health Survey (DHS) in the Dominican Republic. In addition, a qualitative study was conducted at the end of the first phase of the campaign to guide the development of the third phase and to help AIDSCAP staff understand any changes in risk perception among the target audience.

Validation of Materials All campaign materials were pretested through focus group discussions (FGDs) with members of the target audience, and their suggestions were used to guide final production. For example, different actors were chosen after young people in the FGDs indicated the need for a better representation of the diverse ethnic groups in the Dominican Republic.

Tracking Dissemination Diffusion of the TV and radio spots was closely monitored by a commercial advertising agency, which agreed to assist the campaign by providing this service at low cost. The monitoring agency tracked the number of TV and radio spots aired every day, as well as the frequency, time, channels and cost per spot. Its reports showed that TV channels and radio stations were broadcasting the spots far more frequently than they had originally agreed to. Campaign TV spots were aired 19,989 times through channels with nationwide reach and 20,580 times through local UHF channels. The radio spots were broadcast a total of 479,220 times.

Monitoring Contributions A counterpart registration system developed by AIDSCAP made it possible to track and quantify all contributions to the campaign. As reports on broadcasts of the TV and radio spots came in from the monitoring agency, the AIDSCAP/DR's accounting office calculated the cost per air time for each programme according to the official ratings, which were updated monthly. Time and resources donated by private sector organizations and community members, as well as time dedicated by technical staff from collaborating NGOs who were not paid by the AIDSCAP programme were also estimated and tallied regularly during the campaign. Total collaboration was worth more than US\$9 million.

Awards and Honours The campaign received national and international recognition. It was awarded first prize as the best educational effort for adolescents

at the Second Seminar on Communication and Sexual/Reproductive Health for Adolescents of Latin America and the Caribbean in 1996. The "Solamente una Vez" campaign spot won second prize in a nationwide contest for Dominican advertisers, sponsored by Mercado/Advertising Age, the local partner of the U.S.-based Association of Advertising and Marketing Agencies Worldwide. *Advertising Age* magazine, in turn, selected the spot for its international competition.

Improved Services Organizations working with young people used the manual and training provided by AIDSCAP to standardize their criteria for HIV/AIDS/STI education and counselling services. Assessing the impact of this standardization was not one of this project's objectives. Nevertheless, the collaborating organizations have reported increases in young people's demand for HIV/AIDS/STI services and in parental participation in project activities involving young people.

The hotline service also saw increased interest and demand for HIV/AIDS information from young people. In one single day, for example, the hotline reported that 48 of 50 calls received were made by young people requesting information on HIV/AIDS.

Qualitative Findings In April 1996, AIDSCAP carried out a qualitative study consisting of 12 FGDs with members of the primary target audience. The purpose of this study was to assess the effect of first-phase TV and radio spots. Participants included in-school and out-of-school young people from

urban and peri-urban areas of five cities in different regions of the country.

The results were positive, suggesting an increase in HIV/AIDS and STI-risk perception among young people. Prior to the campaign, young people would not have considered themselves at risk of HIV/AIDS/STIs. During this midway evaluation, they clearly identified themselves as being at highest risk, not only on a personal level, but as a group.

FGD participants recognized that the mass media spots were designed to create awareness among young people about their risk of HIV and STI transmission. They easily related the printed materials with the media campaign. Although materials were shown to them during the FGDs, all of them had been previously exposed to them. Message recall was excellent.

National Surveys Results of the DHS conducted in 1996 also indicated high recall of the campaign among young people. This national survey found that 72 per cent of sexually active young women and 66 per cent of sexually active young men remembered seeing some of the spots during the past 12 months. Sixty-three per cent of young men reporting condom use for HIV/AIDS prevention had seen the spots.

AIDSCAP used the results from the ENJOVEN 92 study as a baseline to compare with the answers to the questions that had been added to the HIV/AIDS module of the 1996 DHS. This analysis revealed some significant increases in risk perception and condom use among members of the mass media campaign's target audience.

For example, in 1996, 38.2 per cent of sexually active young men perceived themselves to be at some risk of HIV/AIDS, up from 23.5 per cent in 1992. The increase in risk perception among sexually active young women was not significant (from 22.8 per cent in 1992 to 23.6 per cent in 1996). Qualitative results from AIDSCAP's FGDs, however, suggest that young people of both sexes were beginning to consider themselves as top of the list of those at risk.

Condom use appeared to have increased among sexually active young men and women. In 1992, 31.3 per cent of young women and 75.8 per cent of young men in this group reported current or past use of condoms. In 1996, 42.4 per cent of sexually active young women and 96.3 per cent of sexually active young men reported condom use during the past 12 months. Although these indicators are not directly comparable, they do provide evidence of an overall increase in condom use.

Clearly these changes in HIV-risk perception and behaviour cannot be attributed solely to the AIDSCAP campaign. Rather, they are the combined result of many influences on young people's attitudes, perceptions and behaviours, including the interpersonal interventions the mass media campaign was designed to support. However, the broad reach of the campaign, the high levels of recall of its messages and the impact it had on the members of the target audience who participated in FGDs suggest that it made a substantial contribution to behaviour change for HIV/AIDS prevention among Dominican young people.

BEST PRACTICE CRITERIA

Relevance Young people are at high risk of HIV/AIDS infection in the Dominican Republic, but research conducted during the early 1990s showed that most young people did not consider themselves to be at risk. Despite the broad reach of television and radio and their strong influence on Dominican young people, mass media had never been used to convey HIV/AIDS and STI messages specifically targeted to young people. This campaign not only addressed a population group in urgent need of HIV/AIDS prevention information, but also worked with NGOs and other organizations to improve the delivery of HIV/AIDS/STI services. The campaign attained unprecedented multisectoral involvement and support: for the first time in the history of HIV/AIDS prevention in the Dominican Republic, NGOs, government agencies, international organizations and the private sector worked together for a common cause.

Implementation Efficiency This project made excellent use of existing national resources: technical expertise, the government and NGO infrastructure and financial resources. Supportive interpersonal interventions were executed through existing government organizations and NGOs working with young people nationwide. All print media were distributed through these organizations as part of their education and counselling activities.

Collaboration with organizations and individuals such as artists and printing and monitoring companies kept project costs to a minimum. In addition, convincing mass media outlets to broadcast the spots free of charge saved millions of dollars in airtime

while guaranteeing the widest possible audience. For 18 months a total of 179 radio stations and 20 TV channels aired the spots during their highest-rated programmes. This collaboration was worth more than US\$9.8 million, compared to less than \$2,000 invested in technical support and production costs by USAID through the AIDSCAP project.

Effectiveness/Impact Qualitative evaluations have demonstrated that the campaign helped increase the awareness of HIV/AIDS and perception of risk among young people. A comparison of available baseline data with results from the 1996 DHS survey indicates that condom use among young people increased considerably. The campaign was also effective in involving adults in prevention activities. Organizations working with young people reported an increase in the demand for information about HIV/AIDS and young people from parents, teachers and school counsellors.

The messages conveyed through this campaign have become ingrained in the minds of young Dominicans. Two years after the campaign, young people were still including the campaign slogans in their own songs and poetry. In late 1998, for example, a national newspaper's youth section published a contribution from a young songwriter based on the slogan "Viejo, Si Te Da no Llegas" (Hey man, if you get it, you won't make it).

Ethical Soundness The campaign featured messages that were strong but none the less in tune with the values and principles of Dominican society. Abstinence, delaying

initiation of sexual intercourse, reducing the number of partners, fidelity and condom use were all presented as options for reducing the risk of HIV/AIDS.

Sustainability Building the capacity of organizations for continued delivery of improved HIV/AIDS/STI services to young people was inherent in the project strategy. Staff members from participating organizations were trained so they could provide better services to young people, and they continue to use the manual developed for this purpose. The enhancement of an existing telephone hotline also has had a lasting impact: up-to-date information on HIV/AIDS/STIs, referrals to service providers and crisis management can still be accessed through the INDESUI hotline.

The campaign fostered institutional linkages to ensure sustainability. For example, AIDSCAP guided INDESUI in establishing several collaborative agreements in support of the HIV/AIDS hotline. Through these agreements, a local university, Pontificia Universidad Católica Madre y Maestra (PUCAMAIMA), maintains the database and provides continuous computer training to hotline personnel, the Institute of Human Sexuality (ISH) trains hotline staff in HIV/AIDS and STI issues and the national AIDS control programme gives INDESUI free telephone services obtained from the telephone company, as well as regular updates of epidemiological information. Furthermore, many of the organizations that collaborated on the campaign continue to work together and have since developed numerous joint ventures to address HIV/AIDS issues for young people.

Since the campaign ended, the private sector has remained engaged in supporting HIV/AIDS prevention through the media. Mass media organizations and other commercial firms have found a practical way to contribute to efforts to slow the epidemic. The route to obtaining such contributions was opened through the campaign, and more recent HIV/AIDS campaigns have benefited from it.

Replicability After the mass media campaign received the highest award at the regional IEC workshop on adolescent sexual health, the event's sponsor, the Japanese Organization for International Cooperation in Family Planning (JOICFP), asked AIDSCAP to conduct an extensive evaluation of the potential replicability of campaign materials. The results of this evaluation (by 27 organizations from 10 countries) were very positive. Respondents found the materials clear, creative and useful for reaching parents and young people and stimulating discussion and self-analysis. Ninety per cent of the organizations stated their willingness to use or replicate the campaign materials with some revisions, mainly related to cultural issues.

Replicability of the whole process of campaign design and implementation with multisectoral involvement is indeed possible. While the materials themselves may not be appropriate for use in all countries, the process and its success are highly replicable. The essential elements are careful planning, participation of the target audience and organizations working with that audience throughout all stages of the project, high-quality materials and the support of the mass media.

LESSONS LEARNED

One of the most important lessons learned from this campaign is that mass media interventions are strengthened by involving members of the target audience and the organizations who serve them in all stages of development, implementation and evaluation. Organizations working with young people played a key role in the AIDSCAP campaign, providing valuable information about the target audience and facilitating direct contact with young people. As a result, campaign planners had a better understanding of the audience's needs.

Intensive involvement also gave these organizations a sense of project ownership. This facilitated their collaboration in strengthening HIV/AIDS counselling and education services in order to respond more efficiently to the increased demand for services generated by the campaign.

Another key factor in the success of the campaign was the high quality of all the materials produced. One way to achieve such high quality is to work with a professional advertising agency. However, it is important that project technical staff monitor the work of the agency to ensure total compliance with a project's objectives.

The quality of the campaign materials proved to be important in obtaining support from the private sector. For example, the director of Radio Fiesta, the highest-rated radio station in the city of Santo Domingo, said, "whenever you have such high-quality materials please don't hesitate to bring them over, I'll be more than willing to disseminate them." Punto Final, a four-hour programme

that is one of the highest-rated daily TV shows, aired the "Fiesta" spot 14 times in one single night.

Another way to gain media support is to hold an event to launch a mass media campaign. A well-organized event will put a campaign on the path to success from the very beginning by generating wide media coverage. The launch event for this campaign received national coverage from 14 media outlets, which generated multiple newspaper articles and TV and radio broadcasts. For example, the cover and central pages of *Listin 2000*, the weekly magazine of the largest-circulating newspaper in the country (*Listin Diario*), highlighted the campaign and its launching event.

To facilitate continued collaboration with the media, governmental, nongovernmental and donor agencies should establish a nonpayment policy for diffusion of social messages. Achieving free media coverage was particularly difficult in the Dominican Republic because some health programmes with abundant funding had paid the media for diffusion of messages in the past.

One of the most important lessons learned during this campaign is that collaboration with private sector mass media is possible. Media representatives are willing to contribute to social causes, even when they involve sensitive issues such as HIV/AIDS, but they need to be approached in a professional way with clear, concise information on a project's objectives, methods and rationale. This approach promotes mutual respect and collaboration with media and other sectors.

AUTHORS

Tanya Medrano, AIDSCAP/DR, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Santo Domingo, Dominican Republic

Martha Butler De Lister, AIDSCAP/DR, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Santo Domingo, Dominican Republic

Repeatedly measuring risk behaviours over time in carefully selected population groups that are both at elevated risk of HIV infection and influential to the growth of the epidemic highlights not only where the epidemic has been, but also where it is going, and how programme managers can intervene.



SHEHZAD NOORANI/WOODFIN CAMP

BEHAVIORAL SURVEILLANCE SURVEYS ELICIT IMPORTANT INFORMATION ON GROUPS ESPECIALLY VULNERABLE TO HIV INFECTION, SUCH AS THESE YOUNG NEPALESE SEX WORKERS AT THE SONAGACHI BROTHEL IN CALCUTTA, INDIA.

MONITORING TRENDS IN HIV-RISK BEHAVIOURS: EXPERIENCE USING THE BEHAVIOURAL SURVEILLANCE SURVEY METHODOLOGY IN TAMIL NADU, INDIA, AND SENEGAL

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MONITORING TRENDS IN HIV-RISK BEHAVIOURS: EXPERIENCE USING BEHAVIOURAL SURVEILLANCE SURVEY METHODOLOGY IN TAMIL NADU, INDIA, AND SENEGAL

INTRODUCTION

Monitoring trends in HIV-risk behaviours is essential to understanding the underlying dynamics of HIV epidemics. Two previous UNAIDS Best Practice Case Studies have effectively demonstrated the value of such monitoring to explain and clarify factors influencing the ongoing worldwide HIV/AIDS pandemic.^{1,2} These prior case studies from Uganda and Thailand show that an understanding of the sexual behaviours of a variety of target populations contributes to national AIDS prevention programme efforts in the following ways:

- Behavioural data serves as an early warning system for HIV and sexually transmitted infections (STIs).
- Behavioural data inform effective programme design and direction.
- Tracking behaviour improves programme evaluation.
- Behavioural data can help explain HIV transmission dynamics and variation in prevalence.
- Changes in behaviour help explain changes in HIV incidence.

While the Ugandan and Thai studies present and explain these and other benefits of conducting behavioural surveillance, they do not specifically address the most efficient, effective and sustainable

means for its implementation. The objective of this case study, therefore, is to focus on behavioural surveillance surveys (BSSs) of populations that are highly vulnerable to HIV infection, including marginalized and difficult-to-access groups, and to discuss in detail the implementation and success of BSSs in two diverse settings: Tamil Nadu, India, and Senegal. These examples will also highlight the lessons learned from earlier efforts to institutionalize BSSs as a sustainable approach for national AIDS programmes.

BACKGROUND

Behavioural monitoring in the context of national AIDS programmes has a short history. While pre- and post-intervention research designs and one-time behavioural surveys have been plentiful,³⁻⁶ systematic, long-term surveillance of HIV-risk behaviours is rare. Few industrialized and even fewer non-industrialized countries have conducted multiple and systematic large-scale HIV-related behavioural surveys over time, either in the general population or in specific target groups.⁷⁻¹² Large-scale Demographic and Health Surveys (DHS), while not focused on HIV-risk behaviours, have none the less demonstrated the feasibility and utility of this approach, capturing general population trends

related to contraceptive availability and key family planning indicators in a wide range of non-industrialized countries worldwide.

During the period 1989 to 1998, many national AIDS programmes conducted national surveys to define basic indicators of sexual-partner networking (that is, patterns of risk behaviour, including numbers and types of partners) and condom use related to HIV risk among the general population.^{5,13,14} There are considerable problems with the implementation of these studies, including the under-representation of young men, bias towards urban residents and limited sample sizes ($n < 3000$), which do not allow disaggregation of data beyond the large 15–49 age range.⁵ Other limitations of these studies include the limited information collected on sexual networks and the need for more specific information on partner characteristics, such as duration of relationship, types and frequency of sexual behaviours with each partner and geographical distribution of partners.

General population surveys Large surveys containing a “module” devoted to HIV/AIDS have also been conducted by a variety of international and national organizations for population and family planning studies. These studies generally exhibit many of the constraints described above. In addition, they often confuse respondents by introducing questions on condom use for STI prevention after long sections focused on contraceptive use and by poorly defining multiple-partner classifications after sets of questions addressing family planning with regular partners.

The lack of success of these approaches has been particularly evident in their inability to gather information on high-risk individuals

(for example, female sex workers and their partners, injecting drug users and men who have sex with men) and their lack of detailed information on the behaviours and protective strategies adopted by specific age groups (for example, 15- to 19-year-olds, 20- to 24-year-olds and 25- to 29-year-olds). By this point in the pandemic it is well known that these are the individuals and age groups most affected by the HIV epidemic, and that very different behaviours and risk reduction strategies characterize each age group.

High-risk and vulnerable population surveys

Focused research on specific high-risk and vulnerable populations has been conducted in many non-industrialized countries. However, these studies often use incomparable methodologies and indicators and poorly characterize the populations to which their results are generalizable. In addition, many of these studies are conducted within the context of a specific programme evaluation and are therefore confined to particular geographical zones or to the clients of the interventions. A further weakness of these studies is that they are constrained by project funding, and therefore collect data only at baseline and at a single follow-up point in time. Assessing broader trends (in terms of population groups or time periods) is usually beyond the scope of such research.

Qualitative, ethnographic and hybrid research approaches

In response to these limitations, many researchers have emphasized qualitative and ethnographic studies exploring in detail the contextual factors related to HIV risk.

While these studies have an indisputably important role to play in explaining the dynamics of the HIV epidemic and informing strategic programme approaches, they are not suitable as repeated measures to track and explain HIV trends because they are neither representative nor reproducible. Hybrid approaches, such as small-scale target population quantitative studies, have had some success,¹⁶ but have also been criticized for their lack of strict sampling methods and non-standardized indicators, which results in their being neither generalizable nor replicable.

Conclusions Overall, experience in measuring HIV-risk behaviours over the last 10 to 15 years has led to several conclusions and lessons learned.^{17,18} At the core of these lessons is the recognition that behavioural data-collection systems for national programmes should have at their foundation two repeated, cross-sectional methods:

- one covering the general population using a household-based sampling methodology
- one focusing on selected population groups using non-household-based sampling methods (i.e., BSS)

The specific balance between these two methods and the use of complementary qualitative methods will clearly vary by country. The overall design of the behavioural monitoring system will reflect the needs of the national AIDS programme as well as the stage of the epidemic, the response so far and the political and social environment of each country.

Much as HIV sero-sentinel surveillance systems function to monitor trends in HIV prevalence, behavioural surveillance provides programme managers with essential and timely

information to predict the future course of the epidemic. Repeatedly measuring risk behaviours over time in carefully selected population groups that are both at elevated risk of HIV infection and influential to the growth of the epidemic highlights not only where the epidemic has been, but also where it is going, and how programme managers can intervene.

General population household-based studies have a more established history and use in the study of HIV/AIDS-related risk behaviour, whereas targeted population, non-household-based studies are more recent innovations. Therefore, this case study will focus on the latter, presenting the experience and lessons learned to date from the implementation of such studies.

BEHAVIOURAL SURVEILLANCE SURVEYS IN SELECTED POPULATIONS: AN OVERVIEW

Similar in philosophy to HIV-seroprevalence sentinel surveillance, which collects repeated measures of HIV-seroprevalence in selected populations in order to assess trends, BSSs are repeated, cross-sectional behavioural surveys designed to collect information on trends in HIV-risk behaviours in selected sub-population groups at regular intervals.

Three main questions immediately emerge when considering the implementation of BSSs in national AIDS programmes: who should be included, how shall they be reached (or sampled) and what results can be expected? Clearly, the answers to these questions lie in the detailed context of a specific national programme and the dynamics of the HIV/AIDS epidemic it faces. However, several basic principles can be considered in the overall balance of designing a behavioural surveillance system.

Whom to target Targeted behavioural surveys in sub-populations generally aim to collect data on groups whose behaviour may put them at high risk of HIV infection, but who are normally under-represented in household survey approaches—particularly young, mobile and marginalized populations. These groups often drive the growth of the epidemic in its early stages and continue to fuel more mature epidemics, while providing transmission routes

for HIV into the broader population. Thus, reducing the level of risk behaviours among these individuals is absolutely essential to effective national prevention efforts.

The choice of groups will vary according to the risk situation in each country and the needs of the various individuals, communities and organizations that may use the results. An example of the diversity of populations included in BSSs in a few selected countries is illustrated in Table 1 below.

TABLE 1

Examples of Behavioural Surveys in Selected Population Groups

Country	Female	Male
Cambodia	Sex workers Beer vendors Working women	Military/Police Motorcycle drivers Vocational students
Kenya	High-paid sex workers Low-paid sex workers Youth	Bus drivers Youth
Indonesia	Brothel-based sex workers Non-brothel based sex workers Factory workers High school students	Truck drivers Sailors and seaport workers Factory workers High school students
Senegal	Registered sex workers University students Secondary school students Domestic housekeepers Women in income-generating groups Office workers	University students Secondary school students Truck drivers Apprentices in the informal sector Workers
Thailand	Direct sex workers Indirect sex workers Factory workers Vocational students	Army conscripts Factory workers Vocational students

In countries where little behavioural information is available or target populations are not clearly defined, BSSs might include an initial pilot phase with more in-depth formative research to, for example, establish the characteristics of clients of sex workers. Alternatively, the pilot phase may be built into the first round of data collection, with multiple target populations included. Some of these target populations may be dropped in later rounds or included only in alternate waves.

The key requirements for successful surveys in targeted groups are definable populations and workable sampling frames. It is important that a chosen population is at least minimally stable and cohesive so that it is possible to describe the population and repeat surveys in the group over time in order to measure trends. Gathering information on HIV-risk behavioural trends in a population with rapid, complete turnover and constantly changing demographic dynamics would clearly be impossible to interpret.

How to sample BSS target populations

Populations such as sex workers may contain sub-populations with more or less stability (for example, brothel-based and non-brothel-based workers). Similarly, men who have sex with men may be easier to identify and sample in areas where there are organized social settings, such as gay bars, than in places where male–male sex is highly stigmatized and clandestine. In these situations, careful ethnographic research must be used to describe the multiple settings in which

risk behaviours occur and to create a representative list of locations and estimate of populations (sample frame) accessible at each site.

Where the locations of risk behaviours or populations-at-risk are rapidly changing, reconstruction of the sample frame may be required prior to each survey round. BSSs, unlike HIV-seroprevalence surveillance, do not require that specific site locations be maintained in each round. While the maintenance of sites is generally preferable from a practical point of view, methodologically it is not absolutely required.

Sampling approaches should be consistent and repeatable so that trends in the selected populations can be measured over time. To improve the quality of the results, probability sampling is encouraged whenever possible.

What can be measured? The repeat cross-sectional methodology of target-group-based behavioural surveys provides programmes with more immediate short-term indications of progress, as opposed to epidemiological data such as HIV-prevalence trends, in which the impact of a prevention programme is not evident for several years and is likely to be influenced by many other factors unrelated to interventions. Specific indicators related to condom use, the number of non-regular (or casual) partners, awareness of STI symptoms and appropriate treatment approaches can all be included in BSS systems. (Recommended indicators are included in Appendix I.)

It is important to keep in mind that programme evaluation in general, and behavioural surveillance research in particular, are often expected to answer more questions than is possible. For behavioural surveillance to be successful, certain trade-offs often must be made between the objectives of a surveillance system, an evaluation system and an intervention research system. Each context implies a different set of methodological questions, strengths and weaknesses and possible outcomes of interest. As with any research endeavour, clearly defining and articulating the objective of behavioural surveillance in a participatory manner is essential for its success.

Conclusions The experience of conducting target-population BSSs in nearly a dozen countries worldwide has proven the value of the approach as a best practice methodology and an essential complement to the information provided by general-population behavioural and biological surveys. However, the experience of implementing BSSs in these settings has also demonstrated the importance of tailoring the strategy to the local conditions and needs. The remainder of this case study will focus on two examples of how the BSS approach was tailored in the diverse settings of Tamil Nadu, India, and Senegal. While the examples illustrate the common steps taken in designing and implementing the methodology, they also show how the requirements of each programme demanded different specific details.

BSS IN TAMIL NADU, INDIA

Overview of BSS planning and implementation

Planning for the BSS in the Indian state of Tamil

Nadu began well before the first round of data collection, which was carried out in 1996. The first step was to build consensus by involving all stakeholders from the earliest stages. Planning meetings and workshops were conducted by the United States Agency for International Development (USAID)-funded AIDS Prevention and Control Project (APAC) of Voluntary Health Services in Chennai (formerly Madras), Tamil Nadu, India, in collaboration with local and international non-governmental organizations (NGOs,) university researchers and representatives from the government and donor communities. Participants in these meetings carefully examined the available information related to HIV/AIDS seroprevalence and risk behaviours and identified the additional information required to increase understanding of the dynamics of the HIV epidemic in Tamil Nadu and determine future needs. These meetings led to stakeholder agreement on how to best implement BSS to complement the HIV sentinel surveillance system directed by the Tamil Nadu State AIDS Control Society (a nongovernmental institution set up by the state government) and which target groups to include.

Step 1: Choosing target groups for BSS

A variety of epidemiological, evaluation, accessibility and political-cultural factors affected the choice of target groups in Tamil Nadu. The specific characteristics of the Tamil Nadu epidemic—one of the most severe in India—pointed to sex workers as a prime group to target. Existing behavioural research, both qualitative and quantitative, suggested that clients of sex workers came from various social and economic strata in the population. In order

to capture trends from a manageable variety of these strata, as well as to confirm levels of risk beyond anecdotal data, the following male groups were chosen:

- truck drivers and their helpers
- male factory workers
- male students (late high school/early college)

One additional group, male STI clinic attendees, was added to obtain information on the characteristics of individuals who attend government clinics. This group was added despite recognition that tracking its behavioural trends would be problematic due to the changing profile of STI clinic attendees and the correlation between STIs and behavioural risks. (In other words, men with reduced risk behaviours—and consequently reduced risk of having an STI—would drop out of the population, changing the group dynamic over time).

In addition to sex workers, two groups were chosen to track risk in female sub-population groups: female students (same definition as male students) and female factory workers. These groups were selected because qualitative research results suggested that they were more vulnerable to HIV infection as a result of early sexual initiation, unstable partnerships and the possibility of indirect commercial and casual sex (primarily among the factory workers).

Step 2: Defining the sampling approach

A two-stage cluster sampling approach was used. In the first step, a list was drawn up of 48 priority urban areas in Tamil Nadu. Ten of these were chosen as areas where large

concentrations of the sample target groups were located. In each area, a cluster sample of sites was selected from among all known sites. The minimum number of sites was set at three in each town. With the assistance of nongovernmental and governmental organizations familiar with the sample groups, a mapping exercise was conducted to locate sites and to make reasonable estimates of the sizes of all target groups in all sites in the specified towns.

Because the purpose of the BSS is to measure changes over time, sample sizes were calculated to detect a certain level of change. For the purposes of the BSS in Tamil Nadu, an absolute change of between 10 and 15 percentage points was considered appropriate. Since not all individuals in every sample group reported risk, sample sizes were inflated to ensure that the sample size requirements for the variables of interest could be met. Further sample size inflation was calculated to account for the design effect of a cluster sample.

For the first wave of data collection, baseline levels of risk were unknown in many of the groups (for example, students and factory workers) and had to be estimated for sample size calculations. The sample sizes were updated for the second wave of data collection using the actual data from the first wave, which allowed for more appropriate sample sizes. Table 2 illustrates the estimated percentage of each target group who had non-regular sex partners (which were used to calculate inflated sample sizes) and the final sample sizes of the first wave.

TABLE 2

Selected population groups, levels of risk behaviour and estimated sample sizes for the first round of BSS in Tamil Nadu, India

Sample Group	Estimated % Who Had Non-Regular Sex Partners	Sample Size
Female sex workers	100	400
Male STI clinic attendees	60	600
Truck drivers and helpers	60	600
Male factory workers	25	1300
Female factory workers	20	1600
Male students	20	1700
Female students	10	6000

Step 3: Determining behavioural indicators

In collaboration with USAID and the AIDS Control and Prevention (AIDSCAP) Project of Family Health International (FHI), and drawing upon international experience in indicator development, the APAC Project chose a robust set of nine project indicators. These indicators included four knowledge indicators, two behavioural indicators of non-regular sex partnerships and condom use, one risk perception indicator, one STI symptom indicator and one STI treatment-seeking behaviour indicator (see Appendix I).

The project indicators were a small subset of a variety of knowledge and behavioural variables that were included in the target-group-specific questionnaires. The questionnaires were adapted and pretested from a core set of instruments for use with the BSS methodology. These instruments have been developed from the cumulative experience of hundreds of studies worldwide, and they provide standardized indicators suitable for comparison with other programmes both within and outside India.

Step 4: Analyzing and disseminating results

The BSS in Tamil Nadu was conducted in 1996, 1997 and 1998, under the auspices of the APAC Project, by the Asian Information, Marketing & Social Research (AIMS) research organization. The most important results showed significant decreases ($p < .05$) in non-regular partnerships and increases in condom use—two factors that have a direct impact on the spread of the epidemic.

Results show that two key male population groups—truck drivers and factory workers—reported increases in condom use with both their commercial sex partners and other non-regular sex partners. Truck drivers reporting that they had used a condom during their most recent sexual intercourse with a sex worker increased from 55 per cent in 1996 to 66 per cent in 1997, and up to 75 per cent in 1998. They reported similar increases in condom use with other non-regular partners, from 44 per cent in 1996 to 66 per cent in 1998.

Among male factory workers—who are more representative of the general population—condom use with sex workers increased from 28 per cent in 1996 to 41 per cent in 1997 and 67 per cent in 1998. The factory workers likewise reported an increase in condom use with other non-regular sex partners—from 17 per cent in 1996 to 50 per cent in 1998.

These reported increases in condom use were corroborated by measurements of condom use among the sex worker sample in the BSS. Comparisons of the three data points across time indicated increases in reported condom use among sex workers with their last client—from 56 per cent in 1996 to 80 per cent in 1998.

The BSS also indicated significant change in male patronage of female sex workers. Twenty-five per cent of truck drivers reported visiting at least one sex worker during the past year in 1998, down from 38 per cent in 1996 and 27 per cent in 1997. Factory workers also reported lower levels of commercial sex: 7 per cent in 1996, 4 per cent in 1997 and 5 per cent in 1998. (The differences in the 1997 and 1998 levels are not statistically significant.)

Other non-regular sexual partnerships were also reported to have declined. Truck drivers reporting having had at least one non-regular sex partner in the past year decreased from 48 per cent in 1996 to 32 per cent in 1998. Factory workers also indicated reduced risk, from 15 per cent in 1996 to 9 per cent in 1998. Analysis of HIV-risk behavioural trends was accomplished using the chi-square for trend. Selected results are illustrated in Figures 1 and 2.

FIGURE 1

Condom use during commercial sex among select target populations, Tamil Nadu, India, 1996–1998

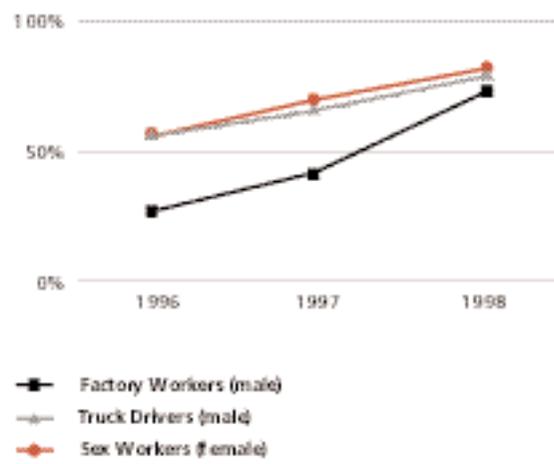
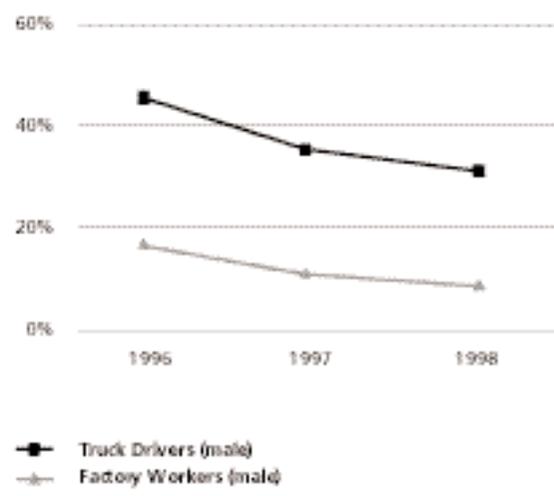


FIGURE 2

Per cent reporting non-regular partnerships in past 12 months, Tamil Nadu, India, 1996–1998



The dissemination of the Tamil Nadu BSS results has occurred through multiple channels, including local workshops, state, national and international conferences and detailed publications. The objectives of the dissemination have been to use the Tamil Nadu results to guide programme design, provide donors with evaluation results and explain and anticipate trends in HIV-seroprevalence data.

Lessons learned from the Tamil Nadu BSS

- The BSS proved to be an effective tool for monitoring behavioural trends in the Indian state of Tamil Nadu, complementing HIV surveillance.
- Sample sizes need to be recalculated after the initial round of data collection wave to confirm that they are large enough to detect trends.
- Knowledge indicators tend to change quickly and become less useful for evaluation over time. Behavioural risks are more challenging to monitor and change.

The student groups in the Tamil Nadu BSS indicated lower risk than was expected; therefore, they were not included after the second wave. Group coverage and inclusion should be re-examined following each wave. If, for example, some groups exhibit low levels of risks, then tracking risks in that group may no longer be feasible or efficient. Conversely, new data may emerge indicating the population sub-groups that should be included in behavioural surveillance.

BSS IN SENEGAL

Overview of planning and implementation of BSS

The HIV epidemic in Senegal can be classified as a concentrated epidemic, with greater than 5 per cent HIV prevalence in so-called core groups (such as sex workers in the case of Senegal) and lower than one per cent prevalence in the general population (usually measured through antenatal clinic attendees, i.e., pregnant women). Very little quantitative information on HIV-risk behaviours was available in Senegal prior to the implementation of BSS in 1997. Only one large-scale population survey had been conducted in the capital, Dakar, in 1989, and limited data relevant to HIV/AIDS was collected from a Demographic and Health Survey (DHS) conducted in 1992.

Senegal was the site of one of the earliest BSS implementations, following successful efforts in Thailand, India and Indonesia. It was the first in Africa, yielding important insights into the implementation of behavioural surveillance in the African setting.

In Senegal, as in Tamil Nadu, the first step in the planning and implementation of the BSS was to build consensus by involving all stakeholders. Planning meetings were conducted in collaboration with the National AIDS Programme and all the major donors working in HIV/AIDS prevention, including the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Health Organization's Global Programme on AIDS (WHO/GPA), its successor, the Joint United Nations

Programme on HIV/AIDS (UNAIDS), the United States Agency for International Development (USAID) and other bilateral donors. At first some stakeholders were sceptical of the viability of the BSS, but interest grew slowly among the various partners and developed into enthusiastic support as results from the first wave of data collection became available.

Step 1: Choosing target groups

for BSS Due to the lack of established sampling frames from high-risk populations in Senegal, it was decided to conduct BSS initially among the most easily definable and accessible young and mobile populations (secondary and university students). Because of the paucity of behavioural data on the general population, a male general population group of office workers was also included. Registered sex workers were also accessible, and therefore included.

In hindsight it is clear that the accessibility of the student populations and the general characterization of these groups as particularly “vulnerable” should not have outweighed their relatively low levels of risk behaviours when target groups were chosen. Particularly in the context of a concentrated epidemic, secondary and university students should not have been a high priority in the selection of target populations. In fact, it was the higher-risk groups—registered and non-registered sex workers and their partners (clients)—who would have been most appropriate to target in the initial wave.

Defining the geographical regions to include was also a challenge, as donors were involved in various zones of the country, creating a patchwork of programmes, messages and targeted audiences. Due to the challenges of designing the BSS in this context, many negotiations and compromises were made. The eventual choice of target groups and geographical zones represented a concession to practical constraints without ignoring key criteria for behavioural-surveillance systems.

The first wave of BSS was constructed as a start-up phase, with three female and three male populations chosen in the four main provincial zones of the country (Dakar, Thies, Kaolack and Ziguinchor, together home to more than 50 per cent of the Senegalese population). In the second wave the BSS was expanded to cover some of the harder-to-reach groups believed to have higher levels of risk behaviours, such as truck drivers and male apprentices. Since the main objective of the BSS is to provide trend data, it also covered female workers and provided repeat measures for students and registered female sex workers (FSWs). Data collection was also expanded to the entire country during the second wave, and sample sizes were increased to allow for separate analysis in the major metropolitan zones with a longer history of HIV/AIDS-prevention programmes and the minor zones with less exposure to interventions. Target populations and sample sizes are summarized in Table 3.

TABLE 3

Senegalese Target Populations and Approximate Sample Sizes

	Sex	Target Population	Approx. Sample Size
Wave 1	Male	Secondary students	400
		University students	500
		Workers	400
	Female	Secondary students	400
		University students	500
		Registered FSWs	400
Wave 2	Male	Workers	500
		Truck drivers	900
		Secondary students	1100
		Apprentices	500
	Female	Young domestic workers	500
		Secondary students	1200
		Workers	1200
		Women's cooperative members	1200
		Registered FSWs	650

Step 2: Defining the sampling approach and frequency of data collection Sampling approaches in Senegal generally followed the model developed for the first BSS in Thailand. Considerable effort was expended in developing sampling frames for every target population, and much was learned about how to sample hard-to-reach, hidden populations. During this period of BSS methodology development, the focus in sampling was increasingly on the use of probability methods whenever possible and, where they were not possible, the use of random, systematic, repeatable approaches.

Many of the BSS target groups chosen for the initial wave proved to have low levels of risk behaviours. This meant that measuring changes in behaviour would be difficult and would require very large sample sizes. Consequently, it was decided during the second wave to conduct future waves among low-risk groups on a biannual basis, allowing greater changes to occur in the context of ongoing interventions. For higher-risk groups, it was decided to maintain annual data. This decision facilitated the selection of a greater overall number of target populations, as requested by the national programme.

Despite the adaptations, by the end of the second wave of data collection the practical constraints of conducting repeated behavioural surveys among low-risk groups—low levels of risk behaviour and consequent difficulty documenting change—became increasingly evident. Current BSS guidelines do not include low-risk groups at all, but rather recommend covering these populations through general population household surveys.

Step 3: Determining behavioural indicators

As in Tamil Nadu, behavioural indicators were chosen for Senegal in collaboration with programme managers and other stakeholders according to internationally recommended standards (see Appendix I). The Senegalese researchers used core questionnaires already developed for behavioural surveillance surveys and customized them through a rigorous process of pretesting that involved focus group discussions with members of each target group.

Step 4: Analyzing and disseminating results

The analysis of first wave results in Senegal was very important to the assessment of programme success and future programme planning. The results were disseminated widely with the active participation of all stakeholders, which was useful for ensuring continued support of the BSS into the second wave. In fact, enthusiasm for the first wave of BSS results led to increased participation and funding from such donors as UNICEF and UNDP.

Results in Senegal show that the percentage of sexually active men who reported visiting a sex worker in the previous 12 months was relatively low: 9 per cent of male workers

(n=465) and 5.3 per cent of male truck drivers (n=837) in 1998. However, 21.5 per cent of male workers and 21.8 per cent of truck drivers reported one or more non-regular partners. In addition, 29 per cent of all male workers sampled (n=500) and 32.7 per cent of all male truck drivers sampled (n=900) reported more than one regular partner in the previous 12 months. There are no trend data yet available from these two groups since they were not monitored in the first waves of data collection. However, it will be important in the future to try to understand whether the lower rates of commercial sex among men compared to Tamil Nadu, despite other multiple partners, are in part responsible for lower levels of HIV in Senegal relative to other countries.

Also of note in Senegal was the very high percentage of sexually active male youth reporting more than one sexual partner in the previous 12 months. In 1998, 40 per cent of sexually active male apprentices (n=186) and 48 per cent of sexually active male secondary school students (n=480) reported more than one sexual partner in the previous 12 months. Sixteen per cent of the apprentices and 22.5 per cent of the students reported more than two different partners in the previous 12 months. It will be important to monitor these groups in the future, especially if HIV levels in Senegal begin to rise.

Lessons learned from the Senegal BSS

The Senegal BSS was the first of its kind conducted in Africa. The fact that it provided crucial data on previously unmonitored groups playing potentially critical roles in the spread of the HIV/AIDS epidemic had

obvious importance, and the experience led to the initiation of BSS systems in several other African countries. Many lessons emerged from the Senegal BSS that have helped pave the way for changes in the BSS methodology. These touch on a range of issues, from the criteria for selecting target groups and geographical locations, to the importance of building an institutional base for maintaining the system.

In terms of the selection of target groups, the most important lesson was that due to the low HIV-prevalence levels in Senegal, surveillance could have been restricted to high-risk groups only (sex workers and their clients). Although registered sex workers were included in the first wave, the BSS also should have included clandestine sex workers, since this group is often said to be at higher risk than registered sex workers. Unlike registered sex workers, who are required to undergo regular STI screening and have an established network that facilitates delivery of support programmes and services, clandestine sex workers often have fewer safer-sex negotiating skills (such as insistence on condom use) and less access to HIV/STI information and services. Researchers historically shy away from hidden groups such as clandestine sex workers because sampling and interviewing them is difficult. However, even if it is not possible to sample such groups using strict probability methods, it is important to find systematic and repeatable ways to sample them because of their potential epidemiological significance. Continual avoidance of difficult groups can result in missed opportunities to slow the HIV/AIDS epidemic.

Another lesson from Senegal was the importance of disaggregating data from different geographical locations. Although it requires fewer resources to include everyone in one large sampling domain, the failure to obtain separate samples by region precludes the possibility of examining site differences, urban/rural differences or differences that may be related to factors such as border proximity, mobility of the population, migration and possible local differences in sexual practices.

In addition to these lessons, the importance of developing the technical capacity of a local institutional base to conduct behavioural surveillance was seen to be of paramount importance. The involvement of independent private research firms without a vested interest in the continued use of the data is problematic and threatens the sustainability of the system. While this was not strictly the case in Senegal, it is clear that without sufficient capacity building and commitment from the national government and international donors, a high-quality surveillance system cannot be maintained. In addition, although in many countries there is increasing focus on decentralization and participation at the regional/provincial level, there is still a need for a solid institutional base at the central level in order to maintain national standards for surveillance.

CONCLUSIONS

Repeated surveys among hard-to-reach populations with high levels of HIV risk are new to most countries. They require skill,

sensitivity and the backing of the communities involved, all of which take time to build. These skills and community involvement must then be maintained over time, requiring careful selection of a community or institutional base that is sustainable. None the less, the value of the information they provide make such efforts worthwhile, and the increased capacity of research institutions will serve data collection activities for the country as a whole. It is the responsibility of the government and the donors to provide the support needed to maintain data collection capacity at a consistent level.

As with general population surveys, repeat behavioural surveys in specific populations should be complemented by qualitative follow-up in order to interpret their findings in a meaningful way that can inform programme direction and design. While HIV-risk behavioural surveillance fills a long-observed gap in efforts to monitor the HIV epidemic, it is not a panacea for all questions about risk behaviours and their correlates.

BEST PRACTICE CRITERIA

Application of BSS methodology to collect behavioural data for national AIDS prevention programmes is an efficient and effective use of resources and can therefore be considered a “best practice.” Specifically, BSS methodology provides:

Relevance The repeated cross-sectional methodology of target-group-based BSS provides programmes with more immediate short-term indications of progress than epidemiological studies. With HIV-prevalence trends, for example, the effects of prevention programmes are not evident for several years.

Efficiency BSS methodology offers a better chance of providing high-quality data than the usual behavioural studies because the methodology is standardized and the research is carried out by firms specialized in data collection, rather than individual project implementers trying to collect their own pre-/post-KABP (knowledge, attitude, beliefs, practices) data among their own constituencies.

Effectiveness Coordinating data collection among target groups across multiple sites is more cost-efficient because it eliminates the need to collect KABP data separately among smaller groups reached by a multitude of separate projects. Such coordination also allows more effective comparison of data across target populations and geographical sites by ensuring that comparable indicators are collected at comparable points in time. Individual KABP and qualitative methods often fail to allow for direct comparisons and are subject to considerable inconsistencies and subsequent difficulties in interpretation.

Sustainability Implementation of BSS often requires considerable planning and consensus building from all stakeholders. This process of capacity building and the development of “ownership” among stakeholders is the first step in ensuring sustainability. The utility of the results provided by BSS is a key second step.

Replicability Since the introduction of BSS in Bangkok in 1993, the BSS model has been implemented in more than 15 countries, with further sites in the planning process.

AUTHORS

Joseph Amon, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia

Stephen Mills, AIDSCAP, Family Health International, Bangkok, Thailand

Tobi Saidel, AIDSCAP, Family Health International, Arlington, Virginia

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APPENDIX I

RECOMMENDED INDICATORS FOR TARGET BASED BEHAVIOURAL SURVEILLANCE SURVEYS

Indicators recommended for all target groups:

1. Percentage of the entire target population citing at least 2 acceptable (accurate) ways of reducing risk of HIV infection (unprompted).
2. Percentage of the entire target population citing at least 2 acceptable (accurate) sex-specific STI symptoms (unprompted).
3. Percentage of the entire target population who know where to obtain a male or female condom.
4. Percentage of the sexually experienced target population reporting that they ever used a male or female condom.
5. Among those reporting STI symptoms during the previous 12 months, the percentage of the target population who report having sought appropriate treatment for their last STI symptom.
6. Among those reporting STI symptoms during the previous 12 months, the percentage of the target population who report obtaining medications for STI symptoms from an appropriate source during the previous 12 months.
7. Percentage of the entire target population who report knowing someone who is infected with HIV or who has died of AIDS.
8. Percentage of the sexually experienced target population who have had an HIV test and know the result.
9. Percentage of the female target population sexually active in the past 12 months who report having been forced to engage in sexual intercourse during the previous 12 months.
10. Percentage of entire target population reporting exposure to a given intervention.

Indicators appropriate for youth:

11. Percentage of entire youth target population ever sexually active.

12. Percentage of youth target population sexually active in the past 12 months reporting more than one sexual partner during the previous 12 months.

19. Percentage of the entire target population reporting unprotected sex with any non-regular or commercial sex partner during the previous 12 months.

Indicators appropriate for adults (non-FSW):

13. Percentage of target population sexually active in past 12 months reporting sexual intercourse with at least one non-regular partner during the previous 12 months.

20. Percentage of target population with a regular sex partner who has ever discussed HIV/STIs with a regular partner.

14. Percentage of target population sexually active in past 12 months reporting at least one commercial sex partner during the past 12 months.

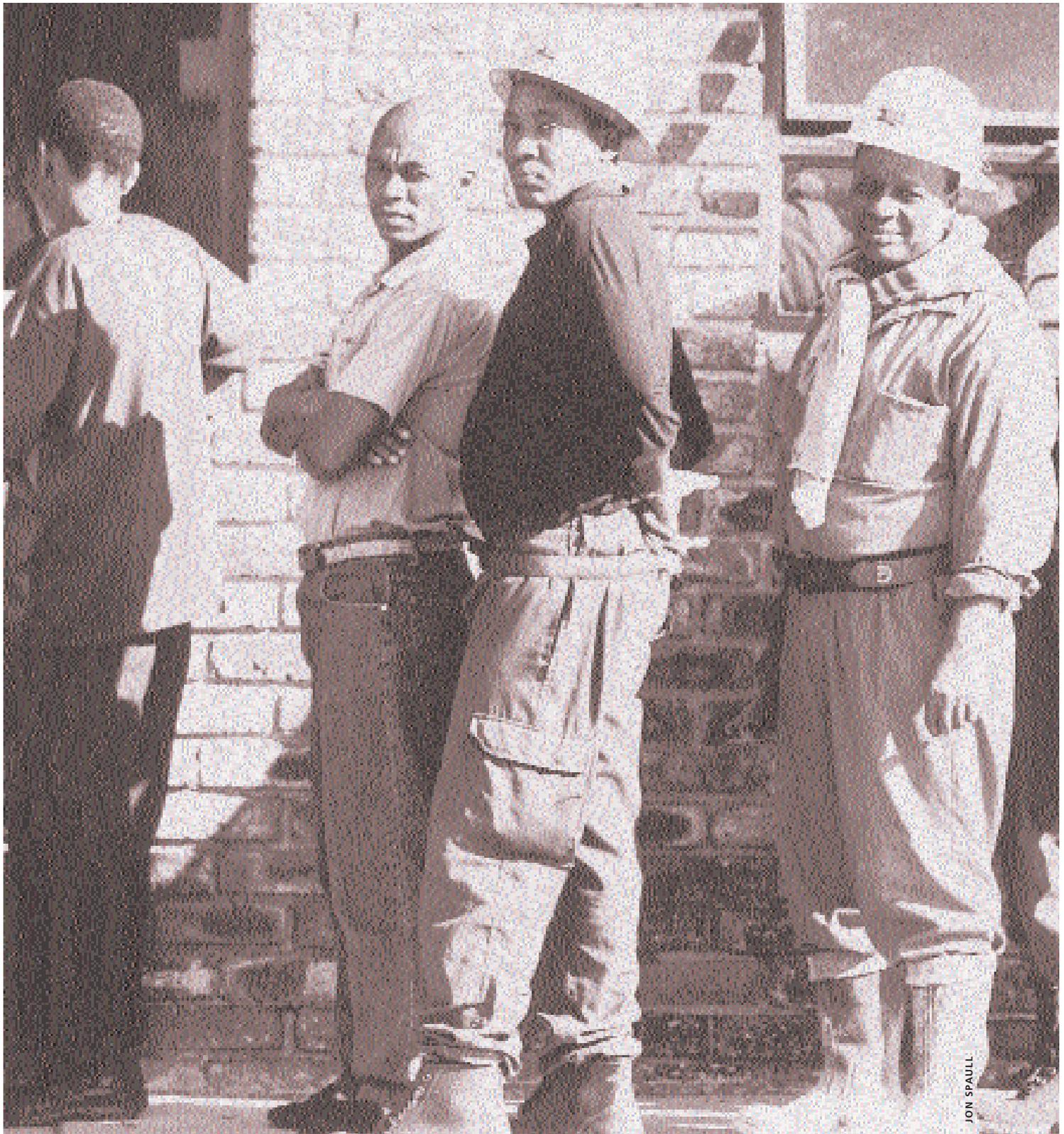
15. Percentage of target population with a non-regular partner in past 12 months reporting condom use during the most recent act of sexual intercourse with a non-regular sex partner during the previous 12 months.

16. Percentage of target population with a regular sex partner in past 12 months reporting condom use during the most recent act of sexual intercourse with a regular sex partner during the previous 12 months.

17. Percentage of target population with a non-regular partner in past 12 months reporting consistent condom use with non-regular sex partners during the previous 12 months.

18. Percentage of target population with a commercial partner in past 12 months reporting consistent condom use with commercial sex partners during the previous 12 months.

Comparing the expected benefits of public health interventions against the implementation costs can provide a powerful argument for sustaining such interventions.



JON SPAULL

HARMONY MINING COMPANY WORKERS WAIT TO RECEIVE THEIR PAYCHECKS IN VIRGINIA, SOUTH AFRICA, THE SITE OF A COMMUNITY PROJECT USING PERIODIC PRESUMPTIVE TREATMENT (PPT) OF SEXUALLY TRANSMITTED INFECTIONS AS AN HIV PREVENTION STRATEGY.

LESEDI: SERVICES FOR WOMEN AT HIGH RISK HELP REDUCE SEXUALLY TRANSMITTED INFECTION (STI) PREVALENCE IN A SOUTH AFRICAN MINING COMMUNITY

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LESEDI: SERVICES FOR WOMEN AT HIGH RISK HELP REDUCE SEXUALLY TRANSMITTED INFECTION (STI) PREVALENCE IN A SOUTH AFRICAN MINING COMMUNITY

INTRODUCTION

The highest rates of HIV infection in the world occur in southern Africa, where some of the countries with the highest per capita income on the continent are most affected. Factors such as rural poverty and the migration of individuals in search of work contribute to the separation of families, resulting in high-risk sexual behaviour. Moreover, high rates of curable sexually transmitted infections (STIs) also facilitate efficient transmission and rapid spread of HIV.

South Africa has seen a major HIV/AIDS epidemic unfold with alarming speed since HIV prevalence was first measured in 1990. Since then, HIV-prevalence rates among pregnant women have increased from less than one per cent to more than 20 per cent in some provinces. Urban areas and regions with large communities based on mining or other industries are strongly affected, but HIV rates are also increasing in the rural areas from which many migrant workers originate. By the end of 1997, 2.9 million South Africans were living with HIV, an estimated 420,000 people had developed AIDS, and 360,000 people had died of AIDS-related illness. In addition, almost 200,000 children under 15 had lost one or both parents to AIDS.

BACKGROUND

Commercial sex is a prominent feature around many South African mines, where thousands of male migrant workers live in single-sex hostels. Genital ulcers due to chancroid, syphilis and herpes simplex virus are common, as are non-ulcerative STIs such as gonorrhoea, chlamydial infection and trichomoniasis. Such high rates of curable STIs in South African mining communities create ideal conditions for HIV transmission.

Sex work encompasses diverse types of relationships in the South African goldfields, where high-risk casual or commercial sexual encounters are common for migrant workers living in the hostels. Many local women, faced with limited economic opportunities, provide sex in exchange for money or other material support. Although they do not necessarily identify themselves as sex workers, they are, nonetheless, highly vulnerable to STIs. While mining companies generally provide quality health services for their employees, the men's casual partners often find themselves with few options for STI prevention or treatment. Miners, in turn, suffer repeat infections when, despite effective treatment, they return to partners who have not been cured.

PROJECT SUMMARY

The Lesedi Project began in October 1996 as a collaboration between Harmony Mine Hospital and Family Health International's (FHI's) AIDS Control and Prevention (AIDSCAP) Project, funded by the United States Agency for International Development (USAID), in response to high rates of STIs, including rapidly increasing HIV prevalence, in South African mining communities. During the first year, mobile-clinic services were established and a peer educator network organized among women at risk in the community.

In the first nine months of the project, peer educators raised awareness of STIs and prevention methods. More than 400 women attended the clinic at least once for examination, counselling and treatment. Clinic protocols were designed to provide effective treatment for the most common curable STIs in the community: all women attending the clinic were offered presumptive antibiotic treatment based on their high risk of exposure. Additional treatment was added, as needed, for women who were symptomatic.

For the evaluation of this first phase of the intervention, STI rates were measured both for the women attending the clinic and the miners living in the area. Among women using the services, STI prevalence was reduced by 70–85 per cent. Local miners screened nine months after the start of the project were found to have a 43 per cent lower rate of gonorrhoea/chlamydia infection and 78 per cent fewer genital ulcers than they had had before the intervention. STI consultation rates at mine health services were also monitored, and miners living in hostels near the intervention had significantly lower rates of symptomatic STIs than those living

farther away. In addition, self-reported condom use during commercial sex rose from negligible levels to 20–30 per cent of encounters within nine months.

By the end of the first year, evaluation results, projections and a cost-benefit analysis were prepared and presented to the management of Harmony Mines. Based on the results, the company, with support from the Department of Health, assumed the management and implementation costs of the project. A steering committee with representation from all stakeholders was formed to oversee the project and guide expansion to neighbouring mining communities.

Since the end of the first phase in mid-1997, services for women at high risk have been expanded. In 1999 the original project area was served by a fixed clinic provided by the mines, and the mobile clinic had been moved to a nearby township. Three full-time nurses were providing services, with plans underway to add two more mobile units. Lesedi peer educators and clinic staff now cover all the high-risk areas in the original town (population >100,000) and have recently started working in a nearby mining town.

PROJECT GOALS

The initial objective of the intervention was to rapidly reduce community prevalence of curable STIs by providing effective STI preventive and curative services to women at high risk of infection.

Current objectives are to extend the intervention to new areas, while maintaining reduced STI prevalence in established areas through a combination of barrier protection and effective treatment services.

MAJOR COMPONENTS OF THE LESEDI PROJECT

The Lesedi intervention was designed and implemented to address a major gap in STI-control efforts in the mining communities: significant reductions in STI rates would not be achieved, it was argued, unless acceptable, effective services were available for the principal groups at risk. The situation analysis carried out during the planning phase revealed that even the most basic services were not available to many of the casual and commercial sex partners of the miners. State-of-the-art STI diagnosis and treatment for miners would have little impact on STI prevalence if the men's partners had poor access to prevention or treatment services.

At the start of the Lesedi Project, this gap was addressed by establishing mobile clinical services for sex workers and other women at high risk of STI infection living around the mines. These services were strongly supported by outreach and behaviour-change activities intended to promote attendance at the clinic and encourage safer sexual practices. Several key principles guided the design of services:

- In order to attract and engage the women most in need of services (with highest STI risk), the women themselves participated in the design of the services provided.
- Since community promotional work was considered as important as clinical services themselves, this aspect was entrusted to peer educators selected from among the women using the services.
- The emphasis was placed on making sex safer—not on eliminating or discouraging commercial or casual sex. Non-judgmental attitudes were considered essential to gain

the trust and participation of the women most in need of project services.

- In order to minimize stigmatization, a broad approach to outreach was adopted. While many of the women who were reached identified themselves as sex workers, others with fewer partners or other jobs did not. Outreach and clinical services were organized to meet the needs of women at increased risk of STI infection because of casual or commercial contact with multiple partners. Labels such as “prostitute” or “sex worker” were avoided to minimize discrimination and facilitate acceptance within a largely conservative rural community.
- Given the inaccuracy (due to low sensitivity) of available diagnostic tests for STI, an approach was needed that effectively treated the maximum number of curable STIs in the women coming for care.

Setting up the Services During the first year of the project, the emphasis was on developing and testing strategies for providing effective STI services that would be used by women at high risk in the community. Key concerns were:

- Reaching the women most in need of STI preventive and curative services.
- Designing the services in such a way that the women would use them.
- Adopting an approach for detecting and treating STIs that would be effective and appropriate for women with high levels of exposure.

As a first step, a situation analysis was undertaken to explore the dynamics of commercial sex around the mines. Researchers from a local university interviewed sex workers, miners, tavern

owners and others. The AIDSCAP *Manual for Targeted Intervention Research on Sexually Transmitted Illnesses for the Setting of Commercial Sex*,¹ an ethnographic research tool for assessing attitudes, perceptions and behaviour related to commercial sex, guided the data collection and interpretation. Results confirmed that STIs and high-risk behaviour were common and that women involved in sex work had poor access to prevention and treatment services.²

Based on these findings, more detailed mapping was carried out in an area chosen for the initial intervention. A residential community with a population of 6,000 to 10,000 situated among three mine hostels (4,000 miners) was mapped to identify taverns, shebeens (informal liquor outlets) and other meeting places where miners relaxed after work. A central location near a shopping area was chosen as the initial site for providing mobile services.

Choosing an Effective Strategy for Diagnosing and Treating STIs

In designing the clinical services for high-risk women, a major concern was to adopt an approach that would accurately identify which women needed treatment. The objectives of the STI- treatment strategy were to:

- Reduce the burden of disease for these women, thus minimizing their risk of STI-related complications and vulnerability to HIV infection.
- Maximize the impact on community STI-prevalence rates by effectively reducing STI prevalence in a key population group most likely to acquire and transmit STI infections.

Previous experience and findings from the situation analysis suggested that many women around the mines were highly vulnerable to STIs, that

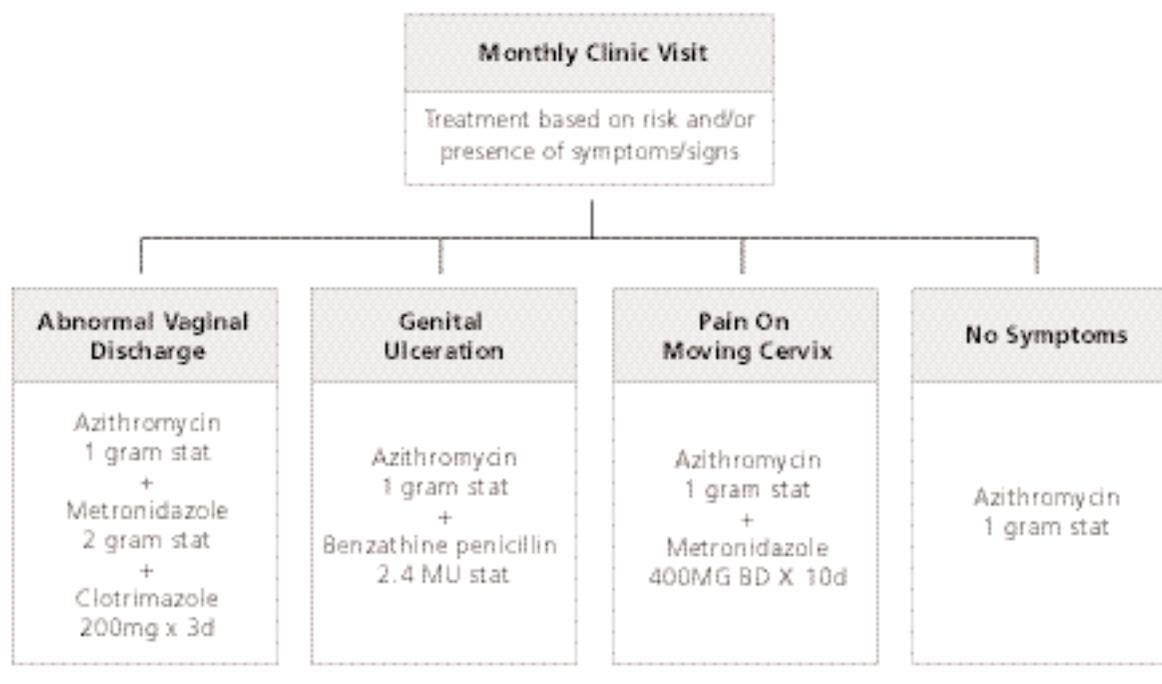
prevalence and exposure rates were high, and that most infections were likely to be asymptomatic. To have maximum impact on STI transmission, it was felt that a “no missed opportunities” strategy was needed to minimize ‘false negative’ results.

As a first step, national syndromic STI guidelines were adapted for use, as previous studies had confirmed their effectiveness for treating individuals with STI symptoms. In addition, two strategies that did not depend on the presence of symptoms in the women were considered. Either periodic screening or presumptive treatment, it was believed, would be sensitive enough to ensure treatment for the majority of women with STIs, regardless of symptoms. Regular screening with sufficiently accurate tests had several disadvantages, however. These included cost, logistical issues and quality control in a community setting. Because of these potential problems, a presumptive treatment strategy was chosen, based on the assumption that prevalence and exposure to STI were high enough to justify treating all the women who presented for care.

The periodic presumptive treatment (PPT) algorithm used at Lesedi is reproduced in Figure 1. All women referred to the clinic by peer educators are encouraged to return monthly for prevention counselling and presumptive treatment with a single one-gram dose of azithromycin. Azithromycin is effective against most of the common curable STIs—chancroid, gonorrhoea, chlamydial infection—and is active against incubating syphilis. Women with symptoms suggestive of STI are given supplemental treatment based on syndromic recommendations. An evaluation of the effectiveness of this approach based on data collected during the first nine months of operation is presented in Sidebar 1.

FIGURE 1

Periodic Presumptive Treatment (PPT) Protocol



Outreach and Promotion of Services

Outreach was organized with the assistance of the condom social marketing company, Society for Family Health/Population Services International (PSI), which was active in the area. Two outreach workers visited the identified meeting places, sought the cooperation of proprietors, introduced themselves to women and explained the purpose of the services. Interested women were given referral cards and encouraged to visit the nurse at the mobile clinic. The nurse, in turn, was able to monitor referrals by means of the cards and met daily with the outreach workers to direct the promotional efforts. Within weeks,

attendance escalated as women attending the services began referring their peers.

Despite early popularity, however, attendance started to drop off after two to three months (see Figure 2). The decrease in first visits was initially interpreted as an indication that most of the eligible women in the area had been reached. However, the team became more concerned when they noted a drop-off in return visits, and the nurse and outreach workers began asking questions. Informal group discussions were held with women who attended the clinic, and perceptions of the services were elicited from women encountered in the community. Several barriers to attendance were identified:

SIDEBAR 1

Periodic Presumptive Treatment: An Approach to STI Service Delivery for Women at High Risk of Infection

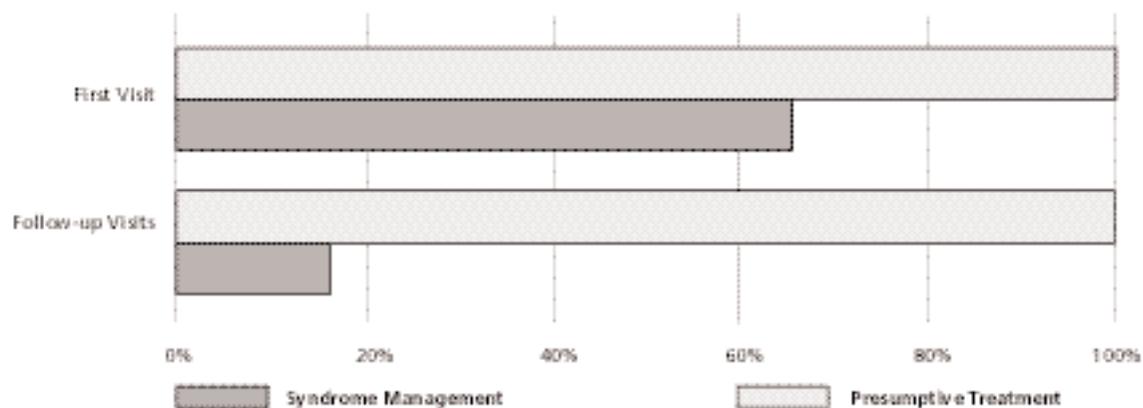
Three STI service delivery strategies (syndrome management, periodic laboratory-based screening and periodic presumptive treatment) were considered when designing clinical services for women highly vulnerable to STI. Both laboratory testing and presumptive treatment require considerably greater resources than syndrome management alone, but may be more cost-effective in populations with high prevalence and exposure to STI.

At Lesedi, periodic presumptive treatment (PPT) was selected over laboratory-based screening because of cost and feasibility concerns and over syndrome management as it was believed that significantly more women with STI would receive the needed treatment if treated presumptively. With syndrome management alone, most STI infections would probably be missed due to the high prevalence of asymptomatic infections. Data collected over the first nine months of the project illustrated the difference in effectiveness between periodic presumptive treatment and syndrome management in treating women with gonorrhoea and/or chlamydial infections.

Using actual prevalence rates of gonorrhoea and chlamydial infection at the initial and follow-up visits, Figure A shows the proportion of STI infections that would be treated using the two approaches. While syndrome management would identify two-thirds of the women needing treatment at first visit (prevalent infections), it performs poorly at detecting new (incident) infection during subsequent visits. Presumptive treatment, by definition, treats all infections.

FIGURE A

Sensitivity of Two Approaches for Treating Gonorrhoea/Chlamydial Infection

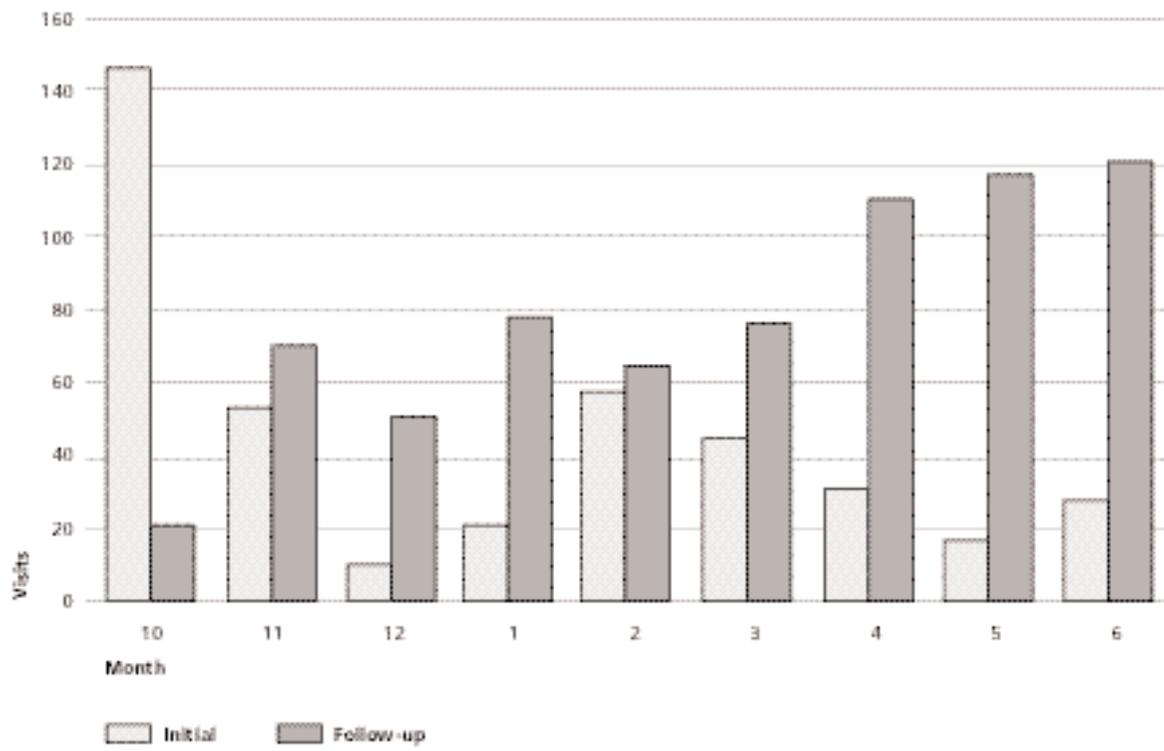


Presumptive treatment would clearly have a much greater impact on STI prevalence than syndrome management alone—at a proportionally higher cost. The cost-benefit analysis summarized in Sidebar 2 considers this cost in relation to the benefits attributable to decreased STI prevalence.

- Rumours about the services were circulating in the community, creating distrust about the objectives of the project. Clinic and outreach staff members were viewed as outsiders with suspect motives and agendas.
- Stigma was also cited as a reason for not attending the clinic. The project nurse heard complaints about the intimate nature of the questionnaire and concerns of clinic visitors that attending the clinic would be seen as evidence that a woman had HIV infection or another STI.
- Women were not convinced of the value of the clinical services and treatment. They expressed confusion about the distinction between HIV and curable STIs and the need for barrier protection against incurable STIs.
- Women disliked having embarrassing questions asked about their sexual practices, and they disliked the discomfort of monthly speculum exams, especially when they had no symptoms. They were also suspicious about the collection of specimens for laboratory testing and were concerned about being identified as having HIV or another STI.

FIGURE 2

Mobile Clinic Attendance Rates: Initial and Follow-Up Visits



Changes were made to address all the issues raised by the women. In order to promote local involvement and build trust, six women who were enthusiastic regular attendees at the clinic were invited to attend a training session for peer educators. An experienced peer education trainer from the Project Support Group in Zimbabwe trained the women and helped organize a system for regular peer educator support and supervision. Peer educators contacted women one-on-one and held group meetings to explain the services and build trust.

The project's clinical services were also adapted to be more acceptable to the women. Since treatment was not dependent on examination findings, a speculum exam was performed at follow-up visits only when women were symptomatic. Efforts were made to improve confidentiality and reduce stigma and to collaborate with the municipal health services to provide a broader range of services, as well as referrals to other needed services. Within a few months of these changes being made, attendance rose to previous levels and more women were returning for follow-up visits.

Consolidation, Expansion and Sustainability

An evaluation of the project, conducted near the end of the first year of operation, confirmed the benefit of the services to the women using them and showed a decrease in STI rates among miners. The clinic was moved to a house provided by the mines with room for an expanded range of services, and the mobile unit was deployed to neighbouring areas. Peer educators met weekly with the nurse to plan activities and discuss solutions to problems encountered. Two nurses were hired for new

project areas. A project steering committee with representation of major project stakeholders met monthly to monitor progress and direct expansion of the project.

PROJECT PARTNERSHIPS AND ALLIANCES

The Lesedi Project began as a collaboration between Harmony Mine Hospital and the AIDSCAP Project of FHI. The initial intervention and evaluation were designed with input from the Reference Centre for STDs of the South African Institute for Medical Research and the Institute of Tropical Medicine, Antwerp, Belgium, and drew on previous AIDSCAP work conducted in the goldfields by the National Progressive Primary Health Care Network and Vista University. The Society for Family Health/PSI assisted with initial outreach efforts and the Project Support Group from Zimbabwe with peer-education training.

With expansion of the Lesedi Project in its second year, a steering committee was formed, chaired by the Harmony medical director and the Lesedi project nurse. Other area mining companies were invited to participate, as were the provincial and national departments of health and the STD Reference Centre. The respective mining companies pledged funds to expand the project in their areas, and the health departments agreed to provide additional support, primarily for evaluation.

Steering committee members have given presentations on the Lesedi Project at regional and national meetings of mine medical officers. The intervention is now being replicated in other mining regions in South Africa.

MONITORING AND EVALUATION

The most comprehensive evaluation of the Lesedi project took place during its first year in the mining community where the intervention was first implemented. Women attending the clinic and local miners were tested for STIs using sensitive assays—urine ligase chain reaction (LCR)—to determine whether the intervention had an effect on STI rates. In addition, continuous monitoring of STI clinic attendance rates in intervention and nearby non-intervention communities has been carried out to follow trends in the common STI syndromes.³

Baseline Levels and Reductions in STI Prevalence and Incidence

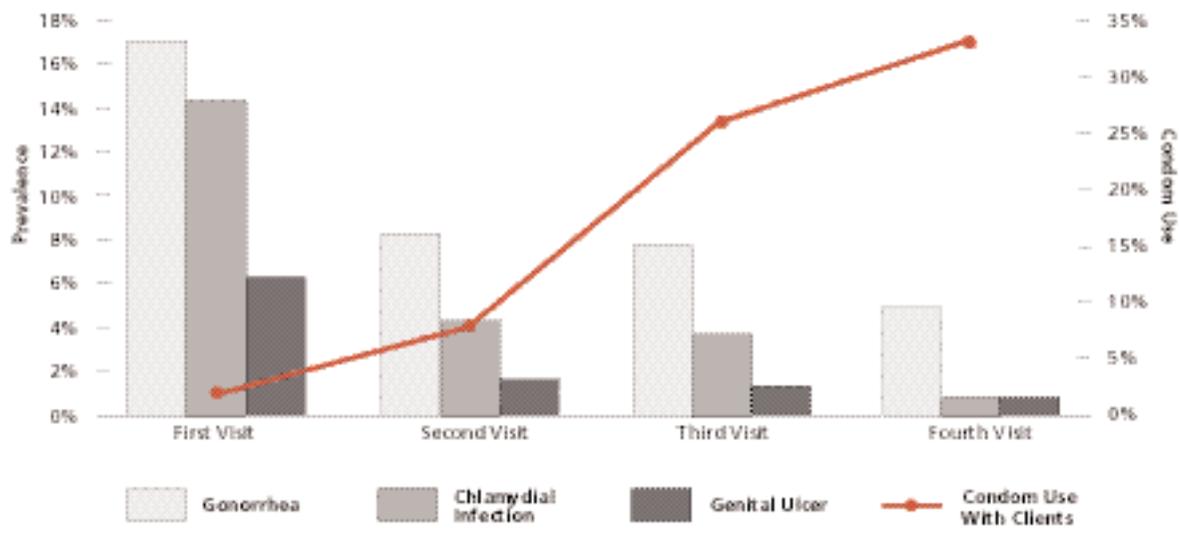
Women using Lesedi services: The prevalence of curable STIs among women who attended the Lesedi clinic for the first time was high. Ten per

cent of the women had genital ulcers diagnosed on examination, and a quarter had either gonorrhoea or chlamydial infection confirmed by LCR. One in three women had a positive syphilis serology (RPR), and half had one or more of the aforementioned curable STIs.

Significant reductions in STI rates (see Figure 3) were documented among women returning for monthly visits, although reinfection was common: within a month of the first visit, 12.3 per cent of returning women had a new gonococcal or chlamydial infection. Despite high rates of exposure, however, monthly treatment effectively suppressed STI prevalence among the women attending the clinic. When calculated as person-months of infection compared to baseline, prevalence of the most common curable STIs decreased by 70–85 per cent. Additional evidence suggests that chancroid may have been virtually

FIGURE 3

STD-prevalence Rates in Women and Reported Condom Use with Clients at Baseline and Follow-up Visits



eradicated from the local mining community within the first few months of the intervention. *Miners:* Two measures of STIs in miners were tracked to find evidence that provision of services for women at high risk of infection would have an effect on transmission among their partners. Miners presenting for routine examination prior to going on annual leave were screened for STI—one group before the intervention started and the other nine months later. Prevalence rates of gonorrhoea and/or chlamydial infection, measured by urine LCR, and of clinical genital ulcers were compared. Rates of consultation

for STI problems have also been monitored at mine medical stations during the project.

Significant decreases in STI prevalence were measured. Miners screened after the start of the intervention had 43 per cent fewer gonorrhoea and/or chlamydial infections and 78 per cent fewer genital ulcers (see Figure 4).

Proximity to the intervention site apparently reduced a miner's risk of acquiring an STI. The miners who lived near the area served by the Lesedi clinic had fewer visits for STI treatment than those living at more distant hostels (see Figure 5).

FIGURE 4
STD Prevalence in Miners Before and Nine Months After Intervention

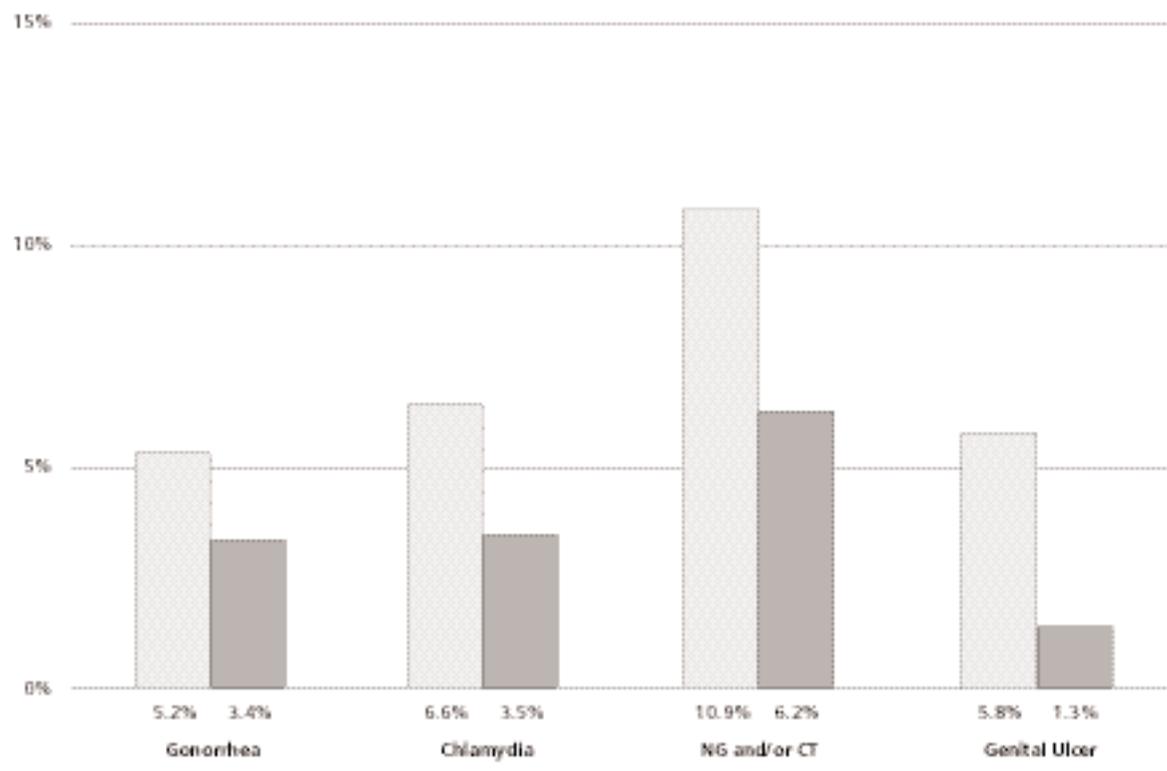
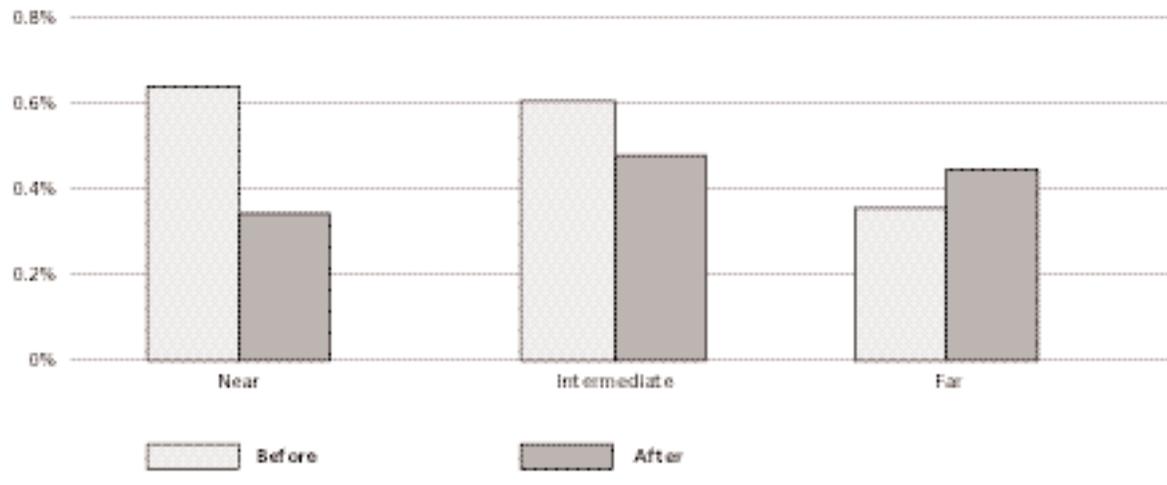


FIGURE 5

Mean Monthly Rates of Outpatient STI Visits (Genital Ulcer Syndrome) by Distance from the Intervention Site



Impact on genital ulcers: Among both women and men, larger decreases in STI prevalence were measured for genital ulcers than for discharges. Because genital ulcers in general, and chancroid specifically, have been closely linked to HIV transmission, further testing was done to determine the specific etiologies responsible for the ulcers.

Samples of ulcer material collected from all the symptomatic women during the first nine months of the intervention were tested. As expected, *H. ducreyi* (chancroid) was the dominant organism detected among women attending the clinic for the first time during the first few months of the project. However, chancroid was not detected in any woman at follow-up visits, nor was it detected among any women attending for the first time after the third month of the intervention. These trends, combined with the dramatic decreases in genital ulcers observed in both the women

and the miners, suggest that chancroid may have been virtually eliminated from the community within a short period of time.

Changes in Self-Reported Risk Behaviour

The risk behaviour of women using the services was assessed by analyzing behavioural data reported at monthly clinic visits. Key indicators were the number of regular/non-regular sex partners and condom use by type of partner. Informal group discussions also were held with peer educators to determine whether any changes in risk behaviour were taking place.

The women's self-reported condom use with their clients increased (see Figure 3), but this reporting may have been influenced by their perception of what was expected of them. Women were also asked to complete coital logs showing the number of sex acts they had engaged in since their last visit and the

proportion where condoms were used. Only about 40 per cent of women completed the coital logs: half reported some condom use, and about one in five sex acts were protected through condom use. Data from miners also indicated a decrease in multiple partners and an increase in condom use during the project period. Peer educators reported that women and miners were having fewer sex partners, were trying to limit the number of casual contact, and were more likely to use condoms, especially with new or casual partners.

Cost-Benefit Analysis Costs of the periodic presumptive treatment (PPT) component of the intervention were tracked and a cost-benefit analysis was carried out based on estimates of averted morbidity and mortality. FHI's AVERT model was used to estimate the number of HIV infections averted in the women using the services and among miners in the area. Hospital costs for inpatient and outpatient care of miners with HIV-related illness were determined from hospital records. (See the cost-benefit calculations presented in Sidebar 2.)

SIDEBAR 2

Cost-benefit Analysis of the Lesedi Project

Comparing the expected benefits of public health interventions against the implementation costs can provide a powerful argument for sustaining such interventions. Simple cost-benefit calculations based on data collected during the first year of the Lesedi project convinced mine management and health authorities to support existing activities and fund expansion of the project.

The costs of carrying out the intervention were derived from project records. Research costs were excluded. Table 1 shows the project costs for one year.

TABLE 1

Lesedi Project Costs For One Year

Annual Costs (In US\$)	
Staff	\$18,000
Outreach	3,360
Rental and utilities	3,600
Supplies and medicines	28,800
Total	\$53,760

SIDEBAR 2 (CONTINUED)

Estimating the potential benefit of the Lesedi intervention is more difficult. As a first step, an estimate of the number of averted HIV infections attributable to the observed changes in STI rates and condom use was made using FHI's *AVERT* model.⁹ Figure B illustrates the estimated averted infections during one year for women using the services (40, or a 39 per cent decrease from what was projected) and miners (195, or a 48 per cent decrease). Table 2 shows the average cost of health services for an HIV-positive patient.

FIGURE B

Estimated Averted HIV Infections

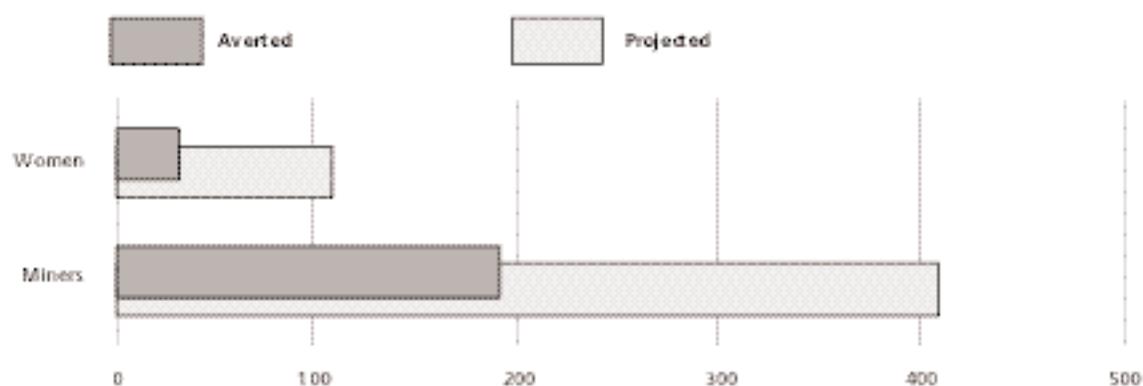


TABLE 2

HIV-related Health Service Costs For Lesedi

Health Service Costs Due To HIV (US\$)	
Average cost/inpatient day	\$72.72
Average cost/outpatient consultation	\$8.87
Average length of stay in hospital	20 days
Average number hospital admissions HIV+	2
Extra outpatient visits for HIV+	15
Average cost per HIV+ patient	\$3,041.60

The medical costs averted—US\$3,042 x 195 estimated averted infections = \$593,190—can then be compared to the annual cost of the intervention: \$53,760.

TABLE 3

Estimated Annual Savings Through the Lesedi Intervention

Estimated Annual Savings (US\$)	
Medical cost savings	\$593,190
Project costs	53,760
Total cost savings	\$539,430

The calculated benefit ratios were high, even when only considering the direct medical costs: the estimated future savings were eleven times the cost of providing the service. A second level of analysis looked at the additional non-medical costs to the mines, including such items as reduced productivity, absenteeism due to illness, labour turnover and retraining, medical repatriation and death benefits. As with medical costs, most averted costs represent expected future savings. Inclusion of non-medical costs increased the benefit ratio more than fourfold.

The AVERT model estimates project outcomes for one year only, which may overestimate the benefit side of the equation. For example, it is not at all certain that someone who avoids HIV infection this year will always avoid becoming infected. Indeed, some costs related to illness might simply be deferred. To account for this possibility, sensitivity analyses were carried out using several different estimates of averted infections, producing a range of 83 to 327 averted infections. However, even the most conservative assumptions resulted in beneficial projections. The direct and indirect costs of HIV are so high that merely averting four infections per year would cover all the costs of the intervention.

Finally, as a cost-benefit exercise for industry, it is important to note that the costs of caring for the other partners of miners who also would become infected with HIV were not considered. Nor was any attempt made to factor in the less quantifiable personal and social costs of HIV infection.

FUTURE DIRECTIONS AND RECOMMENDATIONS

Future challenges for the Lesedi Project, aside from project expansion, include adaptation of the intervention strategy to respond to changing epidemiological and behavioural conditions. Key issues include reducing the frequency of presumptive treatment, increasing levels of barrier protection, strengthening basic STI services and monitoring patterns of antibiotic resistance.

Intensive disease control interventions such as presumptive treatment may be justified when prevalence levels are high enough that the benefits outweigh the costs and potential drawbacks. When effectively implemented, however, they eventually alter the conditions that justify their use. As STI prevalence decreases, for example, monthly presumptive treatment would become less cost-effective—fewer infections would be treated and there would be more unnecessary overtreatment.

Even when justifiable, however, effective STI-treatment strategies are no substitute for primary prevention. Consistent use of barrier methods reduces the risk of all sexually transmitted infection, curable or incurable. High levels (80 per cent or more) of condom use in commercial sex have been shown to reduce STI transmission and maintain lower prevalence rates. It often takes years of behavioural and/or structural interventions, however, to achieve such high rates of condom use.

Presumptive treatment can thus be seen as a potential emergency measure to rapidly reduce STI prevalence in populations with high rates of partner change, low levels

of condom use and high rates of curable STIs. Once STI prevalence is low, however, other more sustainable measures may be more appropriate for maintenance. Such measures should include appropriate support for behaviour change, promotion of consistent barrier protection and access to effective STI treatment. Attention should always be paid to ensuring that preventive and curative services reach those at highest risk of infection.

Future challenges for Lesedi thus include promoting the use of barrier protection at high enough levels to reduce the need for regular presumptive treatment, while adapting STI services to respond cost-effectively to the changing epidemiologic situation. Close monitoring of key indicators, including surveillance of STI trends, is planned, to enable project planners to effectively tailor the intervention to changing conditions. In addition, regular monitoring of antibiotic sensitivity patterns is essential to detect any evidence of emerging drug resistance.

Aspects of the Lesedi experience may be applicable to other settings where commercial sex plays a large role in STI-transmission dynamics. Important principles include participation of the target group in decisions about services, peer empowerment and a comprehensive approach to prevention and treatment. A public health approach, with clear objectives and collection of cost-benefit data, can guide implementation and help ensure sustainability.

It would be more difficult to establish specific criteria (STI prevalence, condom use rates) for including presumptive treatment as an intervention component in other

settings. If condom use is already very high (80 to 90 per cent), there may be little to be gained from presumptive treatment. On the other hand, in commercial sex environments where unprotected sex is common, STI transmission dynamics may justify more aggressive approaches. Any resultant decreases in STI prevalence would serve the interim purpose of reducing HIV-transmission efficiency while the more gradual process of behaviour change takes hold. Protocols recommending different combinations of presumptive treatment and regular screening for sex workers are being evaluated in diverse settings.

BEST PRACTICE CRITERIA

Relevance This experience in implementing a targeted intervention for STI reduction in a mining community is potentially relevant to other communities where the combination of migrant labour and commercial sex create conditions conducive to rapid spread of STIs. It is also an example of the validity of core-group strategies to reduce STI transmission: interventions that effectively reach groups with the highest rates of partner change will have the greatest impact on levels of disease in communities.

Efficiency The demonstrated decrease of STI rates in miners confirms that effectively targeted STI interventions can be highly efficient. Provision of services for 400 women reduced STI prevalence not only in the women themselves, but also in a much larger population of miners as well. Although this was not demonstrated by

the project evaluation, it can be assumed that the benefits of decreased STI transmission also extend to the regular sex partners of the miners.

Effectiveness/Impact Data on STI rates collected during the first year of the project support the effectiveness of this strategy for STI service delivery to women at high risk of infection. Similarly, an impact on STI rates among local miners was documented through several data sources.

Ethical soundness Women and local miners using these services benefited from the project through lower STI prevalence rates. Considerable effort was put into minimizing the possibility of any untoward effect on individuals as a result of participation in the project. Two university-based ethical review boards approved the intervention research protocol, and informed consent was obtained from participants in the course of the project's evaluation activities.

Sustainability The start-up phase of the project was supported largely by donor funds, which were assured for one year only. By the end of the year, after seeing the evaluation results and cost-benefit estimates, mine management and the Department of Health agreed to support the intervention. Since then, the project continued under entirely local support and direction. During the subsequent two years, new areas have been added to the project and two other mining firms have joined the steering committee and pledged support.

AUTHORS

Richard Steen, Africa Regional Office,
AIDS Control and Prevention (AIDSCAP)
Project, Family Health International,
Nairobi, Kenya

Stori Ralepeli, Lesedi Project, Virginia,
South Africa

Tony DeCoito, Harmony Hospital, Virginia,
South Africa

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Qualitative research techniques can be used to assess the knowledge, attitudes and practices of a target audience as they give insight into what, how and why—critical elements in behaviour-change communication.



WENDY STONE/LIAISON

TRAINING OUTREACH WORKERS IN INFORMATION, EDUCATION AND COMMUNICATION SKILLS IS ESSENTIAL FOR COMPREHENSIVE STI AND HIV PREVENTION PROGRAMS, SUCH AS ONE INVOLVING THIS WOMAN IN KENYA.

CAPACITY BUILDING: INFORMATION, EDUCATION AND COMMUNICATION (IEC) TRAINING FOR HIV/AIDS PREVENTION IN KENYA

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CAPACITY BUILDING: INFORMATION, EDUCATION AND COMMUNICATION (IEC) TRAINING FOR HIV/AIDS PREVENTION IN KENYA

INTRODUCTION

Information, education and communication (IEC) materials are an important component of behaviour change communication (BCC) efforts. To be effective, however, they must be carefully designed or selected to meet the specific needs of a target audience. The Kenya AIDS NGO's Consortium (KANCO) recognized that most of the staff of its 200 member organizations did not have the formal IEC training that would allow them to develop much-needed HIV/AIDS-prevention materials or to evaluate the most appropriate existing materials.

In response, the Programme for Appropriate Technology in Health (PATH/ Kenya) and Family Health International's (FHI's) AIDS Control and Prevention (AIDSCAP) Project, funded by the United States Agency for International Development (USAID), collaborated on developing a long-term training approach for KANCO members. This approach provided both a solid theoretical framework and practical grounding in IEC approaches to create a team of NGO programme officers who could promote sound IEC practices for use in future behaviour change programmes.

GOAL AND OBJECTIVES

The overall goal of this technical assistance project was to build the capacity of Kenyan institutions to carry out HIV/AIDS-prevention and control activities by strengthening and institutionalizing IEC media and materials development skills among the programme staff of KANCO member agencies.

The main objectives of these training sessions were to enable programme officers to:

- Understand and practice all the sequential steps for developing IEC materials.
- Acquire skills needed to develop effective IEC materials on HIV/AIDS prevention.
- Develop at least two versions of one new HIV/AIDS IEC material.
- Disseminate the materials developed to all interested groups.
- Share different experiences, expertise and materials.

EXECUTION OF THE TRAINING PROGRAMME

Identification and Selection of Trainees

PATH's aim was to reach as broad an audience as possible. After the list of KANCO member organizations had been updated, letters were sent to the organizational directors with information on the objectives and structure of the proposed

training and a request that they nominate suitable candidates (programme officers)—preferably those working in relevant BCC units.

To further sensitize and inform the directors about the training programme and what it would entail, PATH organized a half-day “kick-off” meeting for key persons from the organizations asked to nominate participants. The purpose of the meeting was to brief participants on the background and rationale for the training and to emphasize the need for nominated persons to attend all the training sessions. The 29 meeting attendees represented 24 Kenyan organizations.

During the meeting PATH conducted an exercise in which participants worked in groups of five to form a square from odd-shaped cards. The lesson drawn from this exercise was that individuals achieve better results when they pool their resources and expertise to work as a group. This reinforced the rationale for KANCO members to meet together for training in effective media and materials development and to then work together to develop communication interventions for their common target audiences.

Training Methodology The training was accomplished through a series of nine two- to three-day training workshops conducted between December 1993 and August 1996. Participants were carefully selected following the meeting with key NGO representatives. This process ensured commitment from the organizations to release their chosen participants for the full training, including essential field activities, and gave programme officers a chance to practice new skills in their work between training sessions.

Before the workshop started, PATH trainers gave a questionnaire to all nominated participants.

This questionnaire was not a test of knowledge. Rather, it sought information on participants’ expectations and prior experience in developing or using BCC materials. Its purpose was to give the trainers insights into the participants and their backgrounds and levels of experience. PATH trainers learned that some participants had been exposed to some of the information the training was designed to cover, while several others were total novices. The task of the trainers, therefore, was to accommodate both groups in a way that maximized the strengths of each. Thus, PATH used a flexible approach to cater to the differing needs of the participants.

PATH programme officers were the lead facilitators/trainers in all the workshop sessions. PATH also invited other professionals (a graphic artist, a radio and TV producer, and a printer) to facilitate relevant sessions and work with the trainees in various workshops. In all cases, PATH trainers used participatory training methodologies and group work and provided relevant handouts for reference.

Participants were grouped into teams that worked together over the course of the project, in both workshop training sessions and the field. The teams selected the target audiences for their materials. In the subsequent training sessions, the course covered all aspects of materials development, production and dissemination. Key topic areas included: qualitative and quantitative research design for an initial needs assessment among the target audience(s); incorporating research results into message design and development, including handling controversial issues; selecting the appropriate media and format; working with artists and producers; field-testing and revising

materials; making costing and production decisions; and, materials dissemination.

Two stages in this process proved very challenging. The first was trying to interpret research findings as the basis for message development. Participants were familiar with the old-school way of assuming “we know what the issues in HIV/ AIDS are...and we can therefore go straight into writing our materials.” In many projects in the past, this assumption has resulted in the production of materials that are laden with information, but ineffective in stimulating decision-making or behaviour change. Thus, PATH trainers worked rigorously and challenged workshop participants to think “outside the box” —in other words, to be creative in thinking “what will be new in my material, and what is the desired action response from those who see or read my message?” The second challenge was in pretesting, getting participants to realize that it is not the writer’s perspective that really matters in gauging the efficacy of the message, but rather that of the target audience. Some participants were very “possessive” of what they had written and reluctant to incorporate the drastic revisions suggested by pretest audiences.

THE MODEL ADOPTED FOR THIS IEC TRAINING SERIES

Effective communication strategies are designed to meet very specific and clearly defined objectives. Over the years PATH has developed a systematic approach for developing effective BCC materials. The framework presents a continuous process, but has seven identifiable steps or stages that overlap and feed into one another. These steps, which were designed to be followed sequentially, are:

- strategic planning and design
- developing messages and designing materials
- pretesting and revising materials
- training in how to use and monitor the use of materials
- evaluating the impact of materials
- planning for continuity.

PATH has used this model in various settings and has produced a comprehensive IEC materials development training curriculum based on it.

In carrying out the training for Kenyan NGO staff, PATH trainers used each of the model’s seven steps to form the content of a two- to three-day workshop. Where necessary, the content of one step was covered in more than one workshop.

Analysis (Workshop One) Changing human behaviour through communication demands that programme implementers maintain a thorough understanding of: the problem to be addressed (to make sure there is understanding of what the issues are); the target audience or the group(s) to be served (segmented by various demographic, geographical, and social and economic factors that influence or shape people’s behaviour); the capabilities of local institutions (including who is doing what and where, in order to build on their work); existing policies and programmes (to capitalize on the positive ones and avoid potential conflict); and, programme priorities (to ensure that they are consistent with programme goals).

During this first workshop, PATH invited an epidemiologist from the National AIDS and STD Control Program of the Ministry of Health to give a presentation on HIV/AIDS in Kenya using a computer model. This model, known as the AIDS Impact Model (AIM), presents HIV/AIDS data that include the profile of

groups infected, projected future trends, the implications of these HIV/AIDS trends for various sectors of the economy, and the effects of different HIV/AIDS-prevention and control interventions on trends in HIV transmission and infection in the population. This session gave trainees updated information on the HIV/AIDS situation in Kenya and helped them identify priority issues and groups for intervention focus.

In addition, participants reviewed the different organizations' approaches and experiences in HIV/AIDS-prevention and control activities, identified primary target groups and reviewed existing IEC materials. After much discussion and review of existing materials, participants agreed to focus on pre-adolescents, adolescents, youth out-of-school, adult men and couples.

Research Methodologies (Workshop Two)

The second workshop exposed trainees to formative research methodologies with an emphasis on qualitative methods, particularly focus group discussions (FGDs) and in-depth interviews. PATH emphasized qualitative research techniques because qualitative data disclose information that may be used to influence the audience's behaviours or allay their fears or doubts. Qualitative research techniques can be used to assess the knowledge, attitudes and practices of a target audience as they give insight into what, how and why—critical elements in behaviour-change communication.

The objectives of this second workshop were to enable participants to learn how to organize and conduct focus group discussions, practice facilitating and note taking in an FGD and develop an FGD topic guide.

Highlighted in the training were the critical interpersonal communication skills needed to conduct effective FGDs. Such interpersonal communication skills include questioning (with an emphasis on probing responses to open-ended questions) and listening skills. Participants were also taken through various perception and values clarification exercises to help them learn that because people's values and perceptions differ, leaders need to remain objective while conducting FGDs.

Data Analysis and Strategic Planning

(Workshop Three) During the third workshop, participants worked together to summarize and analyze the qualitative data they had gathered. Manual analysis involved categorizing the information, identifying key words or phrases from participant responses, identifying patterns in responses (issues that are reported similarly across FGDs) and interpreting (making inferences from) the patterns.

To help participants summarize data, PATH introduced FGD summary sheets grouping information into the following categories: general impressions or observations of the facilitators and note takers based on the main points discussed in the FGD; knowledge about HIV/AIDS; attitudes/beliefs about HIV/AIDS; behaviour/practices related to HIV/AIDS; quotes to illustrate key findings; recommended interventions and media preferences; and, any other relevant information that did not fall directly into any of these categories.

Having summarized the research findings, participants were introduced to the process of developing a strategic plan. A strategic plan in this setting uses the information gathered through

the analysis described in the first workshop, as well as the research findings, to set priorities and formulate clear, specific objectives to be accomplished through the communication strategy. The objectives must be specific, measurable, appropriate, realistic and time-bound (SMART).

Through this process of developing “SMART” objectives, project planners can develop more targeted strategies by identifying where various segments of the target audience are on the behaviour-change continuum. All target audience members pass through several stages as they decide whether or not to adopt a new behaviour. In a simplified description of the decision-making model, the stages of behaviour adoption can be outlined as follows: people become aware of the new behaviour or product, they decide to try it, they learn how to use/do it and, finally, they decide whether or not to continue the learned/adopted behaviour. Each stage needs to be addressed with a different communication strategy and a recognition that people often move back and forth between stages.

Developing Messages and Designing Materials (Workshops Four and Five)

This stage provides the link between the research findings and the targeted communication objectives. If baseline data has been successfully compiled and analyzed, the next questions to ask are:

- How can these findings be translated into messages?
- What are the most appropriate media for disseminating these messages?
- What will make the message and the medium carrying it command the attention of the target audience?

- What is the specific call to action from the message, or what do I expect the audience to think, feel or do as a result of seeing or hearing the message?

During Workshop Four, participants were trained in how to use research findings to design a message. They first discussed various communication approaches, the types of messages that are suitable for each approach and the criteria for choosing a medium.

To help participants work through these topics, PATH introduced a materials design worksheet and a strategic message content outline. The materials design worksheet grouped information into an FGD result or finding, the issue to be addressed, the message addressing that issue and the media proposed to carry that message.

The message content outline further synthesized the information using the following subsections: the problem to be addressed; the communication objective; the primary target audience; the secondary target audience; the key message; the main supporting points (the benefits resulting from practicing the modelled behaviour); the tone of the message; and, the desired action response (the positive reaction expected from the target audience).

Using these worksheets, participants worked with a graphic artist and a radio/TV producer to draft their materials. These tasks were spread out over a longer period, covering two workshops during which the groups began drafting the following materials for the respective target audiences:

- Pre-adolescents and adolescents: a booklet with illustrations giving basic facts and information about HIV and AIDS.

- Out-of-school youth: a drama script, stickers and two posters.
- Adult men: a booklet entitled “What every man should know about HIV/AIDS” and a poster.
- Couples: a drama script with a story line addressing the need for correct information about HIV/AIDS, condom acceptability, limiting or reducing sex partners and practicing self control.

Pretesting and Revising Materials (Workshops Six, Seven and Eight) Pretesting consists of testing the viability of the draft materials with representatives of the intended target audiences before the materials are finalized. Several rounds of pretesting are conducted to obtain audiences’ reactions and recommendations for changes.

Some of the programme messages and aspects of materials that should be tested include:

- Comprehension: Is the message understood or is it subject to misinterpretation?
- Acceptability: Is the material compatible with the cultural norms of the target audience?
- Identification: Do members of the target audience feel the message is directed towards them?
- Motivation/persuasion: Does the message trigger a reaction from the recipient?

Materials also should be reviewed with professionals in the relevant disciplines. This will, among other things, ensure that the content of the materials is technically correct and the messages are consistent with prevailing policies. The results from technical reviews and pretesting are used to guide the revision of the materials as appropriate.

In addition to theoretical learning on why and how to pretest materials in the

workshop setting, PATH took participants out to field sites to practice pretesting skills. The participants regrouped at the training venue to compile pretest information and learned how to use pretest feedback to revise materials.

Process Evaluation After the field practice, PATH administered a mid-course questionnaire to obtain feedback from the training participants. Many offered favourable comments on pretesting, illustrating that the time spent focusing on this skill was worthwhile. Some highlights from participant comments include:

- “This is the first time that I am doing this kind of thing. I never thought that developing materials involves all this. It is certainly a wonderful experience.”
- “It was an exercise I have never done before and I have learned a lot.”
- “It is the first time I have gone out for practical pretesting. I found it difficult to cope with the changes the respondents were giving for my material.”

This exercise confirmed the hypothesis that in many instances agencies take shortcuts in the process of message and materials development. Many of the materials circulating are the work of communication staff who develop them without the benefit of research findings, and they are not rigorously tested to incorporate target audiences’ perspectives.

Training in How to Use the Materials and Monitoring Their Use (Workshop Nine)

Before new materials are distributed, the people who are going to use them need to be trained in how to use them. This stage of the training emphasized that communication materials are

complementary to other forms of communication (e.g., interpersonal) and demonstrated how they can be used to reinforce other initiatives.

Workshop participants learned that monitoring the use of materials can help identify problems as they arise and ensure a prompt response. To monitor effectively, programme designers must set clear indicators for each activity or material.

To ensure that adequate stocks of the materials were maintained, the teams developed forms for tracking distribution and reordering. These forms were retained at the KANCO secretariat, which became the organizational custodian of all the materials printed.

Evaluating the Impact of the Materials and Planning for Continuity (Workshop Nine)

Impact evaluation reveals whether the communication objectives were realized. Some of the programme aspects that can be evaluated include:

- *Knowledge:* What does the target audience know about the issue(s) addressed by the materials?
- *Approval/attitudes:* How has the audience reacted to the materials?
- *Practice:* Has the target audience acted as directed by the message?

Communication is an ongoing process. Sustained behaviour change requires consistent and repeated efforts. Through monitoring and evaluation data, programme designers should identify new issues that need to be addressed through different communication strategies. PATH's model of materials development creates a loop in which evaluation data opens the way for the next cycle of planning, enabling planners to respond to the changing needs of target

audiences as they move through the various steps towards behaviour change.

As a way of promoting the sustainability of IEC materials provision, PATH encouraged KANCO members to sell some of the materials they had produced. Seven organizations agreed to sell one of their joint products, a comic book entitled *Life, Love and AIDS*. After selling the comic book, an organization was to retain half the proceeds and give the other half to a reprinting fund coordinated by the KANCO secretariat.

ACCOMPLISHMENTS

Working in teams, the participants agreed to focus on five target audiences: men, couples, out-of-school youth, adolescents and pre-adolescents. The group was able to develop and produce five different types of materials: two types of laminated stickers; three posters; one question-and-answer booklet entitled *Peter and Anne Discuss AIDS with Aunt Mary*; a drama script—"Life Love and AIDS"—and a complementary discussion guide; and, a comic book based on the "Life Love and AIDS" script.

CONSTRAINTS

The materials development training was very successful. However, there were a few constraints:

This project did not contain a follow-up evaluation component to assess what the participant programme officers were able to develop in their respective organizations. Nevertheless, PATH has continued interacting and collaborating with the individual participants in other capacities and is confident that this training contributed to the pool of expertise in message and materials development among the NGO community in Kenya.

Assuring consistent participation was not easy. Because the nine workshops were spread over a long time period, a number of participants dropped out due to conflicting schedules at their workplaces.

Pretesting and revising materials progressed at a slower pace than anticipated because the teams were encouraged to take full responsibility for scheduling their time and activities. This proved difficult once the trainees returned to their respective agencies, since their regular jobs and assignments then took priority, leading to frequent cancellation and rescheduling of meetings and pretest sessions.

Staff turnover through job changes, transfers and study leave, which took place in most of the organizations involved, affected the progress of some of the teams.

LESSONS LEARNED

This “job-release” model of materials development training, where training is delivered in stages interspersed with on-the-job practice of the new skills, was extremely cost-effective.

The team-training process maximized commitment by the group. In addition, the extended process with its spiral of theory, practice and analysis was very effective in grounding participants’ understanding that training is indeed a process.

The materials development model followed by PATH is very flexible. It enabled the participants to use their own experiences and initiatives as they worked in teams. Consequently, the trainers frequently were able to build on the skills and strengths of some of the participants without antagonizing

any of the others. This helped maintain the enthusiasm and interest of the trainees throughout the series of workshops.

Careful planning of materials dissemination greatly increases the breadth and quality control of the distribution, as well the level of use by the target audience.

In developing materials for HIV/AIDS BCC, people should not be afraid of inciting negative reactions from some social groups. Such negative reactions can in themselves be an “advertisement” for the materials.

BEST PRACTICE CRITERIA

Relevance The training model adopted by PATH challenges programme officers to be creative and start thinking “outside the box” as they develop messages and materials. The training focused on pertinent skills that BCC officers use every day in trying to motivate behaviour change to foster HIV/AIDS prevention.

Effectiveness Using a team-training model enabled organizations to realize the overall goal and targeted objectives of collaboration and networking. Participants from different organizations worked together in teams, which served to solidify the spirit of inter-agency collaboration.

Efficiency This training process helped maximize limited resources to benefit many different organizations. Left on their own, many of the agencies involved would not have been able to access funding for training or for developing their own HIV/AIDS-prevention materials.

Replicability This long-term training model is easily replicable internationally, in resource-constrained as well as other settings.

Sustainability The income-generation approach proved effective in facilitating the sustainability of IEC materials production by producing a 50 per cent profit on all the materials sold, enabling a reprinting fund to be established.

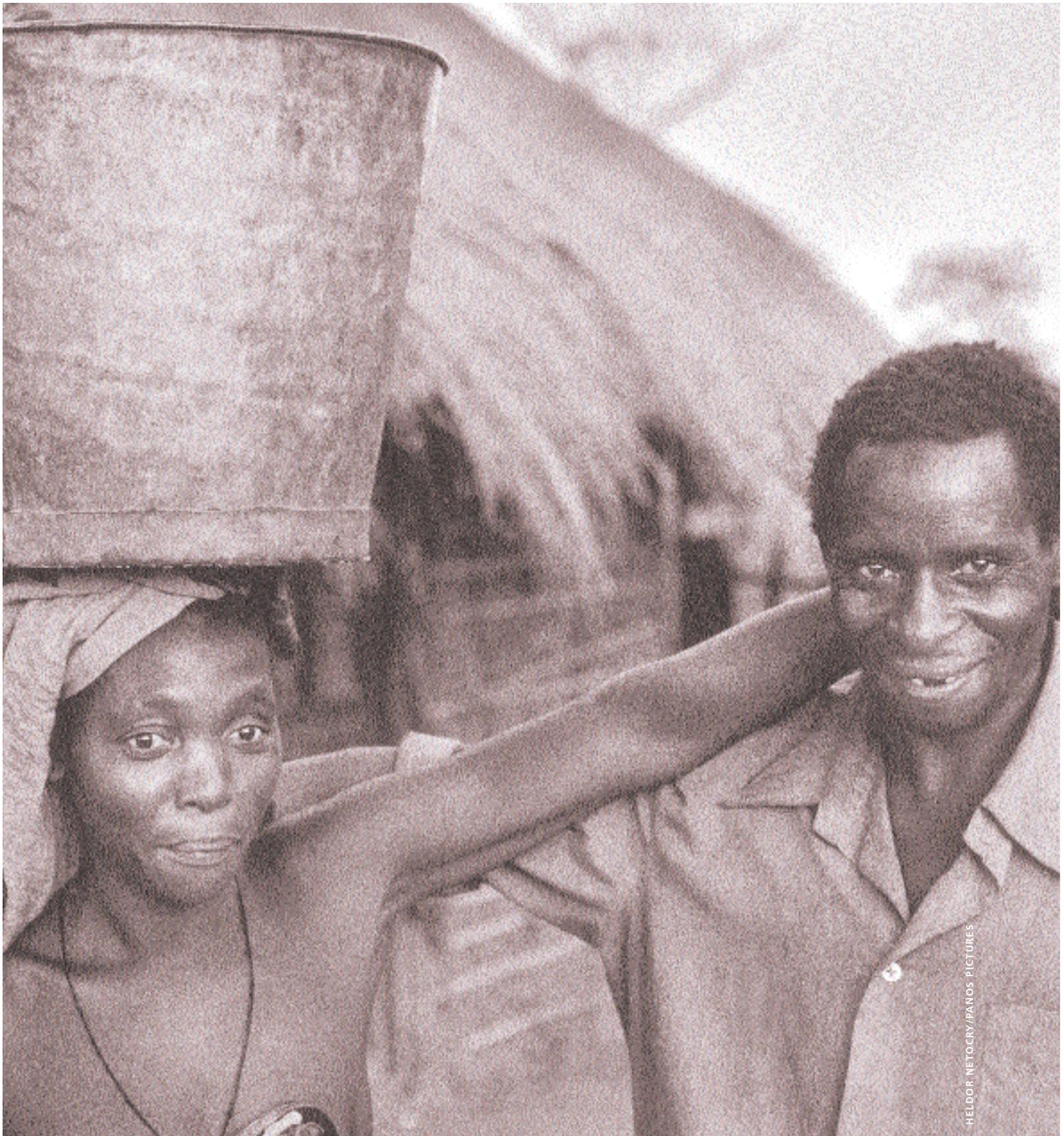
AUTHOR

George Kahuthia, Programme for Appropriate Technology in Health (PATH), Nairobi, Kenya.

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The findings of limited change in the rates of sex with any non-primary partners and a significant reduction in unprotected intercourse with these partners suggests that study participants were not just telling the investigators what they wanted to hear but rather what was really happening in their lives.



HELDOR METOCRY/PANOS PICTURES

AIDSCAP'S VOLUNTARY HIV COUNSELLING AND TESTING (VCT) PROGRAM COUNSELED AND TESTED TANZANIAN COUPLES, SUCH AS THIS ONE, IN THE FIRST RANDOMIZED CONTROLLED TRIAL OF HIV VCT.

VOLUNTARY HIV COUNSELLING AND TESTING IN TANZANIA

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VOLUNTARY HIV COUNSELLING AND TESTING IN TANZANIA

INTRODUCTION

Until recently, voluntary HIV counselling and testing (VCT) was not fully recognized as an effective intervention for behaviour change to reduce the risk of HIV transmission in Tanzania. The inconsistency of existing data regarding the impact of VCT on behaviour and the perceived high cost and low demand for VCT programs led to limited support from the Tanzanian National AIDS Control Program (NACP) and donors working in the country.

HIV counselling and testing activities were mainly provided by nongovernmental organizations (NGOs), such as the Society for Women Against AIDS in Africa (SWAA), Walio Katika Mapambano na AIDS Tanzania (WAMATA), Pastoral Activities and Services for AIDS (PASADA), Service of Health and Development for People Living with HIV/AIDS (SHEDPHA) and others. But these activities were very limited and mainly focused on counselling HIV/AIDS patients who had been tested elsewhere and referred by caregivers or friends for psychosocial support. For others who wanted to know their HIV serostatus, access to this VCT service was very limited. The need for such a service was illustrated by many anecdotal reports of people giving blood

at blood banks or paying significant sums at private clinics and laboratories in order to learn their HIV serostatus.

In order to make programme and policy decisions for VCT, the NACP needed strong and reliable data. In October 1993, the programme was approached by Family Health International's (FHI's) AIDS Control and Prevention (AIDSCAP) Project, in collaboration with the World Health Organization's Global Programme on AIDS (WHO/GPA), with the idea of conducting a study of the efficacy of VCT programmes. Recognizing that the data from such a study would meet its information needs, the NACP agreed to provide full support and facilitated the identification of a local institution to carry out the study.

This case study describes activities related to the research project undertaken in Dar es Salaam, Tanzania, by the Muhimbili University College of Health Sciences (MUCHS), in collaboration with several international organizations as part of a multicentre randomized study of the efficacy of VCT. The project was designed with the following objectives:

- to determine the impact of VCT on behaviour change among individuals seeking VCT services

- to describe the social and psychological effects of VCT
- to determine the cost-effectiveness of the VCT intervention.

The following organizations collaborated with MUCHS in the project: FHI/AIDSCAP, the United States Agency for International Development (USAID), the Joint United Nations Programme on HIV/AIDS (UNAIDS), WHO/GPA, the Center for AIDS Prevention Studies at the University of California at San Francisco, the Kenya Association of Professional Counselors and the Queens Park Counseling Center in Trinidad.

PROJECT DESCRIPTION

Initiation AIDSCAP introduced the idea of conducting a study on the efficacy of VCT at a meeting of its technical working group in May 1993. Following the recommendations from this meeting, AIDSCAP held several discussions and consultations with USAID, WHO/GPA, the U.S. Centers for Disease Control and Prevention (CDC) and numerous other institutions involved in HIV/AIDS prevention. These discussions and consultations led to consensus on the importance of conducting such a study in order to better define the potential contribution of VCT to HIV/AIDS prevention in non-industrialized countries. Collaborative arrangements were made between AIDSCAP and WHO/GPA (later continued by UNAIDS and WHO) to fund and conduct a multicentre randomized study of the efficacy of VCT, with the Center for AIDS Prevention Studies at the University of California at San Francisco as the coordinating centre.

Tanzania was one of the countries selected for the study. To ensure that this research project responded to a real need for data in the country, the idea was presented to the Tanzania NACP for consideration and approval. The USAID mission in Tanzania, one of the Tanzanian government's main partners in HIV/AIDS prevention, was also consulted. Both agencies agreed that such a study was a real necessity in the country. They provided full support to the project and helped identify MUCHS as the local research institution to carry out the project in Tanzania.

Preparation MUCHS investigators collaborated with investigators from the other participating institutions in the development of the study protocol at a workshop in Arusha, Tanzania, in September 1994. During this workshop the investigators agreed on a core protocol for the multicentre study and a site-specific protocol for the study in Tanzania.

Following the workshop, the site-specific protocol was finalized and submitted to the NACP review board for scientific and ethical review. The study groundwork, which began after the review board had approved the protocol, included obtaining a study site (a building on the grounds of the MUCHS teaching hospital), conducting formative research, developing the research instrument and performing a pilot study.

Formative research was conducted between November 1994 and January 1995. The main goals of this research were to: (1) assess the understanding of the concept of "randomization" by members the target population and identify a culturally appropriate way to explain the concept to people in Tanzania; (2) identify the range of social, psychological and emotional

effects experienced by people receiving HIV counselling and testing in the Tanzanian context; (3) develop a concise, culturally appropriate and methodologically sensitive set of questions to measure the major variables identified for the study; (4) develop appropriate response options for each question; and, (5) test the face validity of the questions developed.

The approaches used to achieve these goals were individual interviews with service providers, individual interviews with people recently tested for HIV (HIV-positive and HIV-negative) and focus group discussions with a sample of the target population. Results from the formative research were then used in developing the study instrument and adapting the interventions, and the wording of the consent form used for the study and the advertising materials.

The counselling intervention was based on the CDC client-centred HIV preventive counselling model. Using information from the formative research, this model was tailored to be culturally appropriate, acceptable and sensitive to the needs of Tanzanians. The inclusion of a personalized risk assessment and the development of a personalized risk-reduction plan for each client further distinguished the model. Personalized risk-reduction plans were developed with each client, based on his or her level of knowledge, interpersonal situation, specific risk behaviours and readiness to change. In this counselling model, the content of the sessions and the amount of counselling received were individualized, as determined by each client's specific HIV-risk issues. Counselling sessions lasted an average of 40 minutes.

Information from the formative research was used to develop a script for the HIV health

information intervention that would be offered to the comparison group, taking into account information from the formative research.

The English-language script was translated into Swahili, and a 15-minute video was filmed at the site with a pair of local actors portraying a couple seeking information on HIV. The Tanzanian principal investigator took the role of health information officer. In the video, which was designed to provide accurate information about how HIV is transmitted and how transmission can be prevented, the couple comes to the counselling centre to discuss their concerns about HIV and AIDS. The health information officer begins by providing definitions for HIV and AIDS. He then describes ways in which HIV is and is not transmitted and ways of preventing HIV infection. Both "clients" then ask various questions about the virus and about condom use. As they leave the centre, the couple is given packs of condoms.

Following the development of the video, a three-week pilot study was conducted in April 1995. The objective of this pilot study was to test the laboratory procedures and the various counselling and testing site procedures, including those regarding client flow, informed consent, determination of eligibility, length of the interview and length of the counselling session. Based on the findings, some procedures were modified.

Execution The study's target population was people seeking HIV counselling and testing in Dar es Salaam, Tanzania. Participants had to be 18 years or older, planning to remain in the area for at least a year and unaware of their HIV serostatus. They were not expected to comprise a random

sample of Dar es Salaam. Participants were encouraged to come to the study with their sexual partners and to enroll as a couple. The recruitment goal was 1,600 participants: 400 individual men, 400 individual women and 400 couples.

This research project was carried out from May 1995 to March 1997. Implementation began with citywide advertising of the HIV counselling and testing site. Various publicity strategies were used, including leaflets, posters, newspaper advertisements and a community awareness campaign. Workplaces, churches, local pubs and commercial markets were targeted initially, and radio announcements were added later because the other media were not attracting enough women and couples.

Eligible participants were asked to fill out an informed consent form. The screener explained the study procedures in detail, read the consent form to the volunteer, and asked him or her to provide verbal consent. After consent was obtained, participants were given a structured face-to-face baseline questionnaire that required an average of 45 minutes to complete. The baseline questionnaire collected data on: (1) demographic characteristics; (2) self-reported sexually transmitted infection (STI) symptoms; (3) use of birth control; (4) HIV/AIDS knowledge and concerns about HIV/AIDS; (5) sexual behaviour; (6) condom attitudes and experience; (7) psychological status; and, (8) risk reduction strategies. Following the interview, each participant was asked to provide a urine sample that was frozen and stored for subsequent testing for gonorrhoea and chlamydial infection, to be used as a biological marker to corroborate self-reported behaviour.

Participants were then randomly assigned to receive either HIV counselling and testing or the health information interventions. Couples were randomized together so that both members always received the same intervention. Participants assigned to the VCT intervention met with the counsellor for counselling and to provide consent for HIV testing. Those consenting to the HIV test provided a blood sample and were asked to return two weeks later to receive the test results and appropriate post-test counselling. Those who did not feel ready for the test during their first visit scheduled additional counselling appointments.

Participants enrolling as couples were counselled together or individually, depending on their choice. To ensure accurate risk assessment, each couple member was given individual time with the counsellor. Test results were initially given individually, and then the couple was encouraged to share their results in a joint counselling session. Post-test counselling then proceeded with both members of the couple.

Participants assigned to the health information intervention watched the 15-minute video in the presence of a health information officer, who responded to their questions at the end. This was intended to be a group session; however, because clients came at different times, many video sessions were with individuals.

At the end of the baseline visit, all participants received a supply of 25 condoms and a brochure demonstrating correct condom use. They were also invited to return for additional condoms at any time.

The first all-participant follow-up visit was scheduled six months after baseline. During this visit a face-to-face questionnaire, similar to the one used at baseline, was administered

to all. They were also tested for the classic STIs and treated, as appropriate, if found positive for any STI. At this visit all participants were also offered HIV counselling and testing and asked to provide a urine sample for testing by ligase chain reaction (LCR) for *Neisseria gonorrhoeae* and for *Chlamydia trachomatis*.

All clients' six-month urine samples were tested by LCR for *N. gonorrhoeae* and *C. trachomatis* to estimate the incidence of STI among the participants. For those with a positive six-month sample, baseline urine samples were retrieved and tested by LCR. Participants with a positive test on the six-month urine sample and positive test on the baseline sample were assumed to have a prevalent case of infection. Those with a positive six-month sample, but a negative baseline sample, were considered new cases.

The second follow-up visit was scheduled 12 months after the initial baseline visit. Participants were again given a face-to-face questionnaire and offered HIV counselling and testing if they chose to be tested.

Assuring Confidentiality Confidentiality in this study was protected by: (1) assigning a unique identification number to each participant; (2) filing forms with participants' names in locked filing cabinets; (3) marking samples, test requests and interview forms only with identification numbers and not with names; and (4) training the staff in confidentiality procedures and having them sign a confidentiality oath.

The quality of the service was assured through careful selection and training of counsellors and close monitoring of the counselling process. Counsellors held regular, scheduled group meetings with the site manager

to share experiences and discuss difficult cases. The counselling site manager, a trained psychiatrist with extensive experience in HIV counselling, provided ongoing supervision and support to the counsellors to address their concerns. This was extremely useful in the preventing the "burnout" that often occurs in this difficult line of work.

OUTCOMES

The recruitment phase of the study lasted for nine months, and participants were followed up for 12 months. During the initial two months of the recruitment period, advertising for the service was limited to written materials such as leaflets and posters. These attracted mainly male clients. The addition of radio advertisements significantly increased the participation of both female clients and couples. A total of 1,427 participants were enrolled in the study, comprising 500 males, 489 females and 222 couples. Seven hundred and eleven participants were assigned to receive health information, and 716 were assigned to HIV counselling and testing. The overall HIV prevalence among those assigned to receive HIV counselling and testing at baseline was 21 per cent. The HIV prevalence by gender was 13 per cent for men and 29 per cent for women.

Impact on Behaviour Change Data analysis was conducted in late 1997 and early 1998. Participants in the counselling and testing group were compared with those in the health information group using several behavioural variables. These included: (1) number of sex partners; (2) number of primary sex partners (defined as a spouse or spouses for married people and boyfriend or girlfriend for unmarried people);

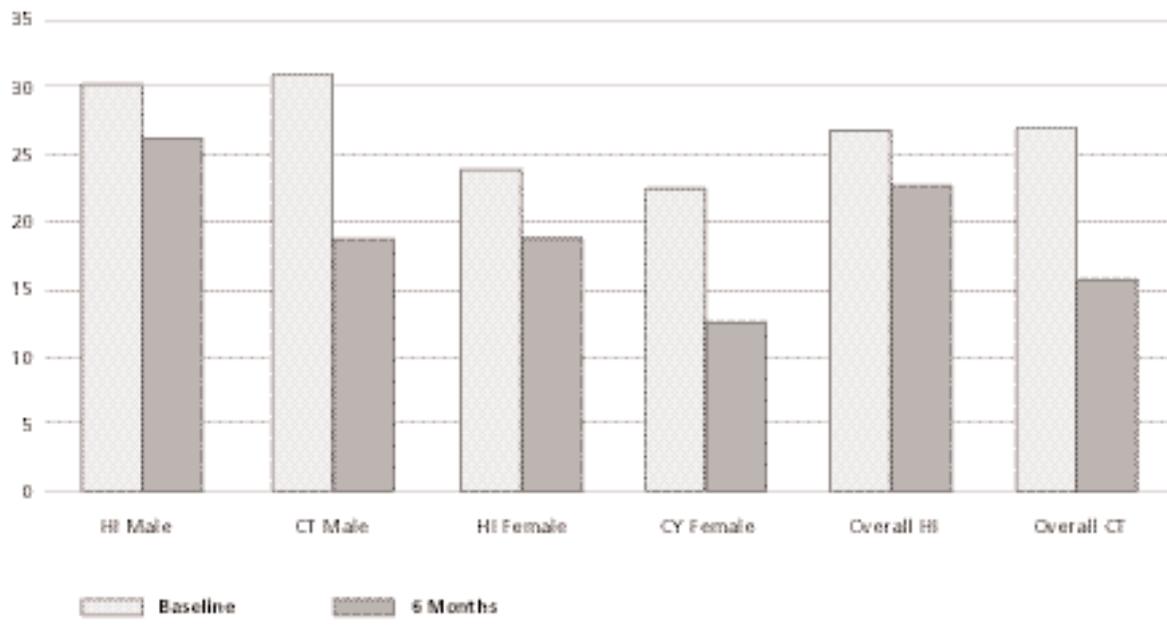
(3) number of non-primary sex partners (defined as any partner who is not the spouse(s) for married people and not the girl/boyfriend for unmarried people); (4) unprotected sex with primary partners; (5) unprotected sex with non-primary partners; and, (6) self-reported risk reduction behaviour in the last two months. This case study will focus on two primary outcomes: proportion of participants reporting sex with any non-primary partner and proportion of participants reporting unprotected sex with non-primary partners.

Following implementation of the two interventions in this study, there was a general decline in risk behaviour among the two study groups. However, individuals who received the

counselling and testing intervention showed more significantly reduced risk behaviour than did those who received health information only. For example, individuals in the counselling and testing group reported a significantly greater reduction in the percentage of unprotected intercourse with non-primary partners. As shown in Figure 1, at baseline the rates of unprotected sex were similar among the two groups. At six months, although there was a reduction in both groups, the reduction was significantly more substantial among men and women who received counselling and testing. (This case study is limited to six-month data, as the 12-month data had not yet been analyzed.) There was also a reduction in reports of

FIGURE 1

Unprotected Intercourse with Non-Primary Partners Decreased Significantly More in VCT Than HI Participants



unprotected intercourse with non-primary partners among couples in both intervention groups. The difference in the reductions between the two study groups, however, was not statistically significant.

Interestingly, the proportion of individuals reporting sex with any non-primary partners was the same in each study group. The findings of limited change in the rates of sex with any non-primary partners and a significant reduction in unprotected intercourse with these partners suggests that study participants were not just telling the investigators what they wanted to hear but rather what was really happening in their lives. In other words, what changed was not so much the number of non-primary partners, but what people did with them.

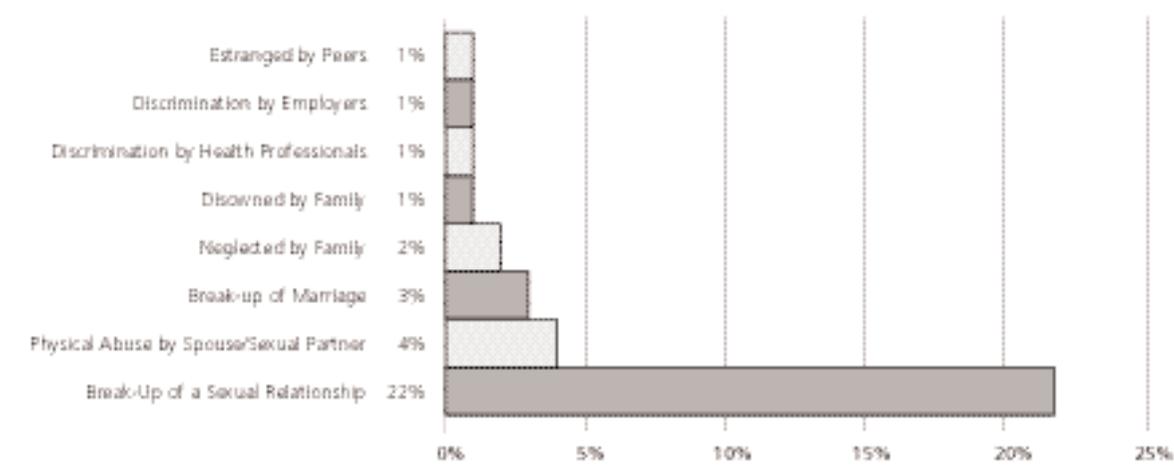
The validity of self-reported behaviour from behavioural research is often questioned. Of interest in this study is the use of STI-incidence data to test the validity of self-reported sexual behaviour among study participants.

Those who reported unprotected intercourse with non-primary partners were at least twice as likely to have contracted an STI since the study began than those who reported no unprotected intercourse with non-primary partners. This result provides evidence of the validity of the self-reported sexual risk behaviours.

With the exception of relationship breakups, negative life events such as suicide, physical violence and discrimination were rare, as shown in Figure 2. The proportion of participants reporting negative life events was similar in both groups. Among those who received counselling and testing, however, those who tested HIV-positive—particularly women—were more likely to report physical violence and breakup of marriage than were those who tested HIV-negative. As a result of their participation in the study, people also reported the occurrence of positive life events such as strengthening of relationships.

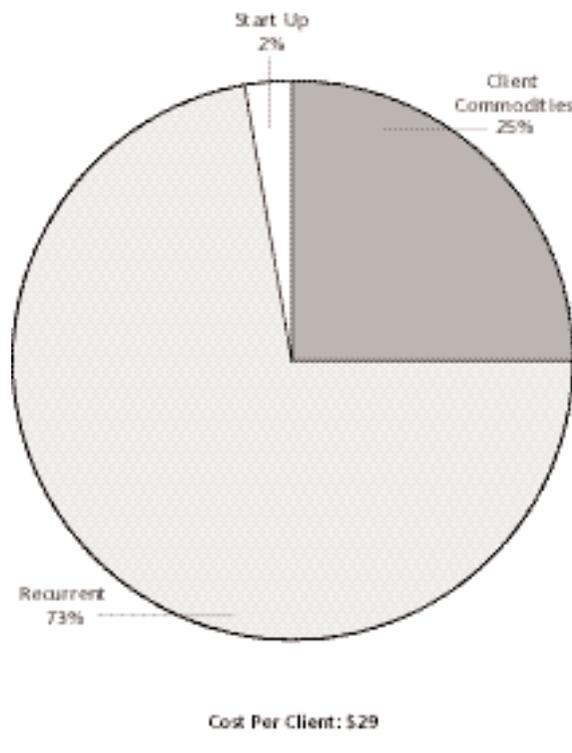
FIGURE 2

Negative Life Events Reported by Study Participants in Both Intervention Groups



Cost Aspects of the Service To estimate the cost of providing HIV counselling and testing, all costs related to the research aspect of this project were identified and subtracted from the total cost of the project. The cost of running the site for a year was estimated at about US\$87,000. Assuming that 3,000 clients could be seen at the site per year, the estimated cost of providing the service was \$29 per client. Recurrent costs such as rent and salaries represented more than 70 per cent of the cost.

FIGURE 3
Cost to Provide the VCT Intervention Per Client: Overview

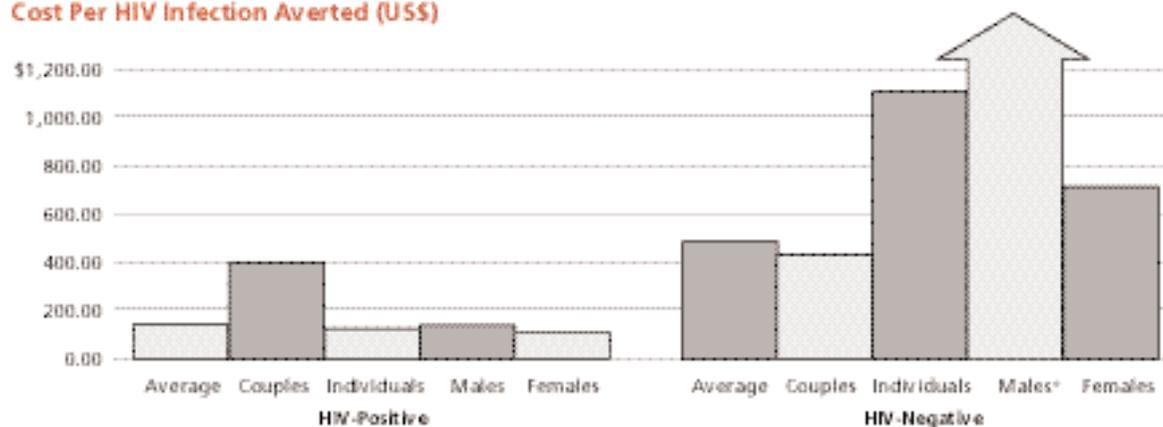


Participants' willingness to pay for the HIV counselling and testing service was explored, and more than 90 per cent reported that they would be willing to do so if asked. On average, participants reported that they would be willing to pay up to US\$5 for the service. However, it is important to note that following completion of the study, introduction of a user fee of \$3 resulted in a significant drop in the number of clients showing up at the counselling site. This number rebounded after the user fee was decreased to \$1.50, clearly suggesting that clients' willingness to pay for a service does not necessarily determine their ability to do so.

To convert behaviour-change data into health outcomes for cost-effectiveness analysis, the estimated number of HIV infections averted was calculated using a probability-based model. The baseline behaviour profile of the study participants was used to estimate the number of infections that would occur based on that profile, and the six-month behaviour profile was used to estimate the number of infections that would occur following the HIV counselling and testing intervention. The six-month figure was then subtracted from the baseline estimate to calculate the number of infections averted by the HIV counselling and testing intervention. To determine the cost per HIV infection averted, the total cost of service provision was divided by the estimated number of infections averted. The average cost per case averted was US\$303, varying from \$105 among HIV-positive women to more than \$3,000 among HIV-negative men. Figure 4 shows the cost per case averted for the different subsets of the study participants.

FIGURE 4

Cost Per HIV Infection Averted (US\$)



* The cost of a male case averted varied to more than \$3,000.

BEST PRACTICE CRITERIA

This project was the first randomized trial of the efficacy of voluntary HIV counselling and testing on behaviour change to take place in non-industrialized countries. It provides the strongest evidence to date of the effectiveness of VCT as a tool to prevent transmission of HIV, and it contributes to the momentum building internationally in support of VCT programmes in non-industrialized countries.

Relevance Demand for VCT services is growing in most developing countries as the HIV/AIDS epidemic matures and increasing numbers of people become sick. This demand will be sustained as HIV/AIDS awareness and knowledge increase among affected populations. Providing VCT services will help support the behaviour change needed to reduce the spread of HIV and provide care and support to the growing number of people affected by the epidemic.

Efficiency The involvement of local collaborators from the beginning of the project significantly facilitated its implementation. Support from the NACP and the USAID mission in Tanzania was instrumental in the successful completion of the project. This project was a very positive demonstration of effective collaboration among the many organizations involved in the multi-centre study and well-coordinated partnership in meeting the study's objective in a timely manner.

Effectiveness The project was able to demonstrate the efficacy of VCT and its cost-effectiveness. It generated greater support for VCT services not only in Tanzania, but also in other countries in East Africa. The Tanzanian NACP is using results from this study; for example, recommendations for district-level HIV counselling and testing have been included in the Tanzania Medium-Term Plan for HIV/AIDS Prevention and Control. The NACP also has provided more support for VCT activities in Tanzania.

Ethical Soundness The project was implemented only after receiving clearance from the Tanzania NACP ethical review committee. Clients' participation was voluntary, and all measures were taken to ensure confidentiality. There was no report of client coercion or leak of information by the site staff. As a result, the VCT continues to achieve confidence and trust among its users, who reported feeling free to express themselves without fear for their privacy.

Sustainability Given the growing demand for VCT and its demonstrated cost-effectiveness as a result of this study, it is likely that the government of Tanzania and international donors working in the country will increase their support for VCT activities. The USAID mission in Tanzania has already demonstrated greater support for VCT by funding the continuation of service provision at the study site, which has become a service site at the Muhimbili University Hospital. USAID also is working with the FHI country office and MUCHS to explore ways of building on the experience gained from the counselling and testing study. According to monitoring data obtained in July 1999, the site continues to see an average of 250 clients each month.

LESSONS LEARNED

The most important lessons learned from this project include:

VCT is an effective intervention for changing risk behaviour, and it is not associated with negative life events. The results achieved in this study were made possible by the quality of the services provided at the study site. The study's client-centred counselling approach helped tailor the intervention to the needs of each client. Strict

confidentiality and the positive relationships built between counselling centre staff (especially counsellors) and their clients facilitated clients' trust and confidence in the service provided.

VCT is cost-effective. The cost of US\$303 per HIV infection averted, documented for this intervention, is well within the range of costs for other HIV-prevention interventions, such as improved syndromic management of STI in Tanzania, which was estimated at about \$250. Targeting communities with high HIV prevalence may make VCT even more cost-effective.

Although clients value VCT service and express willingness to pay for it, they do not necessarily have the means to do so. The pricing of this service must be carefully determined to ensure that people who are in most need of the service are not turned away because of their inability to pay for it.

VCT is in demand in Dar es Salaam and attracts people at relatively high risk of HIV infection, as supported by an overall HIV prevalence of 21 per cent among the VCT site's clients (compared with 14 per cent prevalence estimated in the sexually active population overall in Tanzania). After the study's recruitment period ended, many clients continued to show up for services at the site. To accommodate these clients, efforts were made to keep the centre open as a service site, with support from the USAID mission in Tanzania.

Involving local collaborators early in the project process was instrumental in ensuring a sense of ownership and in developing culturally appropriate instruments, messages and interventions for the study. For example, from the formative research conducted by the local principal investigator, locally appropriate terms

to describe concepts such as randomization (“bahati” in Swahili) and types of sexual relationships were able to be identified.

Close collaboration with the NACP and the USAID mission in Tanzania facilitated continued support for the project and rapid in-country use of the research findings to influence policy and programmes. Based on results from this study, the NACP has included VCT in its third medium-term plan (MTP III), making VCT services more accessible in Tanzania, and VCT has been identified as one of the core functions of Tanzania’s district health teams. The study findings were also used by the USAID mission in Tanzania as the basis for its continued support for the VCT site at Muhimbili University and its overall support for VCT activities in Tanzania.

AUTHORS

Claudes Kamenga, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA

Gloria Sangiwa, Muhimbili University College of Health Sciences, Dar es Salaam, Tanzania

Samuel Kalibala, Joint United Nations Programme on HIV/AIDS (UNAIDS), Geneva, Switzerland

Eric van Praag, World Health Organization (WHO), Geneva, Switzerland

Thomas Coates, Center for AIDS Prevention Studies, University of California-San Francisco, San Francisco, California, USA

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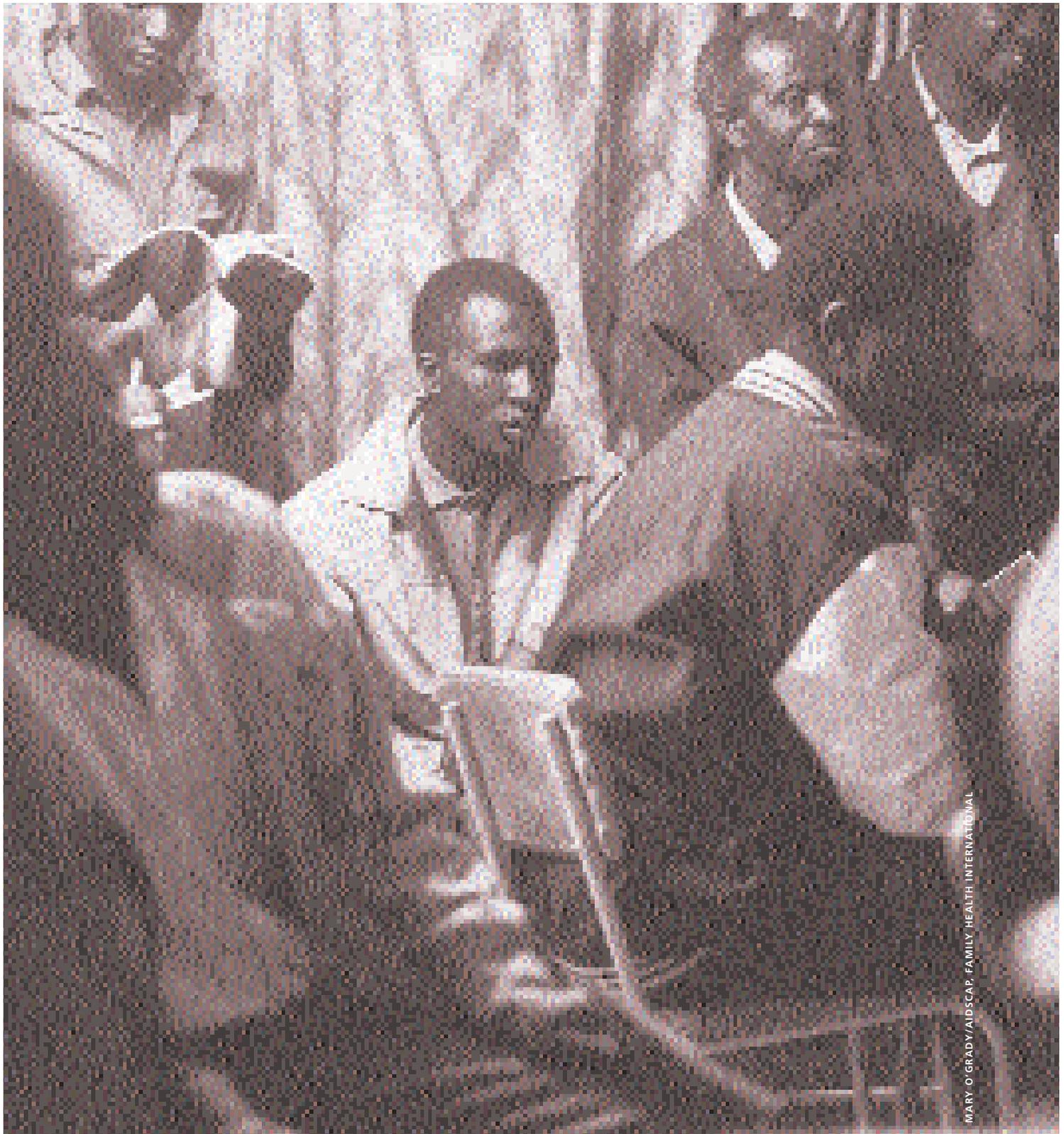
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In the parlance of the private sector
itself, prevention remains to be “sold”
as a viable investment.



MARY O'GRADY/AIDSCAP. FAMILY HEALTH INTERNATIONAL

DRIVERS FOR THE NATIONAL EMPLOYMENT COUNCIL FOR THE TRANSPORT OPERATING INDUSTRIES (NECTOI) PARTICIPATE IN AN AIDSCAP WORKPLACE-BASED HIV PREVENTION PROJECT IN HARARE, ZIMBABWE.

ENGAGING THE PRIVATE SECTOR IN HIV/AIDS PREVENTION

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ENGAGING THE PRIVATE SECTOR IN HIV/AIDS PREVENTION

INTRODUCTION

While there have been numerous warnings about the potential impact of HIV/AIDS on business operations and profits, most companies in developing countries have been slow to respond to the pandemic. Only a small proportion of companies have implemented and sustained prevention programmes for their employees. Those that have developed workplace prevention programmes have not been strong advocates for similar efforts among their peers. Most business managers have not felt compelled to introduce HIV/AIDS prevention programmes in the workplace, especially as governments, nongovernmental organizations (NGOs) and international donors have taken the lead in responding to the epidemic and have only weakly engaged the commercial private sector as equitable partners.

Some members of the business community have responded to HIV/AIDS, but often in a passive way and without clear linkages to national programmes or strategies. They have agreed to let NGOs and government groups create prevention programmes within workplaces, and many business owners or managers have made in-kind contributions by releasing select employees for peer education training and all employees for

occasional education sessions. In Brazil, all employers must provide time for workers to attend health education classes. Business coalitions on AIDS have emerged in several countries—Thailand, Botswana and the United States, for example—and have provided a sense of direction for companies.

In order to help bridge the gap between the commercial private sector on the one side, and HIV/AIDS prevention activists on the other side, the AIDS Control and Prevention (AIDSCAP) Project of Family Health International (FHI) developed a resource for engaging businesses more fully in prevention. Known as the Private Sector AIDS Policy (PSAP) package, it offers a comprehensive set of tools for gauging the financial cost of HIV/AIDS to business profits, developing workplace prevention programmes, and designing HIV/AIDS policies for businesses.

BACKGROUND

In the late 1980s and early 1990s, most business managers felt that HIV/AIDS would pass them by or that they could cope by rapidly replacing workers who became ill or died. A few companies provided employees with basic information on the disease, but the vast majority of companies

avoided the issue altogether by insisting that the epidemic was a health not a business problem, or that employees were responsible for their own behaviour. Fewer than a third of the workplace HIV/AIDS-prevention projects were funded primarily by the companies involved.¹

Several factors converged in the mid-1990s to bring the private sector more intensely into HIV/AIDS-prevention efforts. First was the recognition among companies themselves that the epidemic threatened the welfare of their employees and thus also affected profits.² By this time, in several high-prevalence countries in eastern and southern Africa, large companies dependent on skilled labour became very aware that AIDS was affecting their ability to do business. Barclay's Bank of Zambia, for example, lost many of its senior managers by the mid-1990s and considered closing some branch locations. A 1994 survey of companies in the Zambian capital of Lusaka and the central industrial region of the Copperbelt noted that nearly 70 per cent of companies experienced declines in productivity or difficulties in recruiting appropriately skilled staff because of HIV/AIDS.³ Transportation companies in Uganda and Zimbabwe found that productivity and safety suffered as employees with long experience became ill and died and were replaced with less experienced staff. Even companies that relied on employees without sophisticated technical or managerial skills, such as flower exporters in Kenya, found that the quality of operations and general productivity were undermined by absenteeism and increases in staff turnover. To overcome labour shortages and disruptions resulting from AIDS illnesses among workers, large-scale farmers in southern Africa have considered replacing labourers with mechanical equipment.⁴

“The overall effect of the epidemic on all [South African] businesses will be shattering.”

DEANE MOORE, AN ACTUARY WITH METROPOLITAN LIFE ASSURANCE COMPANY, 1998

Second, workers' organizations, human rights groups and many NGOs were concerned that workers were being tested for HIV, often without counselling or prior consent and their contracts were terminated if the test was positive. Insurance companies screened prospective clients for life insurance coverage—often without informed consent and frequently in conjunction with pre-employment physical examinations. As these cases came to light, AIDS activists demanded that businesses become more accountable by adopting internal policies that outlined acceptable practices.

Third, both international donors and governments sought to diversify and expand funding for HIV/AIDS prevention. Businesses were identified as potential financial allies in national prevention and care efforts.

Fourth, the search for communication approaches that could sustain behaviour changes gained momentum. Basic information programmes no longer met the needs of most people, but prevention activists had yet to design ways to address changing needs. Condom social marketing enjoyed general success during the 1990s, and its example drew attention to commercial marketing approaches that could be applied to other aspects of prevention. It was also recognized that the private sector regularly applied behaviour

change approaches in its advertising and marketing and that these skills could be applied to help stem the HIV/AIDS pandemic.

The AIDSCAP Project, with funding from the United States Agency for International Development (USAID), and a few other HIV/AIDS prevention groups, conducted several qualitative surveys with business managers and worker representatives to better understand their attitudes and motivations. In addition, AIDSCAP sought to better understand the productivity and economic impact of HIV/AIDS on companies. Economic impact studies were undertaken in Kenya, Botswana, Zimbabwe, Thailand and the Dominican Republic.

HIV/AIDS AND BUSINESSES: FINDINGS FROM STUDIES

Economic Impact In Kenya several businesses found that absenteeism due to HIV and AIDS-related illnesses and medical and death benefits were the major costs to be expected. For some businesses, total losses from HIV/AIDS among employees were estimated to reach as high as 20 per cent of profits by the year 2005. In contrast, comprehensive prevention programmes—including education, sexually transmitted infection (STI) treatment and condom distribution—for these companies were likely to cost 2 per cent or less of business profits by the year 2005.⁵ The Botswana Business Coalition estimates that HIV/AIDS cost businesses in that country about 0.7 per cent of profits in 1998, but that the impact will climb to 12 per cent by the year 2002. For struggling economies and individual businesses—both large and small—the impact on profitability and productivity is high and growing.

SIDEBAR 1

Losses to businesses from HIV/AIDS

Increased Expenditures

- Health care costs
- Burial benefits
- Recruitment
- Pension benefits (?)

Reduced Revenues

- HIV absenteeism
 - AIDS absenteeism
 - Funeral attendance
 - Lost productivity during recruitment
 - Lost productivity during training
 - Lost productivity following training (and prior to being fully productive)
-

Not all industries are affected equally by HIV/AIDS. The transportation, mining, tourism and financial sectors tend to be harder hit. However, no sector is immune from the pandemic's impact.

The costs of HIV/AIDS to businesses fall into two broad categories: increased expenditures and reduced revenues. Absenteeism tends to be the greatest cost, followed by health care costs and declines in productivity as experienced workers become ill and die and new workers are brought on but require days, weeks or months to become fully productive.

As HIV/AIDS affects individuals and companies, others feel the economic ripples. National revenues are likely to drop. The ability of suppliers to deliver goods on time may be affected. Consumers gradually shift their buying patterns to medical care and drugs—some studies have found that up to 50 per cent of income may be used this way when a family member develops

full-blown AIDS. Some scholars have suggested that cash crop production may decline as family farmers shift to basic food crops. In some countries, HIV rates among soldiers are 20 to 40 per cent, raising fears about the stability and effectiveness of military forces. Finally, any increase in costs of doing business makes it more difficult to remain competitive locally, nationally and globally.

In part because HIV/AIDS has emerged relatively slowly in most regions, most businesses have not kept close track of trends in absenteeism or health-benefit costs. Thus, they have not developed either an individual business or sector-wide view of the direct and indirect economic impact of the epidemic. One result of the absence of specific and clear data is that businesses are reluctant to invest in prevention programmes, which may not offer returns for long periods of time. While more work is necessary in order to demonstrate the cost-effectiveness of prevention efforts, a study of two businesses in Bangkok, Thailand, which ran peer education and condom distribution programmes, found that benefits almost always exceeded costs. Programmes that were 50 per cent effective yielded benefits five times greater than the costs; programmes that were only 25 per cent effective had benefits two and a half times greater than the costs. In Kenya one study found that costs of running prevention programmes were only half the benefits gained.

Managers' Views The results of qualitative surveys have confirmed that business managers are not comfortable with the topic of HIV/AIDS. Managers argued that sexuality is an individual matter and determining the costs of HIV/AIDS

and benefits of prevention is difficult and imprecise. They also felt that public health is not the purview of most businesses.

Managers in Brazil said that the peak of the epidemic had passed, that earlier predictions of substantial economic costs due to HIV/AIDS had not been borne out, and that other health issues were of greater importance in terms of productivity. In Zimbabwe, most managers knew that the epidemic remained explosive and that it affected their workforces, but they remained sceptical that prevention education had altered or could alter sexual behaviour. Business managers and union officials in Kenya have been increasingly concerned about the likely impact of the epidemic, but have had little experience in developing workplace prevention programmes, and there is little tangible evidence of their efficacy. None the less, several managers in Kenya and Zimbabwe reported that they would continue supporting condom distribution within the workplace, even if external funding ended. Recently, insurance companies in several African countries have noted a decrease in the purchase of life insurance policies as workers refuse to be tested or to report the results of the HIV tests required by the insurance industry.

Changes in national and global economic conditions are affecting many companies, which also influences their responses to the epidemic. Parastatals in particular are downsizing and, as one manager of a transport company in Zimbabwe noted, "Frankly, AIDS fits with our need to shed workers."⁴ Not only is HIV/AIDS fortuitous for some companies amid pressures to reduce labour costs, but downsizing has reduced some of the urgency to maintain or replace workers.²

For managers, HIV/AIDS prevention has increasingly come to mean preventing the employment of people living with HIV/AIDS (PLHA). This attitude seems to pervade much of the thinking of business managers in Asia and Latin America. Although managers unanimously denied that their companies practiced pre-employment testing, HIV screening as a part of a pre-employment physical exam or as a requisite for higher levels of life insurance coverage was noted by activists inside and outside companies. These activists also reported pressure from senior management or the medical department to report “suspicious” symptoms.

In Zimbabwe and South Africa, financial officers are concerned about how to prevent pension funds and other benefit schemes from being depleted by premature retirements and deaths due to AIDS. Various approaches are now being used. One is “counselling” of employees known (or thought) to be HIV-positive to persuade them to retire. In most companies an early retiree no longer receives medical aid and loses life insurance benefits. Moreover, some managers are finding that once PLHA retire, whether they are sick or not, they often die within a short period of time and their spouses often die shortly thereafter; therefore, pension benefits are not drawn for very long. These pension funds had been set up with a schedule of contributions based on projections that retirees would draw benefits for more years than do employees retiring early because of AIDS. Thus, managers from a few companies reported that despite initial concerns that AIDS would deplete their pension funds, their funds are now even “healthier” than anticipated.

Managers in all the countries said that HIV/AIDS was a public health issue and prevention was the responsibility of individuals, governments and NGOs. Notably, in Zimbabwe and Brazil managers felt that the taxes they paid constituted sufficient contributions to national prevention efforts. They argued that paying for prevention activities within their companies was not their responsibility and that asking them to do so would be a form of double taxation. However, they also felt that the government-sponsored prevention programmes suffered from a lack of urgency in conveying the threat of HIV/AIDS and a lack of fiscal and operational transparency.

Other and more recent studies in southern Africa have documented an impressive array of workplace prevention initiatives.⁶ However, the depth and breadth of corporate involvement in HIV/AIDS prevention remains modest.

PRIVATE SECTOR AIDS POLICY (PSAP) PACKAGE

The PSAP package was developed to address many of the business community’s concerns about mounting HIV/AIDS-prevention programmes in the workplace.⁷ The designers sought to create a tool that would be useful to businesses themselves in the development or expansion of AIDS prevention policies and programmes in the workplace. The tool could also be used by organizations—NGOs, unions and national AIDS programmes—working with business management in the development of workplace prevention initiatives.

The kit built upon effective lessons from both international development and HIV/AIDS prevention. It promotes

participatory processes for programme development, encourages clear communication between management and the workforce, focuses on effective and sustainable approaches to HIV/AIDS prevention and recognizes the ethical and business needs of a workplace-based prevention programme. At the same time, the designers of the PSAP package recognized that existing models could not be implanted into diverse communities; flexibility and adaptation of the policy and programme guidelines to fit individual situations was encouraged.

The kit includes basic information on the epidemic for managers who want to become more familiar with HIV/AIDS. It allows users to consider economic, policy, human relations and programme development aspects of HIV/AIDS in the workplace. Designed for use as a stand-alone product, it is a tool that a human relations manager or a financial officer could pick up and selectively consult for issues that are likely to fall within the spectrum of their responsibilities.

The PSAP kit offers detailed guidelines on developing or expanding prevention education, condom promotion and sexually transmitted disease treatment programmes. It also provides examples of workplace policies and methods for developing those policies in order to guide both workers and supervisors if and when situations related to HIV/AIDS arise. Two spreadsheets are included that allow individual businesses to assess the potential impact of HIV/AIDS on profits and the cost of mounting or expanding a prevention programme in the workplace.

A set of 17 case studies, all based on actual companies in Africa, illustrates the diversity of business responses to the epidemic. Finally, the kit includes detailed notes for facilitators to work with business managers in two different settings. For use at a business luncheon or as a part of an introductory workshop on prevention in the workplace, one set of notes provides a quick introduction to HIV/AIDS and businesses. The second set of notes is designed for use at a one-day or two-day training event, with participants from businesses gaining insight into how to work with the spreadsheets, develop workplace HIV/AIDS policies or design a comprehensive workplace prevention programme. Handouts and sample overheads for use in presentations accompany the facilitator materials.

The PSAP package was developed in response to the needs and gaps noted by business managers, worker representatives and NGOs. Initial data collection began in 1994, and the kit was completed and printed in 1996. Designed primarily for target audiences in Africa, the PSAP kit also has been used in Asia, Latin America and the United States. More than 400 copies of the package were distributed to AIDSCAP offices in Africa, to numerous AIDS service organizations in Africa, Latin America and the Caribbean and Asia, and to national AIDS control programmes in Africa. An additional 500 copies were made available to UNAIDS for distribution to global offices and networks.

Funding for development and distribution of the PSAP package was provided by the Africa Bureau of USAID.

The Use of PSAP in HIV/AIDS Prevention

As an educational tool designed to sensitize and inform businesses about HIV/AIDS prevention, the PSAP kit has had its greatest appeal among NGOs seeking to work with and motivate businesses. NGOs in countries as diverse as South Africa, Honduras, Brazil, Kenya, Tanzania and Nepal have used components of the kit for specific purposes. A draft version of the kit provided a model for a Tanzanian national trade union to develop its own training materials. The policy component of PSAP has been of great interest to NGOs because it provides core policies, examples of what several companies have done and suggestions for policy development. Requests for the materials have continued for more than four years, from individual businesses, business coalitions, unions and international donor agencies. At least one state government in the United States has used the materials and 100 copies have been distributed to U.S. embassies and multinational corporations in Africa by the U.S. Department of Commerce.

In Kenya, both policy and programme components of the kit were successfully used to assist ten large-sized and medium-sized companies over a period of 18 months. By the time this support ended, most companies had HIV/AIDS policies in place and were committed to sustaining their prevention programmes.

Several NGOs in Nigeria, Tanzania, Zimbabwe and Brazil have recognized that the PSAP kit is designed to appeal to business managers and represents a potentially useful marketing tool. One NGO in Kenya did attempt to market its HIV/AIDS prevention

services, using the PSAP materials to demonstrate its expertise to business clients. Although there was some initial interest from companies, the NGO was unable to sustain its efforts while waiting for businesses to actually buy into its services.

It was initially expected that there would be a large demand for and interest in PSAP. In reality, the interest has been slower to emerge, but has remained consistent. Among the reasons cited by the limited number of businesses that have been exposed to the kit but are not using it are: (1) waiting for direction and policy guidance from government or a parent company; (2) financial information is too fragmented to create an accurate picture of the impact of HIV/AIDS; (3) waiting for senior management's interest or mandate; and, (4) have own processes for developing policies.

The designers of PSAP did have business users in mind, but it was intended that the materials reach companies through private-sector associations, national AIDS control programmes or NGOs. One weakness in the distribution plan was not carefully targeting key potential users—chambers of commerce and management institutes were largely bypassed.

While numerous organizations have referred to PSAP's importance as a policy and programme tool, they also find the volume of material in the kit somewhat overwhelming. As a how-to manual, PSAP is considered more detailed than many users and facilitators would desire. Elements of the materials have been extracted and adapted to make them locally relevant, and this seems to have been a useful strategy. Using PSAP as a whole does require time, first to absorb the material and then to

initiate a process to bring prevention to a workplace. Many NGOs and government agencies are too stretched to take on more work, although they may want to as well as see the need to work with the private sector.

Making PSAP a Full Tool for Engaging the Private Sector Initial use of the PSAP kit indicates that the materials offer a solid base for NGOs, unions and government agencies to build partnerships with the commercial private sector for HIV/AIDS prevention. The policy development component is being used and the outline for programme development offers a selection of interventions to fit most workplace situations. The structure of the kit, with an emphasis on documenting productivity and the financial costs of the epidemic at company level, has guided other studies. Likewise, the combination of programme and policy responses outlined in the PSAP kit has appealed to unions and workers' councils.

Two major lessons have emerged for more effective use of PSAP. The first is the need to add a component that will describe and document the effectiveness of HIV/AIDS prevention interventions. In addition to this new component, effective use of the PSAP kit will require some updating, notably of the company case studies. The second lesson is the need for a mechanism to transform PSAP from a passive learning tool into a tool for stimulating dialogue and proactive creation of HIV/AIDS-prevention interventions.

The additional component should document the cost and effectiveness of HIV/AIDS prevention interventions. Business managers from Brazil, Zimbabwe and Thailand—among other countries—have voiced concern and scepticism

about the many prevention efforts which, in their view, have not altered individual sexual behaviour, nor slowed the pace of the epidemic. Managers argue that they have already invested in HIV/AIDS prevention through their taxes, but have not seen sufficient evidence that either governmental or nongovernmental programmes have altered sexual behaviour or the course of the epidemic. They do not know how much prevention interventions cost, and thus cannot judge benefits against investments. Fortunately, health economists have started examining costs and comparing them with benefits gained from various interventions.

An increasing number of national and local programmes have demonstrated the effectiveness of HIV/AIDS prevention. Some of these prevention interventions have occurred within companies themselves. An intervention in Zimbabwe, for example, showed that worker-based peer education and condom distribution resulted in a one-third reduction in HIV incidence (rate of new infections in a population in a specific period of time, generally one year), compared with companies without peer education but with other interventions.⁴ This evidence needs to be compiled, synthesized and incorporated into PSAP. Cost-effectiveness analysis is desirable, but not absolutely necessary. Most company managers will be satisfied with a comparison between the cost of investing in prevention interventions and the potential savings accruing from that investment.

The second addition to making PSAP fully useful would be training local and national facilitators to work with companies on applying the policy and programme aspects of PSAP. Several options have been suggested for

expanding local capacity to use PSAP materials and processes with business. The options include the following:

- Start-up support to an existing or new commercial organization to apply commercial marketing principles to promoting HIV/AIDS prevention with the private sector.

Such an organization may be an employer federation, a union umbrella, a business alliance (such as the Thai Business Coalition) or a totally new business to serve other businesses. While the costs of supporting such a professional organization will vary by country and region, it is reasonable to suggest that a sub-regional team of three or four professionals could effectively function for about US\$200,000 per year—with those costs gradually being absorbed by businesses themselves through fee-for-service arrangements.

- Building the capacity of an existing NGO to professionally engage businesses on a fee-for service basis.

A long-term donor commitment to a NGO already involved in HIV/AIDS prevention can enable it to build capacity to market programme and policy design, implementation and monitoring. As business develops and fees are collected, the NGO's need for donor funds will decline. Either national or regional markets can be cultivated, depending on demand.

- Using consultants to work with government, business association, union and NGO groups to expand commitment to and work on HIV/AIDS prevention, including the analytical processes suggested by PSAP.

Either a series of short-term consultancies or longer-term placement can be used to

facilitate technical skill building in workplace HIV/AIDS prevention in various sectors and in the application of the PSAP process.

- Strengthening existing tripartite (government, worker and employer) groups, such as those that exist in South Africa and Zimbabwe, by using PSAP and other materials to focus on specific issues.

Through existing structures and organizations, use PSAP materials to engage interested parties in key workplace prevention issues.

- Supporting a training institution to develop and offer courses relevant to the commercial private sector on HIV/AIDS prevention and mitigation of its effects.

Regional training organizations already exist, and some of them have long-term experience in either HIV/AIDS issues or commercial management training. Again, a fee-for-service arrangement for training courses provides a way to meet the costs of the training institution. With modifications, the framework and facilitator notes within the PSAP kit provide a solid foundation for mounting such a course.

BEST PRACTICE CRITERIA

Effectiveness In terms of its immediate objectives—to produce a set of materials for developing comprehensive HIV/AIDS prevention policies and programmes in the workplace—the PSAP kit was effective. It represents the most comprehensive body of materials for use by or with businesses in developing both workplace policies to deal with HIV/AIDS and workplace prevention interventions. In terms of longer-term objectives, use of the PSAP kit continues to expand, but not at the pace originally envisioned, nor with the level of

intensity and focus that either sustains pressure on businesses to adopt prevention initiatives for their employees or engages business managers in regular discussions about HIV/AIDS prevention.

Ethical Soundness Data collection was done with the clear understanding and approval of senior business managers of its eventual use in a set of materials for promoting workplace-based prevention interventions. Some participating managers asked that the name of their firms be disguised for proprietary reasons. Data collected for specific businesses was aggregated; data on individual employees was not collected. In several instances during data collection, the researchers were able to provide information to companies about the need for employee confidentiality, inform company managers about national or universal guidelines on employee HIV testing and contribute to internal discussions about company policies. The workplace policies section within the PSAP materials follows universal guidelines on testing, confidentiality of information about employees and provision of basic HIV/AIDS prevention services, as outlined by the World Health Organization's Global Programme on AIDS (WHO/GPA) and UNAIDS.

Relevance PSAP was designed at a time when there was strong focus on expanding national responses to the epidemic and creating mechanisms to link non-health sectors to national programmes. Much of that discussion focused on achieving a multisectoral public response, including ministries of finance, planning, transportation and agriculture, for example. Within a number of countries the discussion included incorporating the private sector in the national

response. Thus, the PSAP kit was—and remains—relevant to meeting a broad-based approach to HIV/AIDS. Further, bringing the commercial private sector into prevention efforts more fully offers opportunities to take advantage of some of the skills found in this sector, including creative marketing and logistics management.

Efficiency The development of the PSAP materials took longer and was more labour-intensive than was necessary. A too-extensive focus on initial background research slowed the development process, as did frequent reviews and revisions of the draft materials. However, the availability of the finished product means that other organizations do not have to start at the beginning and can focus on preparing country-specific or region-specific materials.

Sustainability The PSAP materials will remain relevant for at least a decade, with updates to the case studies and commentary on interventions. The processes outlined for developing workplace policies and prevention programmes and the technical material continue to be used and adapted by national, NGO and international programmes. In addition, PSAP has been used in ways that were not originally anticipated, including in the training of agricultural extension staff in Swaziland.

CONCLUSION

Commercial private-sector resources remain a tempting target for national HIV/AIDS-prevention efforts. To successfully draw upon the multiple resources of businesses, prevention needs to be convincingly presented and demonstrated. In the parlance of the private sector itself, preven-

tion remains to be “sold” as a viable investment. The PSAP kit is one tool for selling prevention to businesses. Most users (and potential users) have found this comprehensive resource too extensive for easy access. To take full advantage of the tool, local organizations are likely to need some support—either to facilitate movement through the PSAP process and materials or to build the technical and marketing skills needed to fully engage businesses.

Three areas of HIV/AIDS experience are particularly relevant for public health programme managers striving to engage business managers in prevention efforts. Condom social marketing provides insights into approaches for packaging messages and promoting products and ideas. The lessons learned from behaviour-change programmes—knowledge of audience and adaptation of programmes to meet their changing needs—can add specificity and relevance to contacts with business. And policy and economic analyses provide tools and methods for addressing current and future business concerns, ranging from the financial impact of HIV/AIDS to policy and regulatory issues such as employee HIV screening and benefits provision.

AUTHOR

Bill Rau, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA

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The regionally based teams were recognized early on as a critical mechanism through which decentralized activities could be implemented.



FAMILY HEALTH INTERNATIONAL

A HEALTH EDUCATOR DEMONSTRATES CORRECT CONDOM USE TO A GROUP OF YOUNG MEN IN ADDIS ABABA, ETHIOPIA, AS PART OF AIDSCAP'S HIV PREVENTION PROGRAMMING.

FOCUS SITE INTERVENTION TEAMS IN ETHIOPIA: REGIONAL COORDINATION FOR NATIONAL HIV/AIDS PROGRAMMES

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FOCUS SITE INTERVENTION TEAMS IN ETHIOPIA: REGIONAL COORDINATION FOR NATIONAL HIV/AIDS PROGRAMMES

INTRODUCTION

Within the broader context of the difficult economic, political and environmental challenges faced by many non-industrialized nations, AIDS control programmes struggle to implement interventions due to minimal funding and challenging logistical constraints. Nearly two decades into the pandemic, many localities have become environments where multiple overlapping interventions are being implemented by a wide variety of public and private organizations, all competing for the same limited resources in terms of funds, expertise and materials. Nevertheless, the continued spread of the HIV/AIDS pandemic and its devastating social and economic effects have increased the urgency of expanding interventions.

Effective management of the design, implementation and evaluation of multiple overlapping interventions from a central location and efficient coordination of new interventions with existing efforts become unrealistic without a locally based forum for bringing together key stakeholders.

This case study describes an example of a mechanism used in Ethiopia to improve the efficiency of HIV-risk reduction interventions in four regions of the country outside the capital, Addis Ababa.

HIV/AIDS IN ETHIOPIA

In Ethiopia the first HIV-positive individuals were reported in 1986 among hospital patients.¹ Since then, HIV prevalence has continued to rise among all target groups and the general population, and in all regions. Rates among female sex workers (FSWs) were already 15 per cent in Awassa and 20 per cent in Bahirdar in 1988, over 50 per cent in large urban areas by the early 1990s^{2,3} and more than 65 per cent in Bahirdar and Nazareth by 1991.⁴ HIV prevalence among pregnant women in Addis Ababa was 2 per cent in 1992 and nearly 14 per cent in 1993.⁵ In 1996 the median prevalence among pregnant women in major urban areas was 18.25 per cent, according to UNAIDS.⁴ A 1993 serosurvey of 2,415 general population males and females aged 15 to 49 in six rural areas revealed an overall prevalence of 1.8 per cent.²

In 1994 in Addis Ababa, the prevalence of HIV in adults (15 years and older) was 6 per cent for males and 6.9 per cent for females, with a peak prevalence in the 25- to 29-year-old age group of 16.3 per cent for males and 11.8 per cent for females. From this same community-based study,

estimates of HIV incidence in Addis (per susceptible person per annum) for the 16- to 22-year-old age group ranged from 1.3 per cent to 3.7 per cent for males and from 2.4 per cent to 3.2 per cent for females.⁶ By 1996, estimates of HIV prevalence in the capital ranged from 9 to 26.5 per cent in four antenatal clinics and from 40 to 60 per cent among FSWs.⁷ The HIV epidemic is still in an expansion stage in Addis Ababa, and HIV incidence was high and growing during the two years separating the surveys in 1994 and 1996.⁷ In 1998 UNAIDS estimates that 2.6 million Ethiopian adults and children are living with HIV or AIDS.⁴

The cumulative number of reported AIDS cases jumped from 4,884 at the end of 1992 to 51,781 by the end of 1997. However, the estimated number of actual AIDS cases in 1998 is 1.1 million, according to the latest data analyzed by UNAIDS.⁴ Also based on UNAIDS calculations, the estimated number of adults and children who have died of AIDS since the beginning of the epidemic in Ethiopia totals about one million, with 250,000 having died in 1997 alone. In addition, an estimated 840,000 children (under age 15) have lost either their mother or both parents to AIDS since the beginning of the epidemic.⁴

Among the factors contributing to the spread of HIV in this country of 60 million people are: (1) seasonal migration of workers in search of employment and better economic conditions, leading to increased multiple partner sexual networking; (2) dislocation of populations due to the 17-year civil war, again creating social situations conducive to

increased sexual networking; (3) high sexually transmitted infection (STI) rates in high-risk and general populations; (4) increased sexual activity among youth; and (5) high unemployment rates, including 400,000 demobilized soldiers returning to rural areas, towns and cities after 1991.^{3,8} For the past three decades severe political, economic and ecological crises—including a long civil war, unstable government, recurrent drought, massive environmental degradation and unfavourable international economic environments—have created the context for rapid spread of HIV.

Curable STIs Although national data on incidence and prevalence of curable STIs are not available for Ethiopia, the proportion of men aged 15 to 49 who reported episodes of urethritis in the last 12 months was 4.6 per cent in urban sites in 1994.⁴ The proportion of pregnant women aged 15 to 24 who tested positive for syphilis at antenatal clinics was 8.8 per cent in 1994.⁴ Also in 1994, the most recent year for which data are available, only 19 per cent of people presenting with an STI or seeking STI treatment in health facilities received basic advice on condoms and partner notification, and just 4 per cent of people presenting with STI in health facilities were assessed and treated in ways appropriate to national standards.⁴

AIDSCAP Interventions Between January 1993 and March 1997, Family Health International's (FHI's) AIDS Control and Prevention (AIDSCAP) Project, funded by the United States Agency for International

Development (USAID), collaborated with the Ministries of Health (MOH) and Education (MOE), DKT/Population Services International (PSI) and 14 nongovernmental organizations (NGOs) to implement a comprehensive set of HIV/AIDS prevention activities under two USAID/Ethiopia bilateral projects. Targeting female sex workers, factory and government workers, in- and out-of-school youth and the general population, these interventions helped fill gaps left by the decentralization of HIV/AIDS control activities that occurred at the beginning of AIDSCAP. Twenty sites participated in interventions designed to improve STI services. Of those, four focus sites (Awassa, Bahirdar, Mekele and Nazareth) developed a model of integrated, comprehensive interventions, coordinating public and private resources at the regional level and featuring improved STI care and outreach to individuals at risk of infection. National condom social marketing supported all activities. AIDSCAP/Ethiopia also funded projects in Addis Ababa, a city with a population of 2.3 million.

During the life of the project, AIDSCAP/Ethiopia provided training to nearly 5,000 people, reached over one million people with HIV-prevention messages, distributed nearly 650,000 pieces of educational materials and distributed or sold nearly 45 million condoms.⁹ DKT/PSI has implemented condom social marketing programming nationwide since 1990, receiving part of its funding through AIDSCAP. Since then, it has sold over 80 million condoms throughout

the country. The DKT/PSI project markets 24 million condoms annually,^{9,10} making it one of the most successful condom social marketing projects in Africa.

HIV-Risk Behavioural Data Prevention knowledge rates tend to be high in Ethiopia due to the previous government's early, aggressive approach to coping with the epidemic. In 1994, among samples of the urban general population, 94 per cent of males and 84 per cent of females could cite at least two acceptable methods of protection from HIV.⁴ From the same survey, the proportion of sexually active people reporting at least one sex partner other than a regular partner in the previous 12 months was just 18 per cent for males and 5 per cent for females, while the proportion reporting condom use with a non-regular partner in the previous 12 months was 48 per cent for males and 47 per cent for females.

Among target populations reached by AIDSCAP interventions, improvements in most key indicators occurred during the intervention period (see Table 1), although sampling methods were not strictly identical for the two time periods. Data from focus group discussions and individual interviews combined with the quantitative data suggested that change is occurring among people reached by intensive and comprehensive interventions.¹¹ Unfortunately, the resources available to support sustained intensive interventions nationwide are grossly insufficient in comparison with the scope of the epidemic.

TABLE 1

Key Baseline vs. Follow-up Comparisons: Percentages Reporting

Indicator		1994/5	1996
Knowledge of 2 or more prevention methods	Out-of-school youth	78	98
	Sex workers	32	99
Belief that AIDS can be prevented by not touching an AIDS patient	Sex workers	91	21
Knowledge that an HIV-positive person can look healthy	Out-of-school youth	85	99
	Sex workers	69	55
Sexual activity	Youth	39–69	males 83, females 63
Access to condoms	Out of school youth	78	91
	Sex workers	95	95
Have been examined for STIs at an appropriate health facility during past 3–6 months	FSWs	55	73
> 1 sex partner in past 12 months	Out-of-school youth	12–30	males 50, females 33
Have ever used a condom	Out-of-school youth	31–57	males 72, females 57
	Sex workers	48–97	97
Condom use at last sex with non-regular partner	Out-of-school youth	21–40	males 58, females 48
	Sex workers	45	80

Source: AIDSCAP/Ethiopia Country Program Final Report, Arlington, VA, USA: Family Health International, 1997

FOCUS SITE INTERVENTION TEAMS (FSITS)

Early in the project, USAID and AIDSCAP/Ethiopia observed that implementing agencies were often working in a fragmented and uncoordinated manner. For example, several agencies were targeting the same groups with similar interventions and producing similar educational materials for the same target groups. Some were also using the same peer educators and community workers, thus making unnecessary demands on their time. This kind of repetitive coverage wasted scarce resources. AIDSCAP moved to solve the problem by bringing together the implementing agencies

in each region to review needs and resources and develop a plan for improving the situation.

As a result, the regional health bureaus (RHBs) were approached and the concept of focus site intervention teams (FSITs) was developed. The bureaus took the lead in creating teams comprised of representatives from governmental (GOs) and nongovernmental organizations (NGOs), including religious groups and representatives from work sites, all of whom were working on HIV/AIDS prevention. At each regional site, the RHB representative acted as chairperson of the team, with an NGO or MOE representative as secretary.

FSITs have regular monthly meetings to discuss achievements, problems, plans and activities and to share resources, including information, education and communication (IEC) materials and information on HIV/AIDS and other STIs. Teams share expertise in training and project evaluation, use common resource persons and available STI services for joint referral, and organize and participate jointly in World AIDS Day and other activities. These activities have included organizing and conducting training and seminars for peer educators and managers/coordinators, developing and producing educational materials, sharing information about each others' activities and new ideas for prevention strategies and sharing educational aids, such as audiovisual materials, drama groups and puppets.

The FSIT strategy avoids duplication of efforts by ensuring that members target different population groups for HIV/AIDS-prevention activities and by integrating prevention efforts with support for people living with HIV/AIDS (PLHA). Especially important is the enhanced cooperation between governmental and nongovernmental organizations at the regional level.

One example of FSIT coordination is the sex worker project in Bahirdar, where the Zonal Health Department trained peer educators and supplied them with IEC materials produced in collaboration with the Family Guidance Association of Ethiopia (FGAE). The Ministry of Social Affairs in the zone supported the peer educators in organizing alternative income-generating activities for the sex workers. Condoms were supplied by DKT/PSI for a nominal fee. Sex workers received free STI treatment in the health centre when referred by the city council's sanitarian. The Regional Health Bureau (RHB) and FGAE

collaborated in conducting a baseline behavioural survey, and the RHB staff implemented overall monitoring and coordination.

Table 2 lists the names of FSIT member organizations across all four regions. Those marked with an asterisk were implementing partners in AIDSCAP/Ethiopia. The other members joined the FSITs as voluntary members and did not receive funding directly from AIDSCAP/Ethiopia.

TABLE 2

FSIT Member Organizations in Four Sites, AIDSCAP/Ethiopia 1993-97

Regional Health Bureaus*
Zonal Health Departments*
Hospitals/Health Centres*
Woreda Health Departments
Regional Education Bureaus*
Regional Social Affairs Office
Regional Women's Affairs Office
City Councils
Council of Representatives
Churches
Muslim Sherea Law Office
DKT/Population Services International*
Family Guidance Association of Ethiopia (in Awassa, Bahirdar, Mekele and Nazareth)*
Nazareth Children's Center for Integrated Development (NACID)*
Tigray Development Association (TDA)*
Organization for Social Services for AIDS (OSSA)*
Factories
Population Office
Tourism Bureau
Red Cross Society

* Implementing partner of the AIDSCAP Project in Ethiopia

The regionally based teams were recognized early on as a critical mechanism through which decentralized activities could be implemented. These FSITs led to more efficient use of staff, materials, training and funds among the governmental and nongovernmental implementing agencies in the four project sites. Such collaboration enhances interaction, avoids duplication of efforts and facilitates effective coordination of activities.

Because of the existence of the FSITs, closer working relationships have developed among regional education bureaus and other USAID-financed implementing agencies in Mekele, Bahirdar, Nazareth and Awassa. The FSITs also helped sensitize policy-makers to the seriousness of the epidemic, paving the way for the evolution of the FSITs into regional HIV/AIDS-prevention teams in Mekele, Bahirdar and Nazareth. The FSIT in Awassa continues to operate as it had in the past. In the other three focus sites, the FSITs were still functioning as regional task forces for HIV/AIDS and STI prevention at the end of 1998, nearly two years after the end of AIDSCAP and almost three years after most of the NGOs' external funding had ceased.

In late 1996, FSIT-participating organizations met in Addis Ababa for three days to compare experiences and share lessons learned from the process of implementing HIV-prevention programmes in a decentralized, regionally based model.¹² While the FSITs were judged overall to have been a successful approach to organizing local efforts, several areas of concern emerged from the four

regional experiences. Summarized in Table 3, these challenges to effective implementation were drawn from the conclusions reached by FSIT participants during the seminar.

In early 1997, AIDSCAP/Ethiopia hosted a lessons-learned seminar for 75 representatives from government institutions, NGOs and USAID and other international organizations that had participated in AIDSCAP/Ethiopia activities. This group determined that the most significant lesson learned from four years of programming was the value of FSITs as a unique mechanism through which decentralized activities can be implemented in geographically distant regions. The group recommended that the FSITs should continue to function in the four AIDSCAP regions and that the model should be replicated in other regions.¹³

Four years of activities under AIDSCAP/Ethiopia laid a foundation of mutual support for effective implementation of activities. The member agencies within each FSIT know each other well and are aware of each other's strengths, weaknesses and available resources. They conduct regular quarterly meetings to plan and work together, and membership in each group continues to grow. Support from local policy-makers facilitated the conversion of the FSITs into regional HIV/AIDS intervention teams. On the other hand, as yet there is no budget for each team that could help strengthen the teams' coordinating functions. As the groups are voluntary, their sustainability is less assured without increased support from the government and international donors.

TABLE 3

Implementing Focus Site Intervention Teams: Challenges and Recommendations

Area of Concern/Issues	Recommendations
IEC approaches: drama, videos and innovative educational approaches were more acceptable over traditional didactic approaches, but areas outside the major cities lagged behind in access to information and levels of awareness.	FSITs could more effectively organize regional resources for wider outreach.
Outreach methods: using religious and traditional events to promote HIV awareness and prevention via peer education succeeded in effectively reaching hard-to-reach groups.	Religious and traditional outlets for HIV/AIDS IEC should be encouraged and expanded. Peer education, especially youth-to-youth, should also be expanded and diversified.
Evaluation of materials: need for more in-depth evaluation of educational materials and for tracking distribution of materials.	FSITs could take more of a lead in monitoring and evaluating design, and production and distribution of educational materials.
Availability of materials: exchange of materials between FSIT members helped reduce duplication and minimized production costs, but there were some shortages, some instances of culturally inappropriate materials and some distribution problems.	A balance needs to be reached between centrally produced and locally designed materials in order to maximize efficiency and local appropriateness. FSITs can increase their efforts to act as clearinghouses for regional materials.
Staffing of FSITs: team approach allowed resource people to be involved in multiple activities, but high turnover rate reduces efficiency. Member organizations need to be more supportive of FSIT members' involvement in FSIT activities.	Continue to strengthen FSIT teams; strive for early replacement of departing members with thorough briefing.
Support and commitment to the cause of HIV prevention: programmes do not run as smoothly when support and commitment are weak; inconsistent media coverage leads to denial of severity of the HIV problem by the public.	FSITs should extend sensitization training to health personnel in health facilities and to the military; selection of training participants needs to be gender-balanced; more income generating activities should be developed to encourage support; seminars and workshops for journalists should be held.
Monitoring and evaluation of programme effectiveness: not rigorous enough; problems with number and types of indicators, timing and continuity in evaluation activities needs improvement.	FSITs could participate more intensively in developing better standardized indicators, improving planning and time frames, improving the reporting of process indicator data and in supporting implementation of monitoring and evaluation activities.
Documentation and record keeping: problems with minutes of meetings, reports, training session materials and IEC samples.	FSITs should improve systems for recording and documenting minutes, cataloguing samples of IEC materials and recording and filing reports and training session materials.
Finances: working together as a team, FSITs enhanced fundraising efforts, but there was some unplanned use of funds that affected planned activities.	FSIT member organizations should allocate funds for FSIT activities; budget should be more detailed and linked to action plans.

SUMMARY AND CONCLUSIONS

In collaboration with Regional Health Bureaus, AIDSCAP/Ethiopia developed the concept of FSITs so that HIV/AIDS risk-reduction interventions could be implemented in a more coordinated fashion at the regional level. The members were drawn from the regional and zonal health and education sectors, NGOs, government offices such as the municipalities, regional agricultural offices, factories, religious organizations, local health centres and regional DKT/PSI representatives. Their activities involved convening monthly meetings to discuss achievements and challenges and to plan complementary or joint activities among members. They also shared a wide range of innovative educational materials and tapped into each other's training resources. The FSITs have enabled implementing agencies within specific geographical areas to maximize the types of interventions being implemented and the types of populations being reached. They have also continued to operate beyond the end of AIDSCAP's activities.

Judging the effectiveness of FSITs is not an easy process. In theory, if they were effective, then intervention activities would be implemented more effectively, thus achieving increased levels of behaviour change, which would in turn result over the longer term in reduced incidence of HIV and other STIs. But documenting this wide range of potential changes in the current state of economic and political realities in Ethiopia is not at all a simple undertaking.

In Ethiopia, as in many other non-industrialized countries, non-experimental observational methods are routinely used in outcome evaluations due to resource limitations. The impact of cause and effect from such a design is

problematic because competing explanations for changes over time cannot be ruled out.

As a result of the methodological and practical problems of carrying out rigorous evaluation studies, many countries, implementing agencies and national programmes do not have quantitative and qualitative behavioural data, biomedical data, programmatic process data and detailed contextual data about the same target groups in the same geographical areas, collected at the same times, upon which to base decisions for future programmes.^{14,15} In the case of Ethiopia, the success of the FSITs seemed obvious to all involved; however, independent verification of that success in terms of biological and behavioural change has yet to be made.

Qualitatively, the people participating in AIDSCAP/Ethiopia activities between 1993 and 1997 felt strongly that the FSIT concept greatly enhanced the effectiveness and efficiency of regionally based activities, particularly in regions where the distances and difficult transportation between regional capitals and Addis Ababa made frequent visits expensive and arduous. However, it is clear even from the limited HIV-surveillance activities undertaken so far that HIV incidence is not yet subsiding. Modest changes in some aspects of knowledge, awareness and behaviour have been documented among targeted populations, but better methods for tracking trends in HIV-risk behaviour are needed, including standardized indicators and a more rigorous behavioural surveillance system, to help evaluators understand the course of the epidemic and the impact of prevention interventions.

Nevertheless, assessing trends in behaviour change over multiple points in time (or simply pre- and post-intervention) is frequently

considered sufficient evidence to infer the effectiveness of interventions and models such as the FSITs, regardless of the degree of scientific rigour in evaluation research designs.¹⁵ The practical realities of constricted budgets and the urgency on the part of local NGOs to implement activities and not “waste resources” on expensive, time-consuming research mean that programme implementers must use whatever data are available as they move forward with additional interventions and expand to new geographical regions within countries.

The available behavioural data for some of the target groups exposed to FSIT members’ interventions in Ethiopia suggest that change is occurring, although probably not at a rate sufficient to cause changes in HIV prevalence. From a public health perspective, it may not matter whether the observed changes are due to a particular intervention, but rather that sexual practices are becoming safer, and HIV infection numbers should eventually decrease. Programme implementers in Ethiopia feel that continued support of FSITs in the original four regions and expansion of this model to other regions will eventually result in enough behaviour change to reduce HIV-incidence rates nationwide.

BEST PRACTICE CASE CRITERIA

Relevance The emergence of the FSITs as strong coordinating entities happened logically in response to the government’s decentralization of all activities, particularly national AIDS control efforts. Particularly in a large country such as Ethiopia, with a population of 60 million people, regional coordinating bodies increase the likelihood that effective comprehensive efforts will make more of an impact at the local level.

Efficiency FSITs played a key role in implementing the monitoring and evaluation components of the AIDSCAP programme in Ethiopia and enabled efficient and timely sharing and use of materials, training resources and outreach staff.

Effectiveness Process indicator data exceeded expectations, especially for condom social marketing, which has been one of the most successful social marketing projects in Africa since it began in 1990. Although biological indicators as yet provide no evidence of decreasing HIV prevalence, behavioural indicators and qualitative research suggest that interventions are effective in producing changes in knowledge and behaviour.

Ethical soundness For the past three decades, severe political, economic and ecological crises have created the context for rapid spread of HIV in Ethiopia. The FSIT concept has been embraced as a locally-empowered approach to ensuring participation from all sectors, as well as matching central government’s decentralization mandates.

Sustainability Despite the cessation of AIDSCAP funding when the project ended in 1997, the FSITs have remained organized at the regional level in the four focus sites in order to better coordinate resources and plan activities. Most implementing agencies have managed to continue some activities under other funding; and, with planning support from FHI, the AIDSCAP/Ethiopia country programme office evolved into an independent NGO.

AUTHORS

Jan Hogle, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA

Beletu Mengistu, AIDSCAP/Ethiopia, Family Health International, Addis Ababa, Ethiopia

Fekerte Belete, AIDSCAP/Ethiopia, Family Health International, Addis Ababa, Ethiopia

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Community-based condom distribution involving NGOs can work in almost any setting—but it's critical to keep the process simple and transparent, to guarantee that everyone understands how it works and feels confident that their hard work will be rewarded equitably.



C'est moi!

PANTÈ



KAPÒT PANTÈ se plezi tèt poze, SIDA pa

SEAN SPRAGUE/IMPACT VISUALS

A POSTER ON THE WALL OF A CLINIC IN PORT-AU-PRINCE PROMOTES PANTÈ CONDOMS, DISTRIBUTED THROUGH AIDSCAP/PSI COMMUNITY-BASED DISTRIBUTION IN HAITI.

SOCIAL MARKETING AND COMMUNITY-BASED DISTRIBUTION IN HAITI: WORKING WITH NGOS TO EXPAND ACCESS TO CONDOMS

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SOCIAL MARKETING AND COMMUNITY-BASED DISTRIBUTION IN HAITI: WORKING WITH NGOS TO EXPAND ACCESS TO CONDOMS

INTRODUCTION

In 1991 a military coup ousted Haiti's president, and the country spiraled downward into chaos. Violence and fear became daily facts of life in both the cities and the countryside. When an international economic embargo cut off the supply of imported fuel and raw materials, factories and businesses closed, forcing hundreds of thousands of workers into desperate poverty in an already impoverished nation.

A country torn by political violence and economic deprivation, Haiti hardly seemed the setting for a success story in condom promotion for HIV/AIDS prevention. Yet efforts to promote condoms and make them more accessible to people throughout Haiti did succeed in dramatically increasing both condom sales and the number of locations where condoms could be obtained. This success was achieved through a combination of traditional social marketing techniques and an innovative adaptation of the social marketing model that expanded distribution by enlisting the staff of nongovernmental organizations (NGOs) to act as sales agents. The commitment and ingenuity of these community-based distributors and their NGOs helped Haiti overcome seemingly insurmountable obstacles to build one of the world's leading condom social marketing (CSM) projects.

CONDOMS: A MUCH-NEEDED COMMODITY

Condoms have long been an essential public health tool to prevent HIV infection. Apart from abstinence and mutual sexual fidelity, condom use is one of the very few ways individuals can protect themselves from sexual transmission of HIV. Promoting widespread use of this simple and affordable barrier method has thus become one of the most important strategies of HIV-prevention programmes, especially in the absence of a vaccine or cure.

But while messages that promote condom use have proliferated wherever there are efforts to curb the HIV/AIDS pandemic, the reality is that condoms are not always available, accessible or affordable in many parts of the non-industrialized world. In some places they may be available free of charge through the public health system, but acquiring them might require people to wait in line during limited daytime hours, sometimes miles from home, at sexually transmitted infection (STI) clinics or other locations where one might be reluctant to be seen. And while condoms may be commercially available in many countries, they are often sold at prices that much of the population cannot afford.

In Haiti, for example, condoms were commercially available during the early 1990s for about US\$0.25—a price far too high for most citizens, whose average per capita annual income is only \$400. These condoms could be found for sale in some cities and towns, but not in many villages or rural areas, most of which were simply off the usual commercial distribution grid. Free condoms were also available from some public health clinics and family planning programmes, but were not easily accessible to most people who needed protection.

Such protection is desperately needed in Haiti, which is believed to have the most advanced HIV/AIDS epidemic in the Western Hemisphere. In 1999 seroprevalence has reached 10 per cent in urban areas and is at 4 per cent and rising in rural areas. The country's extreme poverty and high unemployment rate—50 per cent at minimum—have greatly exacerbated the HIV/AIDS epidemic. Ongoing political and economic instability threatens to further disrupt an already weak economy, as does the degradation of the environment through deforestation and soil depletion. Such conditions inevitably lead to an increase in commercial sex, displacement of the population from rural to urban areas due to joblessness and environmental overload, the separation of families and a rising sense of desperation for out-of-school youth without hope of jobs. Within this context of crisis, the stakes have continued to rise for this small country in its struggle against the HIV/AIDS epidemic.

SOCIAL MARKETING SUCCESS IN HAITI

Social marketing has provided an innovative solution for making condoms affordable and accessible to a public that increasingly demands them. A development strategy that has become popular in recent years, social marketing is a not-for-profit enterprise that uses commercial marketing and advertising techniques, affordable pricing and existing retail networks to promote, distribute and sell products that are beneficial to public health and welfare, such as mosquito nets, birth control devices and solar ovens that require no coal or wood to provide heat. Because it involves selling rather than giving away these products, social marketing differs from other government, donor aid and charitable programmes that also seek to prevent disease, promote family planning or improve environmental conditions. The underlying principle is that charging for a product—at a low price that most people can afford—conveys value to consumers and makes them more likely to actually use the product.

In the case of condoms, social marketing projects have focused on increasing the number of places where customers can buy condoms (points of sale), lowering the price, strengthening distribution networks and other improvements that make these devices available, accessible and affordable to low-income people. Other goals of CSM projects are to promote condom use by making them attractive and desirable through advertising and appealing packaging, to market effectively to different target audiences to encourage safe sexual behaviour within promotional campaigns, and to involve community leaders and local organizations in HIV/AIDS prevention efforts.

In 1990 the non-profit organization Population Services International (PSI) launched Pantè (Creole for panther), Haiti's first socially marketed condom. A year later, PSI became a partner in the United States Agency for International Development (USAID)-funded AIDS Control and Prevention (AIDSCAP) Project, managed by Family Health International and Pantè became the centerpiece of AIDSCAP/PSI's condom social marketing effort in Haiti. At about three cents each, Pantè condoms were priced to allow even low-income Haitians to buy them regularly.

Pantè's eye-catching advertising campaign incorporated powerful behaviour-change messages as it built product recognition, portraying the condoms as an essential and everyday purchase both for protection from disease and for enhancement of intimacy. Promotion efforts were extremely successful: Pantè enjoyed widespread recognition and a reputation for quality and reliability. Sales figures soared: by the time AIDSCAP funding to the PSI project ended in 1996, national monthly condom sales had increased from an average of 30,000 in 1990 to more than 540,000. In fact, in per capita sales, the project ranked as one of world's leading CSM projects.

From the start, PSI took advantage of existing commercial networks to distribute Pantè within major markets throughout Haiti, working with more than 100 independent and commercial vendors. Soon, Pantè was available in places where condoms had not been sold before: nightclubs, beauty salons, small shops and other venues offering easy street access and convenient hours. But many parts of rural Haiti—where 70 per cent of the population

live—had never been covered by the standard distribution network, and in many of these regions buying a condom might require a two-hour hike over often mountainous terrain to a larger town on a major road. For these Haitians, behaviour change communication efforts encouraging condom use meant little, with condoms themselves so difficult to find.

COMMUNITY-BASED CONDOM DISTRIBUTION

The margin of profit for profit-making wholesalers or distributors of PSI's socially marketed condoms was a substantial 25 per cent—better than that of most other commercial products. However, the absolute value of that margin—initially about 1.7 U.S. cents per condom but declining to just over one cent as the economy deteriorated—was very small, even at high volumes. This meant that commercial distributors in Haiti had little incentive to go to the expense of increasing their capacity to market condoms beyond the capital city of Port-au-Prince or other major urban areas.

To broaden distribution throughout the country into distant rural districts as well as into more neighbourhoods in Haiti's cities and towns, the project created a partnership with four NGOs involved in AIDSCAP's various HIV/AIDS-prevention activities. PSI trained 175 staff members of these NGOs to act as both wholesale distributors, selling Pantè condoms to retail outlets, and as retail sales agents to consumers. The three-day training sessions covered such topics as preventing transmission of HIV and other STIs, social marketing goals and strategies, interpersonal communication and direct sales techniques, condom use demonstrations, basic money management and other

valuable skills. At the conclusion of each training session, every NGO agent received a free supply of condoms sufficient to generate enough revenue to both reward the seller and to provide reserve capital to purchase additional condoms from PSI.

As regional and district leaders, these NGO members had an intimate knowledge of their communities that helped ensure their success as salespeople, while their experience as HIV/AIDS counsellors, educators and activists enhanced their ability to advise customers on condom use. Apart from their own commitment to curbing the epidemic, these community-based distributors (CBDs) received a sales incentive in the form of a percentage of condom revenues, both for their organizations and for themselves.

Since most of the participating NGOs had multiple levels of supervision, PSI worked with each group to devise a profit structure that would motivate people at each level while ensuring that the individual CBDs kept most of the profits for their personal use. The sale of just two standard packs (three condoms each) would yield enough personal profit to, for example, pay for a packet of peanuts—not much, but a treat a CBD might otherwise have foregone. The sale of ten packs of condoms might pay for a beer, and 20 packs sold would yield a profit of U.S.\$1 in a country with a monthly per capita income of around \$33.

Given the country's economic instability, these profits offered a welcome source of extra income for many CBDs and their intermediate field supervisors. They also provided the sponsoring NGOs with sufficient income to cover the additional administrative costs of the CBD marketing efforts, such as condom storage and delivery and extra supervision and communications.

Despite the common goal of promoting HIV prevention, this kind of rapport between NGOs and social marketing is not automatic. Social marketing specialists operate in the commercial sector, appealing—on the immediate level—to the profit motive rather than altruistic goals. NGO staff members who provide assistance to the impoverished may object philosophically to selling anything to their clients or members. But both groups recognize the urgent need to ensure a reliable condom supply to NGO members and the communities they serve, and that common ground enabled AIDSCAP and PSI to foster productive relationships between social marketing operations and NGOs in Haiti as well as in other countries.

Even after an NGO signs on to participate in a community-based condom sales project, questions and discussion about potential conflicts between the NGO mission and the project's mission may continue. After the project began in Haiti, a community group providing outreach to sex workers expressed concern that NGO salespeople might abandon their original target population because it was easier to sell to more affluent customers. Some of the managers of that NGO were also concerned that—stimulated by the profit motive—some CBDs might neglect their educational obligations and instead concentrate all their efforts on making money through sales.

PSI conducted a study to look at these issues and found that, although CBDs were selling to new customers, sex workers continued to be well served—in part because the CBDs created new retail sales points in their communities that were available at all hours of the day and night. Determining whether CBDs were

doing less HIV/AIDS education in favour of “just selling” was more difficult, but AIDSCAP and PSI staff believed that—given the dramatic increase in the number of condoms sold—CBDs were doing a better job of explaining to people why they needed condoms.

As the Haiti project matured, several advantages of condom sales through community-based distributors became clear:

- Friends and neighbours have much more credibility as salespeople than outsiders, particularly strangers “selling something.”
- CBDs—who usually store condom stocks at their homes—are generally available 24 hours a day for those who need to buy condoms at all hours.
- CBDs are usually available for immediate, morning-after, remedial counselling in condom use if first-time users do not have a problem-free experience, a “service” rarely available from a traditional commercial source.
- CBDs can provide ongoing reinforcement and encouragement of consistent and correct condom use by their customers.

All in all, more than 3,000 points of sale for condoms were created during the project—hundreds of them by CBDs—ensuring availability for hundreds of thousands of potential customers throughout Haiti. A significant number of these sales locations catered specifically to female and adolescent condom buyers. This new distribution network ultimately penetrated eight out of nine of Haiti’s administrative *départements* and 95 per cent of all administrative *communes*, many of them quite difficult to reach—

and NGO-based sales were responsible for opening most new points of sale outside Port-au-Prince. To achieve this kind of geographic coverage, the project expanded to include nine NGOs, involving dozens of their members as CBDs.

Figures for NGO-based Pantè sales were equally impressive and critical to the overall success of the AIDSCAP/PSI project in Haiti. From January 1992 to June 1996, CBDs sold nearly 27 per cent of the more than 15 million condoms sold by the project. The CBD contribution peaked at 43.5 per cent during 1994, when the United Nations embargo of Haiti was in full force and PSI’s direct sales efforts were severely limited by fuel rationing and security concerns. This was a remarkable achievement.

Perhaps the most revealing proof of the value of CBDs is the fact that these successes took place against a background of political unrest and economic uncertainty that disrupted life throughout Haiti. While a lack of supplies and gasoline for delivery vans during the international embargo brought most commercial distribution to a halt, the highly motivated CBDs provided stability to the social marketing project. They continued to open new sales outlets, shared information on gasoline availability and military blockades with each other, and found ways to continue their work despite the dangers and uncertainties that came with each day. Many who have studied the project credit the CBDs for its strong showing during a period in Haitian history when few other commercial enterprises survived.

THE LOGISTICS OF A COMMUNITY-BASED DISTRIBUTION PROJECT

Community-based condom distribution involving NGOs can work in almost any setting—but it's critical to keep the process simple and transparent, to guarantee that everyone understands how it works and feels confident that their hard work will be rewarded equitably.

In the Haitian CSM project and others like it around the world, PSI discovered that the simplest way to operate the supply, sale and resupply chain is to make it a completely cash-based system: no credit and no bookkeeping. To get started, the first set of condom supplies is given free to CBDs. The sale of this first stock will create each CBD's "revolving fund" to keep the system going on a cash-and-carry basis. Once these first condoms are sold, each CBD takes out the agreed-upon percentage for personal profit and returns with the remaining money to the project supervisor to buy replacement stock.

As CBDs sell their stock, they develop the skill to calculate their own profit and set aside the amount needed to resupply. CBDs unable or unwilling to manage their money will be put out of business without endangering the whole organization, as might happen if condoms were given to them on credit that was never repaid. As the project supervisor sells stock wholesale to CBDs, he or she arranges to purchase replacements from the central supply office—again, a cash-only transaction. Throughout the process, no credit needs to be tracked and collected, and no intricate bookkeeping

maintained. Although participating NGOs should consider keeping an emergency reserve of condoms in case fire or rain destroys the stock, or it gets lost or stolen, the whole system remains simple and direct.

To set up an NGO-based condom sales operation, HIV/AIDS programme managers need to:

- Identify a reliable condom source, whether free from the national government or an international donor or wholesale from profit-making retailers or social marketing organizations.
- Work out how and when—and how often—condoms may be obtained from the source, and who will cover any costs involved: wholesale prices, time and/or labour in preparing the stocks for delivery to the NGO, transporting the supply to the NGO, and so on.
- Decide where and how the supplies will be stored before the first condoms are delivered to the NGO and who will have access.
- Determine when and how NGOs can replenish CBDs' stocks, how to keep track of stocks distributed to NGOs, who will decide when new supplies need to be procured, how the supplier will be alerted in advance to prepare a new delivery, and how and by whom the condoms will be delivered.
- Arrange to train the CBDs in basic selling skills and in how to handle the revenues from their profits.
- Decide at what price the condoms are to be sold, and how profits will be divided within the organization.

LESSONS LEARNED FROM THE HAITIAN EXPERIENCE

Allow CBDs to retain and immediately use—for their own purposes—their profits. Profits confiscated do not reward, and reward delayed does not motivate. Profits from condom sales offer real incentive to most CBDs and lead to a greater sales effort—which means more people are offered access to protection.

Make sure that everything concerning profits from sales is transparent. Community-based sales at one NGO in Haiti came to a halt when CBDs discovered that profits remitted to the head of the organization to be shared with other NGO members were being diverted for that individual's personal use.

Everyone must—from the start—agree on and accept how things will work. After training was completed, some of the Haitian NGOs changed the guidelines, particularly on how and when profits would be divided and what the profits would be used for. The effect usually was to eliminate any individual incentives and leave CBDs with the feeling they were being exploited.

Financial incentives are essential to cost-effective condom distribution. Above-average benefit margins for wholesalers and retailers are necessary, due to the product's extremely low per-unit price and the special efforts required for marketing condoms. Quantity discounts encourage vendors to increase the size of their orders and reduce the need for restocking.

Sales through CBDs on a regular basis necessitate intensive management for the sponsoring NGO or the social marketing organization, usually requiring a full-time staff person to deal with logistics and monitor

profits to ensure that they are adequately and equitably distributed among the members of the CBD network. Some participating NGOs may have a tendency to complicate the system with unnecessary bureaucratic requirements.

Community-based sales are not a significant income-generating opportunity for the NGO itself. Even with huge sales, the income potential—because of the very low price of socially marketed condoms—will not be sufficient to keep an NGO without other resources afloat. Attempts to divert profits to support an NGO only serve to discourage the CBDs who make the system work.

CBDs can also contribute to the creation and expansion of for-profit retail sales points. In addition to sales to individuals, some CBDs will be prompted by the profit incentive to seek out and establish retail customers such as bars, brothels and neighbourhood convenience stores. Supplying retail outlets can free up CBDs to spend more time on AIDS/STI prevention education, allowing them to enjoy sales profits while someone else does the selling.

Income generation appears to offset the normal tendency of volunteer CBDs to drop out. One Haitian NGO, operating for more than six years, held on to many of its original volunteers in part because they wanted to continue earning supplemental income as CBDs.

The cost of supporting sales through CBDs was minor, especially when compared to what it would have cost the project to hire more direct sales staff, pay travel, per diems and sales commissions and buy vehicles for product delivery.

BEST PRACTICE CRITERIA

Effectiveness After sales by CBDs were introduced, total sales of socially marketed condoms increased by about 100,000 units a month, or 50 per cent. Target group members surveyed reported more reliable availability of condoms and increased accessibility because the product could be purchased at more locations during more hours of the day. Anecdotal evidence suggests that awareness of condoms as an HIV-prevention method also increased as CBDs, motivated by profit potential, became more consistent and persistent in touting their wares and organizing promotional events. Because CBDs were known and respected members of their communities, their involvement with condom sales and promotion appeared to make condom use a less sensitive issue and to increase acceptance of condoms, which proved to be an invaluable asset in the process of changing social norms.

Efficiency It took very little additional time and human resources to organize and administer the CBD component of the project. The cost of training CBDs in HIV prevention and sales skills and equipping them with a supply of condoms to create a revolving fund to sustain future condom purchases was less than US\$100 per participant.

Relevance The CBDs model is highly relevant to programmes seeking to improve delivery of disease prevention products to socially marginalized or geographically isolated population groups, such as sex workers or people living in remote rural areas.

Replicability This model is replicable wherever a supply of affordable condoms can be obtained and community groups can be mobilized. It also can be adapted as a microbusiness development scheme.

Sustainability The model garnered strong CBD ownership, and the capacity and acceptance of CBDs increased with their experience and their communities' recognition. With proper profit margins, training in revenue management and an adequate initial supply of condoms (working capital), the model is inherently self-sustaining. However, it is important that the implementing agencies take measures to integrate the CBDs into the existing local condom supply network before external funding ends and for the sponsoring NGOs to allow their members to continue selling condoms after donor support for other activities is terminated.

AUTHORS

Margaret Dadian, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA

Robert Clark, Population Services International, Port-au-Prince, Haiti

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By promoting reporting and discussion on HIV/AIDS in the media, the column contributed to a gradual opening of policy dialogue in the country.



CRISPIN HUGHES/PANOS PICTURES

A KENYAN MAN READS A NEWSPAPER IN NAIROBI, ILLUSTRATING THE ACCESSIBILITY OF HIV PREVENTION INFORMATION TO THE KENYAN PUBLIC THROUGH A NEWSPAPER COLUMN.

AIDS WATCH: INFORMING KENYANS ABOUT HIV/AIDS THROUGH A NEWSPAPER COLUMN

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AIDS WATCH: INFORMING KENYANS ABOUT HIV/AIDS THROUGH A NEWSPAPER COLUMN

INTRODUCTION

AIDS Watch, a popular column that appeared in the Sunday edition of the *East African Standard* from 1993 to 1996, was Kenya's only weekly newspaper column dedicated solely to the discussion of HIV/AIDS and related issues. Every week thousands of readers received information and insights on HIV prevention and care for those already infected with the virus.

The column was started in 1991 by a well-known TV journalist, Raphael Tuju, with support from the World Health Organization (WHO). WHO support ended after a few months, however, and in 1993 the AIDS Control and Prevention (AIDSCAP) Project, implemented by Family Health International and funded by the United States Agency for International Development (USAID), decided to revive AIDS Watch. AIDSCAP signed a contract with the journalist's media consulting firm, ACE Communications, based in Nairobi, to research and write a weekly column, and the editors of *The Standard* agreed to publish it in the Sunday magazine.

Although AIDS Watch was aimed at both rural and urban audiences, its primary target audiences lived in the urban areas where *The Standard* had its highest circulation. In 1993 urban areas in Kenya already had an estimated

HIV-prevalence rate of 11 per cent, compared to a rural prevalence of about 4 per cent. Readers of *The Standard* include opinion leaders, such as government officials, junior and senior managers in businesses and institutions, educators and heads of households, as well as housewives and secondary school students. The column was placed in the Sunday magazine specifically to reach youth, who are more likely to read the magazine than other sections of the paper.

When the column resumed under AIDSCAP, public discussion about HIV/AIDS was still very limited. Much of what appeared in the media was sensational and ill-informed. Sexual behaviours and their relationship to HIV were not discussed. And Kenyan newspapers, including *The Standard*, restricted discussion of condoms and refused to run photos of the prophylactics.

AIDS Watch encouraged behaviour change at several levels—individual, social and policy—to achieve different but complementary objectives. The major objective of the column was to inform Kenyans about HIV and other sexually transmitted infections (STIs), to correct myths and misinformation and to promote discussion. The column also aimed to sensitize readers in order to help them change their risky sexual beliefs, attitudes and practices. Other important

objectives were to reduce discriminatory attitudes and behaviours toward people living with HIV/AIDS (PLHA) and to rally support for prevention and care among opinion leaders and the general public.

OPENING A DIALOGUE

The AIDS Watch project was fortunate in being able to build on the AIDS column that had run in *The Standard* in 1991. As a result of that experience, the newspaper's editors recognized the need for such a column. They also knew that the work of journalist Raphael Tuju, who had been writing columns for them on various issues since 1980, was popular with their readers, and that his celebrity gave the newspaper and the column a higher profile.

More than 100 AIDS Watch columns were published over three years. The columns were reviewed by AIDSCAP and Kenya's National AIDS Control Programme staff and were based solidly on research from scientists, status reports from scientific institutions, focus group discussions and interviews. Those interviewed for the column included professionals and PLHA and their families and friends.

Identifying the right people to interview was a challenge. Stigmatization of PLHA is still pervasive in Kenya, and many were afraid to reveal their HIV status to family, friends and acquaintances, let alone give interviews to the press. Even some physicians were reluctant to be interviewed about HIV/AIDS. Thus, organizations for PLHA, such as the Kenya AIDS Society and the Society for Persons with AIDS in Kenya, were instrumental in finding individuals who were willing to speak about how the disease had affected their lives. Others were drawn to share

their experiences through the column because of the sensitivity with which subject was addressed.

Another challenge was finding the time and resources needed to do the thorough research that was required for the weekly column and to answer hundreds of letters from readers. The project hired a full-time researcher, who was assisted by several part-time researchers at various times during the project, to review the current literature and consult with experts on the topics covered in the column and in responses to individual readers' letters. This researcher, who had a master's degree in journalism, also made monthly visits to rural areas to interview people and collect information. The columnist spent one day writing each weekly column. The time involved in responding to letters varied, based on the number of letters received each week and the types of questions asked. A standard reply that could be personalized was designed to answer the most frequently asked questions, but more specific questions required extra attention.

AIDS Watch encouraged letters from readers and became recognized as a reliable source for personal advice. All correspondents received a reply including a booklet of HIV/AIDS information that had been produced by the Kenyan Red Cross. Some also received referrals to sources of help in their areas. As part of the AIDS Watch Project, ACE Communications and AIDSCAP built relationships with a core team of professionals, including physicians, social workers and counsellors, to whom readers could be referred. Collaborating organizations included the Kenya Federation of Employers, the Kenya AIDS Society, the Association of People with AIDS and Kenyatta National Hospital.

READERS RESPOND

Readers' letters revealed that many people, though aware of HIV/AIDS, were uncertain of some basic facts. Typical questions included: "Can condoms really protect one from getting infected by HIV? ", "How is the virus transmitted? ", "Is it true that the virus can be transmitted through eating fish? ", "Can shaking hands spread AIDS?"; "What symptoms will show that one has the AIDS-causing virus HIV?"

The letters also provided insight on how the epidemic was affecting individuals and families. People living with the virus were often neglected and lacked money to buy food and medicine. Many families and communities were grappling with the problem of caring for orphans as more and more people died of AIDS.

"My relatives ceased to care about me," one person wrote. "I no longer mattered to them. During the good times my house was always full with relatives." Another noted: "When one member of the family is infected, the whole family suffers."

This input from readers became increasingly important in shaping the column. In response to readers' needs and the changing realities of the epidemic in Kenya, the column moved beyond the "ABCs" of HIV transmission and prevention to address a broader range of issues. These included care of AIDS patients, living with HIV, orphans, and the vulnerability of youth and women to HIV. The column did not shy away from sensitive topics such as condom use and traditional cultural practices that increase the risk of HIV transmission, and it made some hard-hitting attacks on discrimination and ignorance.

Replying to readers' questions about condoms in the column proved an effective

way to broach this controversial topic at a time when newspapers restricted such discussion. This approach also made it possible to combat misinformation without being accusatory. The information was reported ("We've been hearing about condoms being laced with the HIV virus"), then facts and expert opinion were presented.

PROJECT OUTCOMES

Although funding was not available for a rigorous evaluation of the AIDS Watch project, the response to the column indicates that it provided a much-needed and useful service. A survey conducted by the *Sunday Standard* in 1996 found that within a short period of time AIDS Watch had become one of the paper's five most popular columns.

Based on the survey results and the circulation figures for *The Standard*, it can be assumed that AIDS Watch reached a large audience. *The Standard* sells 70,000 copies of its Sunday edition and has an estimated readership of 350,000.

AIDS Watch received about 1,400 letters from readers. The content of these letters suggests that the project achieved its objective of informing people and promoting discussion about HIV/AIDS. For many correspondents, the column and personal responses from AIDS Watch were their only source of accurate information about HIV/AIDS.

The column's role in encouraging dialogue about HIV/AIDS was most notable on the subject of condoms. As the first newspaper column in Kenya to discuss condoms and include photos of the device, AIDS Watch was responsible for changing the policies of several newspapers that had restricted publication of information about condoms. It also appeared

to encourage other newspapers to report on the HIV/AIDS pandemic by raising issues that the media had not covered before. AIDS Watch was quoted several times in the *Daily Nation* and other Kenyan newspapers.

By promoting reporting and discussion on HIV/AIDS in the media, the column contributed to a gradual opening of policy dialogue in the country. Many of the issues it raised were addressed in a law passed by the Kenyan parliament in 1997 that represents the country's first national policy on HIV/AIDS.

The column also helped foster understanding of the difficulties faced by people living with HIV/AIDS. In Busia and Nairobi, for example, several PLHA and their families received help from people who had read about their plight in AIDS Watch. Readers wrote in asking how they could volunteer their services to support HIV/AIDS causes, and more than 20 people called to offer assistance to some of the individuals featured in the column. One person even arrived in *The Standard* newsroom with food and money to give to one family affected by HIV/AIDS.

QUALITATIVE ASSESSMENT

A qualitative assessment of AIDSCAP media activities in Kenya also provided some insights into how the column was perceived and how it might have affected the target audiences. Two focus group discussions on AIDS Watch were held: one with young trainee journalists and the other with NGO programme officers working on HIV/AIDS. In addition, key informant interviews were held with the two *Standard* editors responsible for the column and with the columnist himself. The purpose of these discussions was to gather additional information

about the column's effectiveness in achieving its objectives and to assess whether there was still a role for a newspaper column about HIV/AIDS.

All respondents thought that the column had effectively contributed to raising awareness and changing attitudes and behaviour. According to the trainee journalists, the column significantly increased awareness in urban areas of high-risk sexual behaviour and of the needs of PLHA. Those interviewed also indicated that the column had succeeded in humanizing the HIV/AIDS pandemic, as many of the PLHA in Kenya who went public about their HIV status did so through the column. It was reported that parents used the column to educate their children.

Responses showed satisfaction with the way the column had handled regional issues in multicultural Kenya. Material for the column was collected from different parts of the country, particularly in areas most affected by the disease. It was thought that potentially divisive cultural issues such as circumcision, polygamy and wife inheritance had been addressed effectively in the column, with openness and moderation.

The column appeared to have satisfied the informational needs of members of both focus groups. Journalism students interviewed spoke of having learned about how to cope with HIV/AIDS, AIDS symptoms, condoms and the importance of abstinence. NGO programme managers talked about how they had used information from the column in their work. For example, one manager said that an article on AIDS orphans had been of immense use to her organization. Another manager photocopied the columns for use in an NGO resource centre.

The respondents recommended reviving the column, but made the following recommendations to improve its effectiveness:

- Address different audiences, such as youth (including young girls and out-of-school youth), senior management executives and people in rural areas.
- Focus more attention on condom use.
- Publish the column once a month, in order to give more time for preparation.
- Use other print media, such as the Kiswahili-language dailies and youth newspapers, to reach different audiences effectively.
- Build a monitoring and evaluation system into the project. This could include, but should not be limited to, an anonymous panel of selected readers providing feedback on each column.

LESSONS LEARNED

AIDS Watch derived most of its strength from the fact that it covered issues raised by readers. It was a communication process, not a monologue. The column's interactive style enabled it to be responsive to readers' information needs and provided an acceptable context for addressing controversial topics and countering misinformation.

It was essential to establish the credibility of the AIDS Watch column so that it could challenge the inaccurate information about HIV/AIDS routinely disseminated in the Kenyan media. The most important strategy for establishing credibility was the decision to support a column written by a well-known and respected journalist who already had wide public recognition from his work as a TV newsreader. Other effective strategies included

sending prompt and reliable responses to all letters sent to AIDS Watch and building linkages with medical and counselling services. A box appeared in each column advising readers that "your letters are answered confidentially by a team of experts at the Kenya National AIDS Control Programme."

Focus group participants agreed that the journalistic skills of the people involved in the project were also important. They identified the ability to interview PLHA, collect information from authoritative sources and convey it in clear, compelling terms as factors key to the success of the AIDS Watch column.

BEST PRACTICE CRITERIA

Relevance When the AIDS Watch column began running in 1993, Kenyan society was in denial about a national HIV epidemic that had already affected more than three-quarters of a million people. Public information about the virus and its prevention was severely limited and often inaccurate. Survey results, qualitative research and the volume and content of hundreds of letters from AIDS Watch readers showed that people needed such an authoritative and responsive source of information about HIV/AIDS.

Efficiency The newspaper column directed the attention of the public to the epidemic in an easily accessible form, reaching a large number of readers in high-prevalence urban areas. Ongoing feedback from readers' letters provided a way to monitor whether the column was meeting peoples' needs. The column was written in an easy-to-read style, maximizing its impact among the functionally literate population.

Effectiveness/Impact Although rigorous evaluation of the project was not undertaken, letters from readers and data from qualitative research suggest that the project met its objectives of informing Kenyans about HIV/AIDS prevention and care, encouraging discussion about the topic and changing attitudes toward people living with HIV/AIDS. The column was named one of the Sunday *Standard's* top five columns in a poll taken by the newspaper. AIDS Watch was also the first column in Kenya to discuss condoms, which led to several newspapers changing their editorial policy on the subject.

Ethical Soundness The columnist and researchers were careful to protect the anonymity of those who requested advice through the column. Readers' letters were usually published under a pseudonym, and the names of people interviewed for the column were often changed. Those who did not request anonymity were counselled about the possible consequences of going public. Each person who agreed to be profiled in the column with a photo signed a waiver granting permission and accepting the possible stigmatization he or she might experience.

Sustainability *The Standard* editors and others interviewed as part of the qualitative assessment of the project believe that the quality of the writing is the key to sustaining a column such as AIDS Watch. If a columnist can present such difficult subject matter in a way that engages readers, editors will be willing to provide editorial space. Some other organizations and individuals have had to pay

to publish HIV/AIDS information in Kenyan newspapers. More formal linkages with HIV/AIDS organizations might help support the research required to write columns and answer readers' questions.

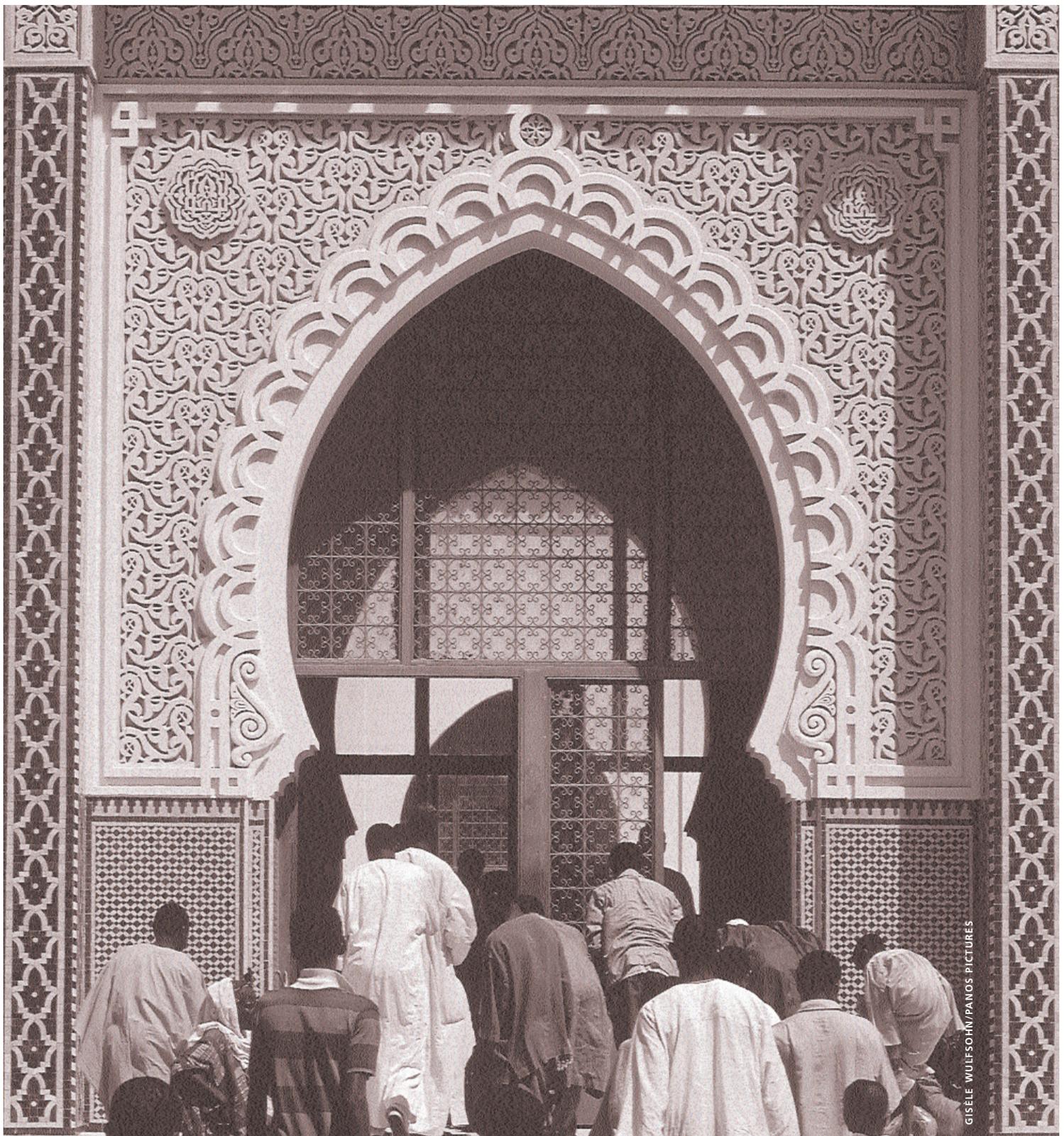
AUTHORS

Raphael Tuju, ACE Communications, Nairobi, Kenya

Maureen Ong'ombe, ACE Communications, Nairobi, Kenya

Kathleen Henry, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA

For a long time a large proportion of the population had doubted the existence of the HIV/AIDS epidemic, but when they heard their religious leaders speak with tolerance, they understood the gravity of the problem.



GISELE WULFSOHN/PANOS PICTURES

FAMILIES ENTERING A MOSQUE IN DAKAR, SENEGAL, SHOW THE POTENTIAL REACH OF RELIGIOUS-BASED INITIATIVES TOWARD INFLUENCING SAFE SEXUAL BEHAVIOR AS A COMMUNITY NORM.

WORKING WITH RELIGIOUS LEADERS TO PREVENT THE SPREAD OF HIV/AIDS IN SENEGAL

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WORKING WITH RELIGIOUS LEADERS TO PREVENT THE SPREAD OF HIV/AIDS IN SENEGAL

INTRODUCTION

In order to create an environment conducive to HIV/AIDS-prevention activities, it is crucial to involve the community leaders who have the greatest influence in a community's everyday life. This means that behaviour-change interventions to reduce HIV transmission must be given credibility through the involvement of moral and religious authorities. The challenges, then, become increasing awareness and understanding among these leaders of the demographic, social and economic impact of HIV/AIDS; eliminating policy barriers to the implementation of HIV/AIDS intervention; and educating and building support among opinion leaders for effective HIV/AIDS programmes.

This case study explores the process used in Senegal to involve religious leaders in the national response to HIV/AIDS and the impact this involvement has had on interventions by religious organizations, other nongovernmental organisations (NGOs) and the community at large.

HIV/AIDS IN SENEGAL

The HIV/AIDS epidemic in Senegal is characterized by a relatively low seroprevalence rate compared to those of other West African

countries. Statistics from the National AIDS Control Programme (NACP) show that in 1993, 911 cumulative AIDS cases had been documented in Senegal. By May 1995, that number had risen to 1,573—a 73 per cent increase in two years. As of the end of 1997, an estimated 75,000 to 80,000 people were living with HIV in Senegal.

The prevalence of HIV among hospital patients in 1993 was 15.9 per cent, and the highest level of infection was found among registered sex workers. However, data from 1997, the most recent available, show that the prevalence of HIV infection among pregnant women seen at maternity clinics in major cities ranged from 0.5 per cent to 1.9 per cent. The overall national prevalence rate is around 2 per cent, with a male-to-female ratio of approximately 1:1. Subtypes HIV-1 and -2 have both been identified among the general population. HIV-2 prevalence was initially identified as being more prevalent than HIV-1, but at present the frequency is relatively similar.

The contrast between Senegal's HIV epidemiological situation and those of other West African countries has raised a number of questions. Do the existing data conclusively demonstrate that Senegal does have lower HIV-prevalence rates than other countries in

the region? And if so, is this lower prevalence due to social behaviour specific to Senegal?

Senegal's apparent success in maintaining relatively low levels of HIV/AIDS has been explained as being the result of a number of factors, including the existence of a sentinel surveillance system; special screening of registered sex workers; effective management of sexually transmitted infections (STIs); the promotion and utilization of condoms; sensitization campaigns targeting different population groups; and, the involvement of NGOs, associations and political and religious leaders. The role of religion in Senegalese society also has been cited as part of the explanation for the comparatively low prevalence of HIV in the country.

THE ROLE OF RELIGION IN SENEGAL

Senegal is a country of two predominant religions: Islam and Christianity. The Islamic community, which represents 94 per cent of the population, operates within numerous and diverse religious networks: religious associations (*Dahiras*), regular school establishments, Koranic schools (*Daara*) and networks of Imams. It is structured within a religious confraternity (brotherhood) network. Approximately 900 Islamic associations are registered with the Ministry of Interior, and numerous others are not registered. These religious associations account for 3.5 million adherents, and represent 45 per cent of the Senegalese population. They are involved in diverse social activities affecting every aspect of people's lives.

Christian communities—both Catholic and Protestant—comprise 4.9 per cent of the population. They operate through well-structured

institutions, such as schools, health facilities and youth movements, which allow leaders to reach all strata of Senegalese society. In general, religion plays a strong role in the culture and beliefs of the Senegalese people.

KEY PLAYERS IN RELIGIOUS-FOCUSED PREVENTION PROJECTS

The National AIDS Control Programme

Created in 1987 within the Ministry of Health, the National AIDS Control Programme (NACP) is responsible for coordinating HIV/AIDS-prevention activities at the national level. In collaboration with national and international partners, the NACP has planned, supported and followed up on successful strategies for establishing a policy dialogue with Senegalese opinion leaders.

The official starting point for NACP to work with religious leaders was the 28th ordinary session of Organization of African Unity (OAU) heads of state in Addis Ababa, Ethiopia, in 1992. At this conference, the Senegalese delegation presented a resolution calling for the mobilization of the entire society in the response to HIV/AIDS, but particularly the involvement of traditional and religious leaders. The NACP had recognized that the success of behaviour-change activities depended on validation by religious and moral authorities. Its initiation of this resolution facilitated the emergence of policy dialogue on HIV/AIDS with Senegalese religious leaders.

Jamra

Founded in 1982, Jamra is an Islamic NGO devoted to combating social ills, such as illicit drugs and sex work. Due to the links between this mission and HIV transmission, Jamra

became involved in prevention efforts soon after the appearance of the first-known cases of AIDS in Senegal. As early as 1987, Jamra's leaders contacted the NACP to express their organization's interest in contributing to the national response to AIDS and to request training in the scientific aspects of the problem. However, Jamra developed its own approach by elaborating messages based on the beliefs and convictions of its members.

In 1989 Jamra and the NACP signed a formal agreement that provided a basis for sensitization sessions targeting Imams, Khalifs and traditional leaders in each of Senegal's ten regions. For both Jamra and NACP staff members, this partnership laid the groundwork for effective involvement of religious leaders in HIV/AIDS-prevention efforts in Senegal.

SIDA-Service

In 1991 the Association of Catholic Health Posts of Senegal and the private Catholic schools unit of the Catholic church created SIDA-Service in response to the urgent need to inform its youth about the gravity of HIV/AIDS. This organization is made up of priests, nuns, doctors, teachers, health personnel and youth. The drive behind SIDA-Service efforts is the need to acknowledge moral responsibility and reaffirm fundamental moral values.

Before the founding of SIDA-Service, the Association of Catholic Health Posts was already collaborating with the Ministry of Health in controlling diseases, including sexually transmitted infections (STIs), through its 72 health facilities across Senegal. These health posts are believed to provide 40 per cent of all medical consultations in the country. The private

Catholic schools also represent a considerable resource for reaching youth: according to Ministry of Education statistics, the private Catholic schools unit operates 70 secondary schools. The NACP has recognized the role of the Catholic community, too, in the response to HIV/AIDS, as demonstrated by involvement of Catholic health posts in STI case management.

OBJECTIVES OF POLICY DIALOGUE IN SENEGAL

Family Health International's (FHI's) AIDS Prevention and Control (AIDSCAP) Project, funded by the United States Agency for International Development (USAID), recognized the importance of involving religious leaders in HIV/AIDS-prevention efforts in Senegal at an early stage. These leaders were among the most important audiences targeted by AIDSCAP's policy dialogue efforts. Four objectives were identified for policy dialogue in Senegal:

- Increase the awareness and understanding of Senegalese opinion leaders of the demographic, social and economic impact of the HIV/AIDS epidemic and the relative efficacy of various prevention strategies.
- Reduce or eliminate policy barriers to the implementation of behaviour-change communication activities, condom promotion and STI-control strategies.
- Strengthen the capacity of the NACP to carry out policy assessment, development and reform.
- Educate and build support among policy-makers and opinion leaders for an effective, comprehensive HIV/AIDS prevention programme in Senegal by helping initiate and facilitate policy dialogue.

PROJECT METHODOLOGY

The approach FHI and its partners developed for establishing policy dialogue in Senegal was based on quantitative studies, targeted sensitization and outreach contacts.

Assessment studies: Indispensable

prerequisites In 1988, 47 per cent of the population surveyed cited condom use as a means of HIV prevention. The only modes of protection officially recognized by religious leaders were fidelity and abstinence. The results of a study among religious leaders, conducted in June 1994 by the NACP with support from FHI/AIDSCAP, led to the following conclusions:

- Religious leaders felt excluded simply because they lacked information about HIV/AIDS—particularly information on the magnitude and severity of the epidemic.
- Once sensitized to the need for intervention, these leaders were ready to get involved because of the moral issues involved.

This study also provided the background information the NACP needed to organize national sensitization seminars on HIV/AIDS and religion in collaboration with JAMRA, SIDA-Service and other national NGOs and international organizations.

Targeted sensitization Jamra and its network provided an invaluable mechanism for involving Islamic religious leaders in HIV/AIDS-prevention efforts. In the case of the Christian community, SIDA-Service was the entry point for progressively drawing in Catholic clergy while respecting their church's hierarchy.

Using outreach contacts Jamra capitalized on its knowledge of the field and its privileged relations with important 'marabou' (traditional religious leaders) to introduce HIV/AIDS issues to religious communities. This was accomplished through organized field trips across the ten regions of Senegal, during which meetings were held with representatives of these leaders. Jamra succeeded in involving known personalities and leaders of all the five different sects (Tarikha) within the Islamic community.

SIDA-Service's approach was very similar to that of Jamra, except that they approached the leaders rather than their representatives. Key members of SIDA-Service personally met with the bishops of each of the six Catholic dioceses. This outreach approach was fully supported by the cardinal and resulted in the bringing together, in a formal meeting, of all the bishops who ordinarily met twice a year. This approach progressively reached other Catholic structures such as schools, health posts, youth and women's groups, developmental initiatives, the clergy and training schools. In order to ensure total participation by the entire Christian community, SIDA-Service followed the same approach with the Protestant community, despite the serious differences that exist between the two churches.

Adapting pedagogy by linking the Koran

and scientific facts In order to establish a sensitization process, Jamra drew on messages from the Koran and Hadiths (rules dictated by the Prophet) to mobilize the Muslim community on questions that touch on Islam. By articulating scientific arguments and religious precepts, Jamra was able to arouse the interest

of religious personalities and leaders. Jamra also called for the participation of the scientific committee of the NACP in the sensitization sessions. More important, however, Jamra assumed ownership of the scientific facts in a form more appropriate to the religious leaders by linking them to the Koran and Hadiths.

Reaching religious leaders As a general rule, religious leaders did not participate in sensitization sessions. The tendency was to send representatives, who participated at these sessions along with community members. However, these sessions were filmed and recorded for the religious leaders. From these recordings, the religious leaders understood that members of the general population were aware of the HIV/AIDS problem, but were interested in hearing the views of their moral leaders. Thus, this approach made the religious leaders aware of the concerns of their communities.

The Christian community was more schematic in its approach. A scientific committee was formed to prepare appropriate texts, which were subsequently reviewed and refined by church officials. The substance of the text was designed to underline the socioeconomic impact of HIV/AIDS in ways that would attract the commitment of the church.

Involvement of people living with HIV/AIDS The Jamra team was often accompanied by people living with HIV/AIDS (PLHA) during their sensitization campaigns with members of the Islamic community. Due to the low seroprevalence of HIV in Senegal, many people had not come into contact with people who had been infected with the virus.

Therefore, it was important to give the epidemic a human face in order to convince many influential people of its existence.

This approach was also important for the Christian community, but more in showing what the church could do for those already infected. The experiences of other churches elsewhere in the world were made available to the bishops, as well as excerpts from Pope John Paul II on HIV/AIDS, to enable them to formulate an appropriate approach for their communities in Senegal.

FORMALIZING THE POLICY DIALOGUE

The study undertaken in 1994, together with Jamra's and SIDA-service's personal contacts with religious leaders, provided enough background information to organize the first national colloquium on HIV/AIDS and Islam in 1995. A joint collaboration between NACP, Jamra and FHI, this meeting was the first of its kind held in Africa and the first time in Senegal's history that government and religious leaders met to exchange views on sensitive issues. In 1996 another landmark seminar, "Christian Response to AIDS," followed. A collaborative effort between the NACP, SIDA-Service and FHI, this seminar became a forum for inter-religious discussions and debates on educating youth, non-discrimination against PLHA, and the care of AIDS patients.

Neither the Muslim nor the Christian leaders condemned condom use. While the Muslims underlined values such as fidelity and abstinence before marriage, they recommended condom use when one partner was infected. The Christian leaders maintained the same stance, but were more eloquent with regard to PLHA. In such

instances, condoms were considered the lesser of two evils in comparison to the commandment “thou shalt not kill.” These positions were to play an important—though not exclusive—role in the increase of condom use in Senegal.

PROJECT ACCOMPLISHMENTS

Mobilizing media outreach The immediate result of the two national meetings of religious leaders was their adoption of more formalized information, education and communication (IEC) methods as a prevention strategy. Of note was the multiplication of sensitization efforts through channels such as conferences, structured educational sessions and radio and TV behaviour-change message spots. The results of a study conducted in January 1997 to assess the impact of mass media (radio in three regions of Senegal)

as a communication strategy for HIV/AIDS prevention suggested that direct religious sessions were the favourite channel of communication (see Figure 1). More than 40 per cent of those surveyed said they preferred to listen to HIV/AIDS messages during religious sessions.

Another study, which focused on capacity building, demonstrated that a large number of local organizations involved in IEC activities injected a religious flavour into their messages. This has contributed to an increase in the level of knowledge of HIV/AIDS, a first step in the behaviour-change process. According to the third Demographic and Health Survey (DHS) in Senegal in 1997, 90 per cent of the Senegalese population is well informed about HIV/AIDS, including having knowledge about all the means of protection.

FIGURE 1
Preferred Communication Strategy

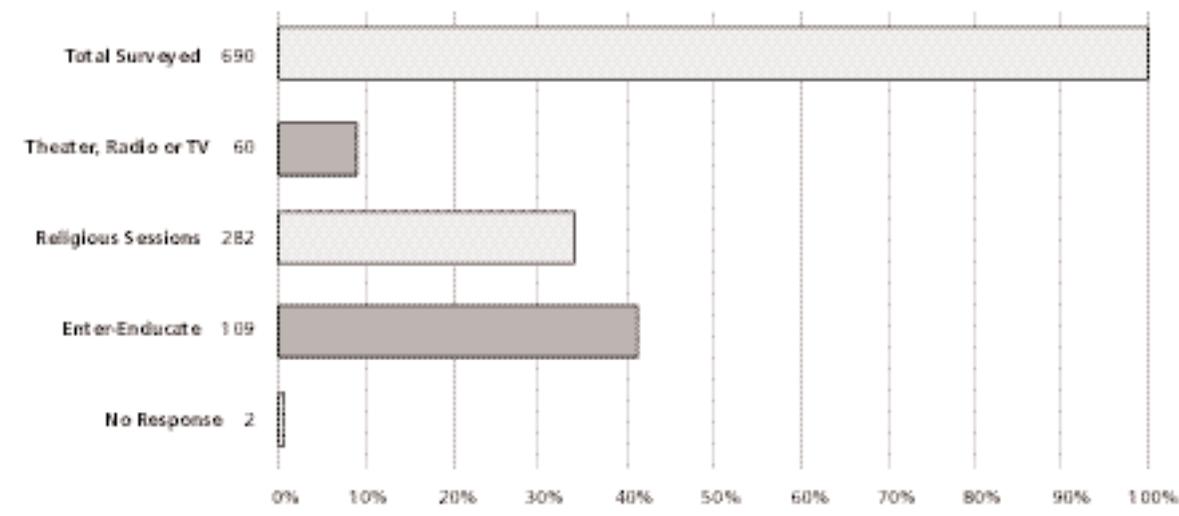
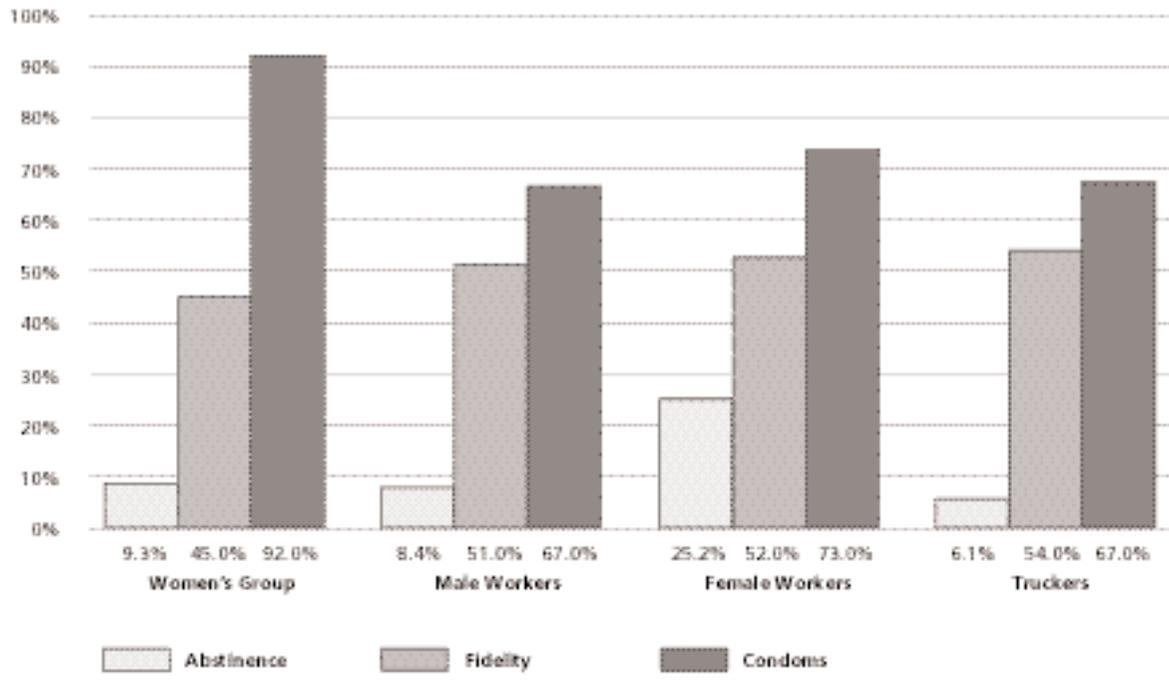


FIGURE 2

Means of Protection



Results from the 1998 Behavioural Surveillance Survey (BSS) on HIV-risk behaviour demonstrate an interesting comparison between abstinence, fidelity and the use of condoms among the populations surveyed (see Figure 2). This survey appears to indicate that the use of condoms as a means of protection against HIV/AIDS has overtaken abstinence and fidelity, which were the means favoured in surveys prior to 1995. As indicated elsewhere in this case study, 1995 also marked the formalization of policy dialogue with religious leaders in Senegal.

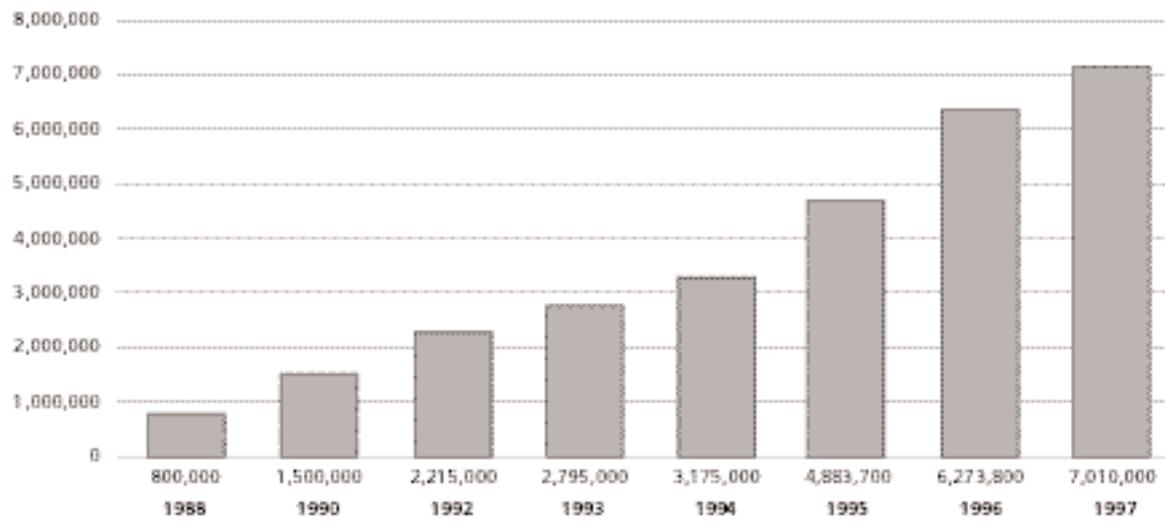
During the 1995 colloquium on HIV/AIDS and Islam, a renowned Islamic Scholar stated that “the Islamic religion has no official position with regard to condoms because Islam prescribes

principles. If condom use is aimed at preserving the couple’s life, then Islam subscribes perfectly to this principle for the well being of mankind. Man has therefore a mission to fulfill. Condom as a means of protection is therefore accepted by Islam.”

In 1996, at a similar colloquium for the Christian minority, the Catholic Archbishop of Dakar said, “The church does not impose on anybody how to fight against this pandemic. Condom use in cases where one has no choice is the least of the evils compared to imposing death on a third party.” Thus, the two religions adopted a tolerant tone with regard to condoms, as opposed to the previously assumed condemnation of condom use.

FIGURE 3

Condom Promotion



Condom distribution figures also show substantial increases in condom use in Senegal (see Figure 3). From 1995 to 1997, condom distribution almost doubled. It has been estimated that approximately half the number of condoms distributed or sold during the two years can be attributed to the impact of the involvement of religious leaders and the tolerance demonstrated by these leaders through their messages on HIV/AIDS. For a long time a large proportion of the population had doubted the existence of the HIV/AIDS epidemic, but when they heard their religious leaders speak with tolerance, they understood the gravity of the problem.

The impact on prevention mobilization

of NGOs and associations The participation of religious leaders also legitimized HIV/AIDS interventions at the community level. As a result,

local NGOs and community-based organisations (CBOs) felt free to participate in HIV/AIDS activities including delivering messages on condoms and distributing condoms.

The involvement of religious leaders has also resulted in a more sustainable form of community mobilization through local NGOs and associations. The most successful of these organizations have been Jamra and SIDA–Service, which had the advantage of being involved in the process from the outset.

With Jamra this involvement has expanded through the multiplication of its structures in the regions and the establishment of information kiosks specializing in materials that touch on both religion and HIV/AIDS. The Jamra network has created special groups within diverse residential areas and secondary schools in Dakar. The role of these groups is to provide educational sessions for the residents and secondary school students.

The network has also developed brochures for use by Imams and religious associations. Jamra continues mass sensitization through religious sermons and radio.

Follow-up action by SIDA-Service has been more structured. Through its dioceses, it works with PLHA, including running income-generation projects, which provide minimum revenue for participants and their families. These projects are closely monitored by volunteers, and according to a recent evaluation, their success rate is high (83 per cent).

Other activities with PLHA include counselling at Catholic health post facilities or at the homes of PLHA. A total of 872 persons have thus far been counselled through 250 visits. SIDA-Service also provides free medication for opportunistic infections. The group recently extended its IEC outreach activities to prisons in Dakar. So far 69 educational activities have been conducted, reaching 800 people.

LESSONS LEARNED

- The participation and support of political, religious, traditional and opinion leaders has been essential to effective HIV/AIDS-prevention programming in Senegal.
- HIV/AIDS project staff must initiate dialogue with leaders, taking into account cultural beliefs and adapt training and behaviour-change communication messages accordingly.
- It is necessary to have ongoing communication with policy and opinion leaders to maintain their support and participation in HIV/AIDS-prevention efforts.
- Special attention needs to be given to involving PLHA in dialogue and decision-making processes at all levels. This focus

should be built into any future HIV/AIDS programming.

- Efforts to establish policy dialogue should begin with a systematic effort to identify and engage the people who influence policy. Without a defined group to facilitate policy development and sustain attention, policy efforts can be scattered and unconnected.

CONCLUSION

Through the efforts of the NACP, Jamra, SIDA-Service and other organizations working in HIV/AIDS prevention in Senegal, the country has clearly moved from avoidance of political dialogue and only timid attempts to reach out to religious leaders to an active, all-out effort to involve opinion leaders in the search for effective responses to the epidemic. There has been a qualitative and quantitative change in the involvement of the leaders and an increase in the frequency and intensity of public discussions of HIV/AIDS-related issues. While these improvements have yet to result in a clear national HIV/AIDS policy, much progress has been made in this direction.

BEST PRACTICE CRITERIA

Within certain cultures, it is important to create a favourable environment for an effective HIV/AIDS-prevention programme by involving leaders who have an influence on individual sexual behaviour.

Relevance One of the main goals of an HIV-prevention programme is to mobilize the whole community. In conservative societies, creating a favourable environment to achieve this mobilization can be a challenge. The

involvement of religious leaders gave impetus to community mobilization by individuals, NGOs and associations.

Effectiveness The primary objective of involving religious leaders in HIV/AIDS prevention was to promote risk behaviour change. The increase in condom use cited in this case study points to acceptance by the population of support from religious leaders for this method of AIDS prevention.

Ethical Soundness The resolution presented by the Senegalese delegation during the 28th session of the OAU Heads of State meeting in 1992 provided unequivocal support for the involvement of religious leaders in the national response to HIV/AIDS. Subsequent interventions were supported by the ministries of Health, Youth and Women's Affairs.

Sustainability The cost of involving religious leaders and religious organizations in behaviour-change activities is minimal. Religion already plays an important role in every aspect of people's lives. After creating awareness among religious leaders, the leaders continue to maintain their support and participation in prevention efforts. In Senegal there is a clear commitment from some local organizations to continue HIV/AIDS-prevention activities with encouragement from the government, religious leaders and very little support from international and bilateral agencies.

AUTHOR

Pamela Onyango, AIDSCAP/Senegal, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Dakar, Senegal.

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The HIV/AIDS epidemic is an emerging multisectoral phenomenon, requiring assessments that capture the widest potential impact on countries and regions.



BILL STEPHENSON/PANOS PICTURES

AN HIV-POSITIVE SEX WORKER IN SAN PEDRO SULA, HONDURAS, EPITOMIZES THE NEED FOR A SUPPORTIVE HIV-FOCUSED POLICY PROCESS IN CENTRAL AMERICA AND ELSEWHERE.

USING SOCIOECONOMIC IMPACT ASSESSMENTS TO STRENGTHEN THE HIV/AIDS POLICY PROCESS IN CENTRAL AMERICA

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USING SOCIOECONOMIC IMPACT ASSESSMENTS TO STRENGTHEN THE HIV/AIDS POLICY PROCESS IN CENTRAL AMERICA

INTRODUCTION

Socioeconomic Impact Assessments A socioeconomic impact assessment (SEIA) is a tool that has increasingly been used to evaluate the potential consequences of the HIV/AIDS epidemic on a given country. Epidemiologists, health economists, sociologists and policy analysts have used SEIAs to describe and predict the multisectoral impact of the epidemic. The intention of these assessments has largely gone beyond research; they have more often been used to inform and assist public and private sector decision-makers in developing policies to mitigate the impact of the epidemic.

In some cases SEIAs have emphasized household impact, thus encouraging policies to provide greater support for affected families. Other studies have emphasized the sectoral impact of HIV/AIDS, identifying the sectors of society (including the health sector) most likely to be affected by the epidemic. Finally, some SEIAs have focused on macro-level impacts, describing the ways HIV/AIDS is likely to affect the health, demography and national economies of certain countries.

Family Health International's (FHI's) experience in a number of countries (including Burundi, Colombia, Côte d'Ivoire,

the Dominican Republic, Kenya, Malawi and Peru) indicates that the HIV/AIDS policy environment is enhanced when local collaborators are trained using tools such as epidemiological modelling, economic impact assessments and policy dialogue. Furthermore, there is strong evidence that the process is most successful when an assessment is used to target both those who influence and those who make policy.

The process of training staff and developing SEIAs requires flexibility and adequate attention to local concerns. FHI's experience suggests that as long as the process is responsive to local concerns, it can be replicable and extremely useful in both high- and low-prevalence countries. The challenge is to design an assessment that focuses on a country's most critical issues and provides realistic recommendations that can be implemented by policy-makers. Ultimately, the goal of a successful SEIA should be to inform policy-makers so that limited resources can be used strategically to prevent or mitigate the impact of the HIV/AIDS epidemic.

This case study illustrates the importance of using SEIAs to better inform the policy process in developing countries. It is hoped that future policy interventions in this area can gain from the lessons learned from FHI's experience.

FHI's Experience in Central America

FHI's use of SEIAs in Honduras, Guatemala, Nicaragua, El Salvador and Costa Rica has resulted in significant policy changes and increased investment in HIV/AIDS prevention. The successes have included increased spending on HIV/AIDS prevention by the United States Agency for International Development (USAID) in Honduras and in the region as a whole,

“Due to my participation in the (FHI) workshop, I am committed to promoting and generating the will among decision-makers in my country to provide economic support and education in the fight against AIDS.”

WORKSHOP PARTICIPANT, GUATEMALA CITY, FEBRUARY 1995

and the development of national HIV/AIDS policies. Awareness of the current and potential impact of HIV/AIDS has increased, and work plans have been developed for positioning the epidemic as a priority for policy-makers in each country. Central American collaborators who were trained in the methodology for performing SEIAs strongly indicated in subsequent evaluations that they benefited from the process and were better prepared to participate in, and influence, the policy-making process in their own countries.

FHI's experience was unique, in that it was possible not only to develop national assessments, but also to evaluate the impact of the epidemic from the perspective of a significant part of the Central American

region. Performing SEIAs in five countries made it possible to progressively improve upon the methodology through the experience gained in the region.

This experience also yielded a number of lessons about performing SEIAs and a number of recommendations on better ways to perform such studies. It is the objective of this FHI/UNAIDS case study to describe what appears to have succeeded and what failed, based on FHI's experience in Central America, and to discuss possible reasons for success or failure. While the case study is specific to the five Central American countries where FHI helped conduct SEIAs, it is likely that many of the lessons learned could be applied by others wishing to assess and project the impact of the HIV/AIDS epidemic in order to inform the policy process within their own countries.

STATUS OF THE EPIDEMIC IN CENTRAL AMERICA

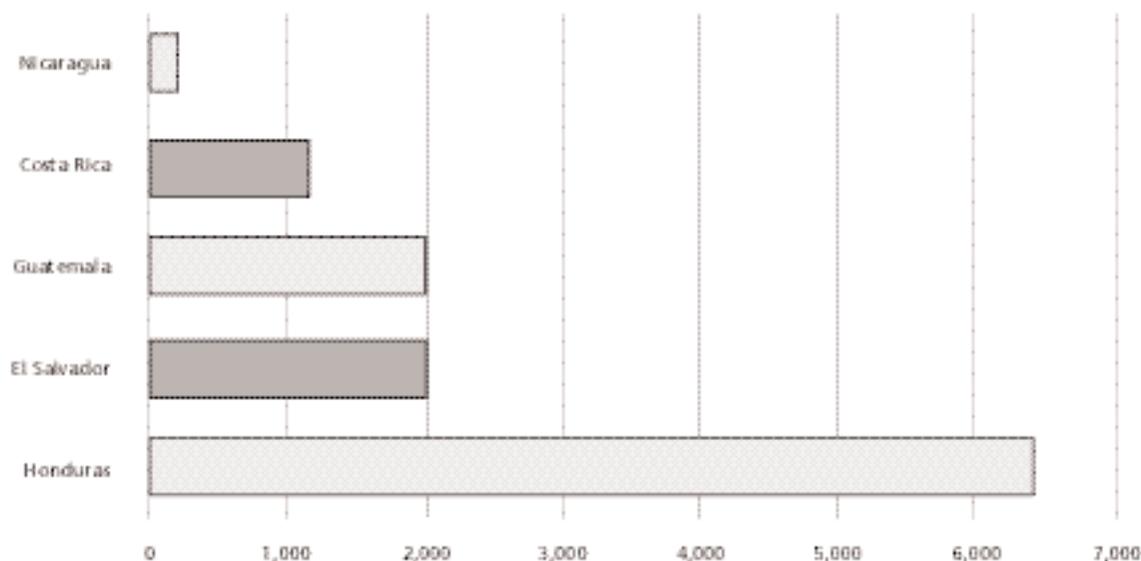
The diversity in HIV/AIDS epidemic patterns in Central America is striking. In fact, the spread of HIV in the region appears to result from many different epidemics, which started at different points in time and involve different population groups in each country. For example, in Honduras, the male-to-female ratio among AIDS cases indicates increasing heterosexual transmission, while in Costa Rica the ratio suggests that the epidemic remains predominantly among men having sex with men (MWM).

Figure 1 presents the distribution of the reported cases in the five countries where FHI conducted these assessments. Based on

the number of reported AIDS cases and sentinel surveillance data, it is clear that Honduras has the largest HIV/AIDS epidemic in Central America. Honduras is home to 17 per cent of Central America's population, but it accounts for 57 per cent of its AIDS cases (a proportion that can only partially be attributed to better tracking of AIDS cases in Honduras). In turn, data suggest that within Honduras, San Pedro Sula is much more severely affected by HIV/AIDS than any other city in the region. While the HIV prevalence among pregnant women was 0.3 per cent in Tegucigalpa, the Honduran capital, in 1993 and less than 0.5 per cent in the rest of Central America, it was 2.5 per cent in San Pedro Sula. That same year the prevalence of HIV among sex workers in San Pedro Sula was 15 per cent.

In Costa Rica, prevalence is estimated to be 0.2 per cent among people living in low-income communities, 0.26 per cent among pregnant women, 0.61 per cent among sexually transmitted infection (STI) patients and 2 per cent among sex workers. In El Salvador, prevalence among pregnant women was constant at 0.5 per cent in 1991 and 1992, but rose to 0.7 per cent in 1993. Among 452 Salvadoran sex workers, 2.2 per cent were seropositive for HIV. In Guatemala, HIV prevalence was 0.7 per cent among heterosexual men and 8.5 per cent among STI patients with genital ulcers. Prevalence in Nicaragua has remained low in recent reports among high- and low-risk sub-populations, with the exception of sex workers (1.6 per cent).^{1,2}

FIGURE 1
Reported AIDS Cases (June 1998)



Source: UNAIDS, WHO, Report on the Global HIV/AIDS Epidemic, June 1998

DESCRIPTION OF INTERVENTIONS

Between January 1993 and April 1997, epidemiological and economic data were collected and analyzed in five Central American countries, and 30 collaborators (ten from Guatemala, eight from El Salvador, seven from Nicaragua, three from Honduras and two from Costa Rica) were trained in the methods for performing SEIAs. Teams from three of the countries (Guatemala, El Salvador and Nicaragua) participated in a three-week regional training workshop in Guatemala City in February 1995. In each of the five countries, the objectives of these assessments were to inform policy-makers about the potential impact of HIV/AIDS and recommend public- and private-sector policies to mitigate the impact of the epidemic.

Honduras The process of performing an SEIA in Honduras was initiated in January 1993, with a needs assessment trip sponsored by the Latin America Bureau of USAID. Members of the assessment team identified a serious need to better inform donors and the Honduran government about the potential impact of the HIV/AIDS epidemic in the country. Based on the success of SEIAs completed in Kenya³ and Malawi,⁴ it was determined that FHI should undertake a similar assessment in Honduras. However, unlike the Kenya and Malawi studies, this study was to be locally driven by Honduran collaborators trained from the start in the methodological approach. The Ministry of Health identified a Honduran economist and two epidemiologists who worked in conjunction with FHI's two-person technical

assistance team composed of an economist and an epidemiologist.

From the start of the intervention until February 1995, more than a dozen technical assistance visits were conducted between Tegucigalpa, Honduras, and Washington, D.C., USA. These visits were designed to assist the Honduran collaborators in collecting and analyzing the data, as well as developing a plan for disseminating the study results. The Honduran team was provided with a laptop computer and modem in order to collect and analyze data, as well as to maintain communication with FHI. The project culminated in a meeting with the President and First Lady of Honduras and the completion of a project report summarizing the findings of this study.⁵ Accounts of the meeting were subsequently published in Honduran newspapers and in the magazine of FHI's AIDS Control and Prevention (AIDSCAP) Project, *AIDSCaptions*.

Guatemala, Nicaragua and El Salvador

The Honduran SEIA experience inspired an interest in offering similar training in Guatemala, Nicaragua and El Salvador. In February 1995, FHI and the Pan American Health Organization (PAHO) conducted a three-week workshop in Guatemala City. Prior to this workshop, the Ministry of Health in each of these countries was provided with funding to collect epidemiological and economic data (including a review of the hospital records of persons with HIV/AIDS). A standard form was used to guide each team in collecting the data. Each team was also provided with a laptop computer and

modem for data collection and analysis. This equipment also served to open lines of communication between the teams from the three countries regarding methodologies and obstacles encountered while collecting data.

FHI requested that each of the three teams include epidemiologists, economists and policy-makers. The final composition of the teams represented key sectors of society: public health, public sector planning units, nongovernmental organizations (NGOs), academic and research institutions, legislative bodies, the military, social security institutes and international organizations. In addition, individuals from the media, religious organizations (Roman Catholic and Evangelical), academic institutions, NGOs, international donor organizations and the private sector made presentations during the workshop.

At the conclusion of the workshop, members of each team were given the task of preparing and presenting the comprehensive findings of their SEIA. These presentations were developed in conjunction with policy-makers and policy influencers from each of the three countries. The teams also designed work plans for dissemination, advocacy and further policy development that were carried out within their respective countries following the workshop. A few months after the workshop, members of the FHI technical assistance team visited each of the countries to determine the impact of the training. Their findings are described in a report and a lessons-learned summary document assessing the usefulness of the training in informing and influencing policy decisions.^{7,8}

All three countries achieved some level of success in using their SEIAs to influence policy. For example, in 1995 a Guatemalan AIDS coalition was formed, including representatives from the government sector, NGOs, the military and religious groups, which helped foster cooperation and collaboration among organizations involved in HIV/AIDS prevention. This coalition used the SEIA to sensitize policy-makers and as a basis for discussing the impact of the HIV/AIDS epidemic in Guatemala. Since most of the participants in this coalition were very familiar with HIV/AIDS issues, each of the members was actively involved in disseminating the results.

Costa Rica Two representatives from FHI travelled to Costa Rica to provide technical assistance in HIV/AIDS epidemiological modelling and economic impact assessments. This project was funded by Iniciativa Regional sobre SIDA para Latino América y el Caribe (SIDALAC) in Mexico, which in turn was funded by the World Bank. Due to budgetary constraints, a rapid methodology was pursued, with two visits made by each member of FHI's technical team. Much of the data collection was performed prior to the first visit in November 1996.

A final report was completed in April 1997, but there continued to be disagreement on the validity of the projections. In addition to the standard impact description, the report also attempted to provide preliminary projections on the possible impact of a full government subsidy for the provision of highly active anti-retroviral therapy (HAART) to people living with HIV/AIDS (PLHA). These initial estimates suggested that HAART in Costa Rica probably

would not produce cost savings, but would be likely to result in significant medical and economic benefits. The FHI team recommended performing a more comprehensive review of the potential medical and economic benefits of HAART in order to clarify both the costs and benefits of providing these drugs.

The Costa Rican Social Security Institute subsequently did not choose to pursue additional research, yet concluded that the purchase of HAART was too expensive and should not be considered further. The projections of the benefits of HAART and the resulting conclusions were not supported by the Ministry of Health and were viewed sceptically by policy-makers and NGOs.⁹ A subsequent Costa Rican Supreme Court decision overruled the Social Security Institute and concluded that the Institute did have a constitutional obligation to offer HAART to people in Costa Rica living with HIV/AIDS.¹⁰

HIV/AIDS PROJECTIONS IN CENTRAL AMERICA

Honduras In Honduras estimates and projections of HIV prevalence were developed based on antenatal clinic (ANC) surveillance data from Tegucigalpa and San Pedro Sula. Due to the lack of surveillance data from other parts of the country at the time, it was concluded that estimates could only be made for these two cities and that national projections were unlikely to be reliable.

FHI's projections, developed between 1993 and 1995 using the World Health Organization's (WHO's) EpiModel, suggested that the prevalence of HIV among adults in Tegucigalpa was likely to reach between

3.5 and 12 per cent in 2000. Projections in San Pedro Sula indicated that the prevalence was likely to range between 10 and 17 per cent.

Costa Rica In Costa Rica it was estimated that the prevalence of HIV in 1997 was between 0.15 and 0.50 per cent. This range was based on estimates suggesting that the prevalence of HIV among pregnant women was 0.26 per cent in both 1994 and 1997. It was projected that Costa Rica's prevalence could rise to between 0.27 and 0.97 per cent by 2000.

El Salvador, Guatemala and Nicaragua

In the case of El Salvador, Guatemala, and Nicaragua, national estimates of HIV prevalence were developed using baseline data from 1994. The national prevalence in El Salvador was estimated to be between 0.26 and 0.52 per cent. Guatemala, which appeared to have an epidemic similar to El Salvador's, had an estimated national prevalence of between 0.2 and 0.4 per cent. In Nicaragua, where the epidemic appeared to be at an earlier stage, prevalence was estimated to be between 0.07 and 0.22 per cent. As shown in Table 1, the prevalence was projected to double or treble in each country between 1994 and 2000.

Overall, it was concluded that the areas hit hardest by the HIV/AIDS epidemic would continue to be the urban areas of Honduras, while Nicaragua would continue to have the smallest epidemic. However, Nicaragua's high incidence of STIs and significant population mobility (due to its former military conflicts) are factors that could contribute to a rapidly expanding epidemic in the country.

TABLE 1

Estimated and Projected HIV Prevalence (Low and High Scenarios)

	1994		2000	
	Low	High	Low	High
Nicaragua	0.07%	0.22%	0.26%	0.79%
Costa Rica	0.15%	0.50%	0.27%	0.94%
Guatemala	0.20%	0.40%	0.55%	1.08%
El Salvador	0.26%	0.52%	0.61%	1.23%
Tegucigalpa, Honduras	1.46%	2.50%	3.75%	12.68%
San Pedro Sula, Honduras	6.79%	8.28%	10.61%	17.59%

LESSONS LEARNED

Target SEIAs to address specific policy issues. One of the key lessons learned in performing these SEIAs in Central America was the importance of focusing the assessments on specific, relevant policy issues, rather than producing general impact assessments. The intervention in Honduras, for example, appears to have been initially less successful at producing specific policy recommendations, as the project focused on a generic direct/indirect cost analysis. (Following the initial SEIA, however, USAID and FHI planned activities that placed much greater emphasis on informing policy-makers and policy influencers and developing specific recommendations). This experience highlighted the importance of performing policy-specific SEIAs and using this information to target policy-makers with specific recommendations. The subsequent studies in Guatemala, Nicaragua, El Salvador and Costa Rica were informed by the experience in Honduras and had a greater emphasis on addressing policy issues.

The Guatemalan experience is an excellent example of how SEIAs can be used to address specific policy issues. Although a general impact assessment was created as a framework, a number of specific presentations were also designed and targeted to specific groups of influential policy-makers. Having a multisectoral team write the final report in Guatemala was also found to be very advantageous, as it allowed for the development of presentations on an array of issues.

“I believe that it is necessary and urgent to do similar workshops in other countries to raise awareness about the problems caused by the virus.”

FHI WORKSHOP PARTICIPANT, GUATEMALA CITY,
FEBRUARY 1995

In Guatemala, the study's emphasis on the economic impact of HIV/AIDS greatly contributed to subsequent policy dialogues with the private sector. As a result, companies in Guatemala have increased their participation in workplace HIV/AIDS interventions.

Another common recommendation that emerged from each SEIA was that more information be provided in order to improve targeting. In each of the assessments there was a consistent lack of information regarding target populations. As a result, all five of the Central American countries emphasized the need to increase sentinel surveillance. These recommendations succeeded in expanding HIV surveillance in most of the five countries.

Clearly SEIAs require careful definition of objectives from the beginning. In most countries, since general awareness about the epidemic is fairly high, it is important that future SEIAs be oriented toward addressing specific policy issues rather than further awareness raising.

Have a gender-balanced and multidisciplinary team performing the SEIA In each of the five countries, FHI attempted to emphasize having a gender-balanced team, so that issues that are specific to women would be adequately addressed. In Guatemala and El Salvador, FHI was very successful in maintaining such a balance among the trainers and the trainees. This balance greatly enhanced the comprehensiveness of the final report in these two countries.

A successful example of the importance of a multisectoral team that includes committed NGOs and government organizations was observed in Guatemala. Two years after FHI's workshop, Guatemala changed governments,

and the director of the National AIDS Programme was replaced. The new director delegated responsibility for the dissemination and use of the SEIA to an NGO, the Guatemalan Association for AIDS Prevention and Control (AGPCS), which had actively participated in the FHI workshop in 1995.

AGPCS worked closely with the public and private sectors to carry out dissemination activities and to present the findings of the assessment in a number of fora. Using its own resources, AGPCS prepared copies of slides, a guide to each of the presentations and a summary fact sheet of the main findings of the SEIA in Guatemala. A series of workshops was held to train all the AGPCS project coordinators to: (1) use the information resulting from the SEIA; (2) select different sets of slides depending upon the audience; and, (3) deal with questions related to the technical process of preparing the assessment. (This approach increased the credibility of the information conveyed by the lecturer.) In addition, fact sheets served as a summary of the assessment of HIV/AIDS in Guatemala. The fact sheets were popular when scholars and/or the media needed a rapid overview of the impact of HIV/AIDS in the country. They were also useful for briefing policy-makers on the extent and the likely impact of the HIV/AIDS epidemic.

SEIA results were also used extensively in AGPCS' collaboration with the commercial private sector to promote HIV/AIDS-prevention activities among Guatemalan workers. Using the information derived from the impact assessment, AGPCS representatives were able to sensitize policy-makers and owners of these enterprises of the need for HIV/AIDS prevention among workers. They also succeeded in initiating a

series of workshops with business leaders in order to encourage the development of appropriate HIV/AIDS workplace policies and programmes.

AGPCS prepared presentations for the new health minister and senior-level government and congressional representatives. There were also three formal outlets for disseminating the results of the Guatemalan SEIA: (1) a popular magazine targeting mid- and senior-level Guatemalan policy-makers; (2) a Guatemalan medical journal; and, (3) a presentation at the XIth international AIDS conference in Vancouver, Canada, in 1996.

In conclusion, it appears that in order to best use an SEIA and to sustain the dissemination of results, it is necessary to: (1) have a gender-balanced and multidisciplinary team of trainers and trainees, (2) involve organizations with a high level of commitment to HIV/AIDS-prevention programmes (such as AGPCS); (3) ensure the participation of government policy-makers; and, (4) ensure adequate resources for updating and disseminating the projections.

Influence policy-makers from multiple levels. An important lesson learned through FHI's experience in Honduras was that SEIAs should not be focused exclusively on policy-makers at the highest levels. Initial efforts in Honduras focused on training technical staff within the Ministry of Health, who, in turn, were asked to develop recommendations for senior policy-makers.

The primary focus of the Honduran SEIA became a presentation planned for the President and the First Lady of Honduras. One understandable concern was raised when the technical staff from the Ministry of Health, who were trained

by FHI, were unwilling to make specific recommendations directly to the President in this forum. Asking technical staff to make recommendations to the President was, in many ways, contrary to existing Honduran protocol, as it essentially bypassed people who should have been involved in the decision-making process (including the Minister of Health).

Despite certain obstacles, this approach of first reaching the President and the First Lady in Honduras (who were then expected to create appropriate policies that would be passed down to lower-level policy-makers) was initially successful. Presentations were made in both Tegucigalpa and San Pedro Sula, and the First Lady agreed to take on HIV/AIDS issues as a personal cause. Journalists were present and emphasized the potentially significant impact the epidemic might have in Honduras in their reports. The policy process itself was viewed as being highly successful, and it was therefore assumed that the country's policy environment would essentially be improved via presidential decree.

However, in the long run, this "top-down" approach was not sustained. Soon after the presentation, the President and his party were voted out of office. The former First Lady lost much of her credibility, influence and interest in HIV/AIDS issues. The new government, in turn, was relatively uneducated about the potential impact of HIV/AIDS, and there were no systems or resources in place to educate them about the findings of the study.

Realizing that the SEIA message was not being disseminated, FHI began to focus its attention on a more "bottom-up" and

“peer-to-peer” approach for influencing Honduran policy-makers. This new approach focused on making presentations to policy influencers who worked in NGOs, the private sector and religious institutions. To this end, a video about the social and economic impact of HIV/AIDS on the country was produced by FHI. This video was played on Honduran television and was successful at gaining the attention of the general population and the news media. This new approach, while consuming significantly more time and resources, appears to have been successful in creating a more sustainable policy environment in the country.

A more multi-leveled approach was taken to using the SEIA to influence policies in El Salvador. The intervention was successful in large part because the Salvadoran team was able to sustain pressure on policy-makers in a variety of ways. The team from El Salvador was a multidisciplinary group, including senior-level policy-makers, policy influencers and technical staff from the Ministry of Health. The SEIA and the policy activities instituted by the Salvadoran team contributed to the country’s subsequent success in developing a national AIDS policy.

FHI’s experience suggests that SEIAs should begin with a carefully planned strategy for using the SEIA to influence policy-makers and policy influencers. It is not sufficient to merely influence the senior-level policy-makers and expect them to enforce a national change in policy. Instead, a sustainable mechanism for continuing to influence the policy process is imperative. Thus, it appears that the most successful policy processes are those that take both a “top-down” and a “bottom-up” and “peer-to-peer” approach to policy change.

Involve policy-makers and policy influencers in the technical process

One of the most important lessons learned concerned the importance of including policy-makers in the technical process. This was very difficult to do, as it involved ensuring the attendance of people with severe time constraints. In the case of Costa Rica, it was not possible to directly involve policy-makers and, as a result, various government policy-makers expressed serious doubts about the validity of the data. Furthermore, gay activists (who had been only peripherally involved in the process) expressed concern that the projections were being used for political purposes to deny access to HAART for PLHA. If these policy-makers and policy influencers could have been brought into the technical training process, many of the subsequent political obstacles might have been avoided.

In the cases of Guatemala, Nicaragua and El Salvador, each country was required to send policy-makers to attend at least the last week of the three-week training course. As a result, the policy-makers had a vested interest in the technical and the political process. In some cases, the trained policy-makers returned to their country and became advocates for HIV/AIDS prevention. In one surprising example, a conservative legislator, who was admittedly homophobic, became an outspoken national advocate for investing further resources in HIV/AIDS prevention.

As a result of FHI’s experience in these countries, it is recommended that policy-makers be involved in the technical process of performing an SEIA. While senior policy-makers may not be able to attend an entire training workshop, it is critical that they understand the process and the implications of the results.

Projections can be significantly overestimated- or underestimated if surveillance data are limited The challenges of making projections based on limited surveillance are illustrated by FHI's experience in Honduras, the first Central American country to develop an SEIA. Data from 1991 indicated that HIV prevalence among pregnant women in San Pedro Sula was 3.6 per cent. At the time, this high prevalence was considered to be influenced by a number of factors, including the city's proximity to free trade zones, a U.S. military base and the largest seaport in Central America (Puerto Cortés). The data suggested that the city was experiencing an explosive growth in new HIV infections and, as a result, HIV prevalence in San Pedro Sula was projected to reach between 10 and 17 per cent by 2000.

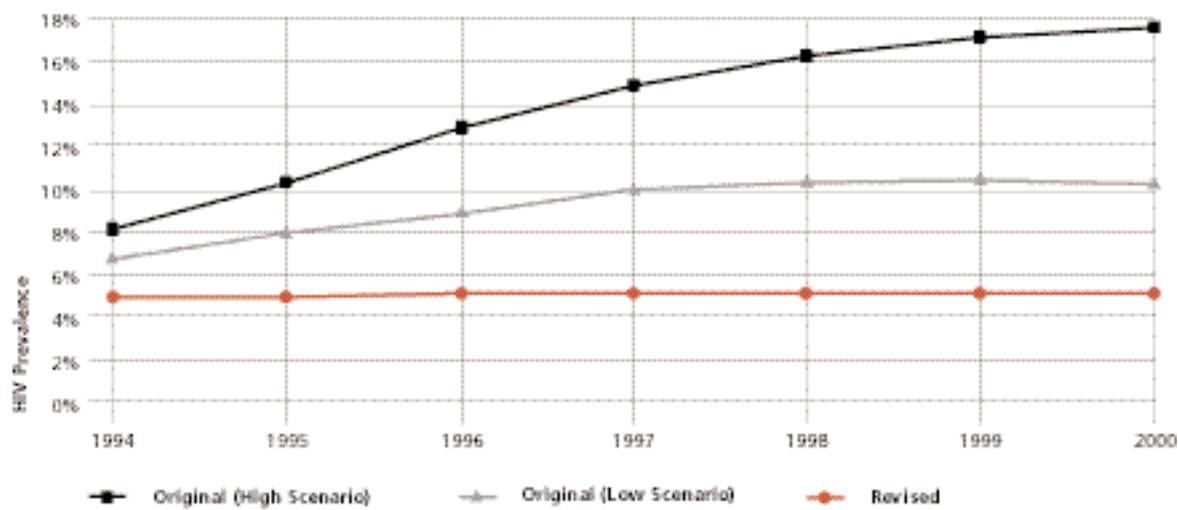
Subsequently, it appeared that HIV prevalence in San Pedro Sula was growing more slowly than predicted, and the original low

and high projections were recognized to be overestimates. In 1997 The Futures Group International reviewed the original estimates and developed revised projections based on the latest surveillance data, using essentially the same methodology FHI had used in its original projections. As shown in the "revised" line in Figure 2, estimates indicate that HIV prevalence among all adults in San Pedro Sula reached 5.2 per cent in 1995, which is significantly less than the 8 to 10 per cent originally projected in FHI's low and high scenarios. Revised projections now suggest that the prevalence of HIV will not exceed 5.5 per cent by the 2000, or about half of the original low-scenario projection.¹¹

The projections in Honduras did create significant awareness of the potential impact of the epidemic and contributed to a decision by USAID and Honduras to make a significant investment in HIV/AIDS-prevention activities. However, in subsequent years there were

FIGURE 2

Projected Prevalence in San Pedro Sula



repercussions to overestimating the spread of the epidemic. For example, the overestimates gave some people the impression that the epidemic was not truly serious because explosive growth did not occur or that Honduras had succeeded in limiting the growth of the epidemic through prevention activities, which may or may not be the case. Overestimating the extent of the HIV/AIDS epidemic in Honduras also damaged the credibility of projections in other countries.

Subsequent projections in Guatemala, Nicaragua, El Salvador and Costa Rica were made with a better understanding of the limitations of the existing data, and therefore produced more conservative projections of the course of the epidemic. Based on subsequent data collection, the projections appear to be a fairly accurate representation of the direction the epidemic has taken. However, it would be very useful to perform a follow-up assessment to evaluate the accuracy of these original projections, as was done in Honduras.

While the data from San Pedro Sula show that there is a risk of overstating the growth of the epidemic, it is also important to consider the reasons why estimates may be understated. The most likely cause for underestimating the extent of the epidemic in Central America is the lack of data among high-risk individuals, who represent a disproportionate share of AIDS cases.

Most countries in Central America continue to have an epidemic that remains concentrated in certain groups at particularly high risk of HIV infection, including men who have sex with men (MWM). As a result, the male-to-female ratio of those with AIDS remains high in most of Central America. In countries where the male-to-female ratio is nearly 1:1, it is probably

legitimate to focus on data on pregnant women as representative of the general population. However, in countries where the epidemic is concentrated in men, the use of ANC surveillance data to make epidemiological projections can result in severe underestimations of the extent of the HIV/AIDS epidemic.

A good example of this problem was seen in Costa Rica, where the male-to-female ratio of new AIDS cases is 8:1. In Costa Rica, ANC surveillance data suggested that HIV prevalence was 0.26 per cent. In developing projections, the Social Security Institute maintained that the ANC data were an accurate reflection of HIV prevalence in the general population. However, FHI was concerned that the ANC data might not reflect an epidemic that was so male-dominated. Therefore, a simple exercise was performed to look specifically at the impact of HIV among MWM on HIV prevalence within the entire Costa Rican population.

For the purposes of this exercise, it was assumed that: (1) 5 per cent of all men in Costa Rica were gay (2.5 per cent of Costa Rica's entire population); (2) HIV prevalence among gay men was 10 per cent; and, (3) prevalence was 0.26 per cent among the heterosexual population (as suggested by ANC surveillance). If these assumptions are correct, the HIV prevalence in the entire population would have to be at least 0.5 per cent $((2.5\% \times 10\%) + (97.5\% \times 0.26\%))$. In other words, the real national prevalence (0.5 per cent) would be nearly double the prevalence derived from ANC data (0.26 per cent) if gay men were included in the

analysis, even though they make up a relatively small proportion of the population. Similarly, lack of data on other relatively small population groups with a disproportionately high HIV prevalence, such as sex workers and sexually transmitted infection clinic attendees, could lead to a severe underestimation of an epidemic.

This concern was raised throughout the estimation process in Central America but was never completely resolved due to the lack of data. Because of the very high prevalence among specific groups, actual HIV prevalence in each country might be two or three times higher than the ANC surveillance data suggest.

In conclusion, a number of factors might explain inaccurate projections (either over- or underestimates). These include: (1) a lack of sufficient time-series data necessary to project the course of the epidemic; (2) the unknown level of HIV infection among certain groups that are likely to represent a disproportionately high percentage of the HIV/AIDS cases; and (3) uncertainty regarding the impact and extent of changes in transmission mechanisms (i.e., possible changes from a predominantly homosexual to a predominantly heterosexual epidemic). As a result, the range of scenarios projected for an SEIA should be wide enough to allow for the uncertainty regarding the future course of the epidemic. It is also critical to continually evaluate and update estimates based on currently available data.

FHI's experience also illustrates the importance of collecting surveillance data among MWM and sex workers in Central America. Where such data are available, they should be included in estimates of HIV prevalence, which often rely exclusively on ANC data.

Sustain the policy process The importance of sustaining pressure on policy-makers was a critical lesson learned. In most cases, little thought was given to the resources that would be required after an SEIA had been performed. For the most part, the teams involved in the SEIA found themselves inundated by work once they had completed their assessments and returned to their own countries, and thus they were not able to sustain their commitment to follow up the study recommendations. In general, the teams did not have the resources necessary to sustain dialogue with policy-makers about the potential impact of the epidemic and ways to mitigate it. As a result, in countries such as Nicaragua, the SEIAs ended up being an isolated activity with limited follow-up.

In Honduras, however, following the presentation to the country's President and First Lady (and after they lost the next election), USAID/Honduras and FHI pursued a renewed effort to sustain and disseminate the SEIA. This sustained effort included the development of a videotape that was shown on national television, as well as successful efforts to involve evangelical churches and NGOs in promoting HIV/AIDS-prevention activities in the country.

This lesson shows that it is critical to develop a sustainability plan during the design of a policy intervention (or any other intervention). The impact of such interventions will be much greater if they include mechanisms for transferring the skills and providing the resources necessary to sustain messages about the potential impact of HIV/AIDS to a dedicated team of local collaborators.

CONCLUSIONS

This review of SEIAs in Central America reveals a number of important lessons about the policy process that are likely to be applicable to future SEIAs. It is crucial that such reviews address specific policy issues, rather than providing a broad overview of impact. It is also critical to assess many of the gender-related issues surrounding the spread of HIV.

SEIAs must also move beyond the basic collection of epidemiological and economic data. The HIV/AIDS epidemic is an emerging multisectoral phenomenon, requiring assessments that capture the widest potential impact on countries and regions. An approach that recognizes the changing nature of the epidemic will produce a more complete picture of the problem in each country and region and permit the development of policies that are most conducive to mitigating its impact.

The FHI-supported policy interventions were effective in influencing the policy process in each of the five countries, eventually leading to the establishment of national HIV/AIDS policies and laws. However, the effectiveness of the SEIA depended greatly on the teams selected to participate in the process and their access to resources. It was found that multi-disciplinary, gender-balanced teams that included policy-makers were the most effective in continuing dialogue to influence policies after the assessments were written.

The sustainability of each country's HIV/AIDS interventions was enhanced by the formation of local teams to develop

epidemiological projections and explain the likely socioeconomic impact of the epidemic. By investing in local teams rather than performing research from an outside perspective, FHI increased the likelihood that the policy dialogue in Central America will be sustained. However, greater attention should be given to ways of sustaining a policy dialogue around HIV/AIDS and its potential impact in the long term.

In terms of the policy process, FHI's experience in Central America reveals that a "top-down," "bottom-up" and "peer-to-peer" approach is needed. In other words, it is most important to reach an array of policy-makers and to sustain the policy process by strengthening the ability of those who influence policy to inform the entire process. While there is no fixed recipe for changing policies, what does appear to be necessary is that constituents, peers and supervisors reach policy-makers.

Next, it is critical that epidemiological projections be realistic and perhaps even somewhat conservative, while reflecting the unique aspects of the epidemic in the particular region. In much of Latin America it is critically important to consider the impact that MWM are likely to have on the spread of the epidemic.

Finally, FHI's experience in Central America has revealed the importance of having medium- and long-term follow-up to evaluate the impact of SEIAs in informing the policy process. Such follow-up is likely to produce further "lessons learned" about the benefits and weaknesses of such a policy intervention.

AUTHORS

Steven Forsythe, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA

Blanca Samayoa-Herrera, Tulane University, New Orleans, Louisiana, USA

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Behaviour change communication uses behavioural and communication theories and research to develop interventions that influence individual behaviours and the social contexts in which they occur.



CRISPIN HUGHES/PANOS PICTURES

TWO MEN READING A BOOK TOGETHER IN ANGOLA DEMONSTRATE THE POTENTIAL OF DISSEMINATING HIV PREVENTION SKILLS AND INFORMATION THROUGH HIP-POCKET-SIZED HANDBOOKS.

CREATING AND APPLYING A TOOL FOR UPGRADING BEHAVIOUR CHANGE SKILLS ON-THE-JOB

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CREATING AND APPLYING A TOOL FOR UPGRADING BEHAVIOUR CHANGE SKILLS ON-THE-JOB

INTRODUCTION

During the past two decades, health educators and health promoters have had to adapt and change their methods in order to meet new challenges. None of these challenges has affected the theory and practice of health communication more profoundly than the HIV/AIDS pandemic.

HIV was initially considered to be a health problem, and Ministries of Health were tasked with getting the word out. The ministries were soon joined by nongovernmental organizations (NGOs), including many new NGOs created specifically to respond to the HIV/AIDS pandemic, and other organizations mounting their own prevention programmes, from the military to the transport industry.

Many of the educators involved were already skilled in providing information and skills training, but they did not know how to address sexual behaviour change. Rather than encouraging relatively easy and acceptable behaviours, such as immunization or hand washing, they were now being asked to talk about much more disturbing changes—changes that at first glance seemed to challenge both their culture and their instincts. These changes would affect the way people would lead the rest of their lives.

From IEC to BCC In earlier years, many health educators had transformed themselves into “information, education and communication (IEC)” specialists—often without the benefit of training. Bestowed by ministries or donor-funded projects, this new title implied that health educators should do more than talk to patients or communities. They were now expected to produce posters and leaflets and the occasional radio programme as well. To their credit, health educators all over the world took up the challenge. However, self-taught as many were, the quality of some products suffered.

By the early 1990s, in response to the HIV/AIDS pandemic and other global health challenges, health educators/IEC specialists in the public and private sectors were confronted with yet another new title: “Behaviour change communication (BCC)” specialist had become the term preferred by many organizations. Again, however, new titles were bestowed without the corresponding skills. The new BCC specialists reported a lack of satisfaction with the results of their work. Few felt that they were having much impact on people’s behaviour.

BCC is not a new concept, but it is often misunderstood and poorly applied. BCC uses

behavioural and communication theories and research to develop interventions that influence individual behaviours and the social contexts in which they occur. To facilitate and support individual behaviour change, a BCC specialist needs to understand the social structures that influence individuals' knowledge, attitudes and behaviours. Consequently, a BCC programme must consider demographics, economics, epidemiology, politics and cultural and social norms. In addition, BCC specialists must be aware of the values, concerns, needs, behaviours, habits, beliefs and difficulties of each audience.

The skills and knowledge required of a BCC practitioner are wide ranging, including anthropology, sociology, psychology, social work, communications, marketing, education and public health. Few people have received training in all these areas. As a result, a variety of talented people—from social workers to mid-level health workers—found themselves struggling on their own with theories of behaviour change, communication strategies, radio scripts and the arcane jargon of printers. What they needed was a way to learn how to become knowledgeable and skilled BCC practitioners who could then develop interventions to take people beyond knowledge of disease and into the realm of real and sustained behaviour change.

A Tool for On-the-Job Training Family Health International's (FHI) task under the AIDS Control and Prevention (AIDSCAP) Project was to provide BCC skills and information to as many people as possible as quickly as possible. With over 500 behaviour-change interventions underway in 40 countries, it was impossible to provide ongoing personal assistance to every

BCC specialist in each of the hundreds of organizations helping FHI implement the AIDSCAP Project. However, the problem seemed more manageable when reports from AIDSCAP field staff and implementing partners revealed a common pattern of information and skill deficiencies. Whether in Latin America, Asia or Africa, the shortage of experienced and trained behaviour-change specialists was evident.

When the cause of a problem is thought to be lack of skills or knowledge, a common response is to organize training sessions. However, sometimes harried workers are sent to so many workshops that their regular work suffers. Moreover, while some training sessions do undoubtedly increase skills, workshops are not the only or even the best way to help people learn BCC skills. People learn in different ways. Some need the stimulation and discussion of group learning. Others need on-the-job practise of a new skill. For some, reading, underlining and rereading material is an easy way to comprehend a new idea. For others, reading is a chore to be avoided.

FHI decided to develop a publication that would facilitate on-the-job learning by all types of learners. This decision was taken in the belief that, both from an adult-learning perspective and a logistical point of view, easy-to-comprehend texts that addressed real field implementation issues would contribute to capacity building and thus to improved HIV/AIDS prevention and care. In addition, it was thought that providing handbooks could be a cost-effective way to help upgrade the skills of large numbers of people.

The content, design, format and style of the publication were based on the following premises:

- Information about behaviour change processes and techniques, as well as about communication theory and practice for behaviour change, was needed.
- One large publication containing all the information would be unwieldy and complex. A series of smaller handbooks would be more user-friendly.
- The handbooks would be written in English, a language known—if rarely used—by most of the intended users. Since users' reading and comprehension levels in this second language would range from very high to very low, rigorous pretesting would be particularly important to eliminate confusion caused by difficult sentence structures and verb tenses. The drafts would be tested against common readability guides.
- Much of the information did not need to be “learned for life.” In the same way that computer manuals come in handy for certain tasks, some of the information that would lead to more effective BCC was reference material.
- The material should appeal to readers in a variety of settings. Examples should transfer or translate to different cultures, stages of the epidemic and target audiences.

MAKING THE HANDBOOKS USER-FRIENDLY

Format Initially, the format was based on the authors' personal judgment and experience. Feedback from pretests and field use confirmed those choices, and very few changes were made. The first decision was size. Rather than one

large, heavy text that was likely to be used only in an office or at home, the material would be presented in small, easy-to-carry booklets. These could be used in the field or read during a bus or taxi ride—a convenient “hip-pocket” guide. The booklets are small (8" x 5") and thin (from 31 to 73 pages).

Easy Indexing Recognizing that the intended users were very busy, and not wanting them to be overwhelmed by the thought of reading an entire book, the authors decided to divide each booklet into subtopics with tabbed dividers. The tabs also serve as a kind of index, making it easy for a reader to flip to the necessary section (such as “Support and Supervision of Peer Educators,” “Steps in Policy Development,” “Influencing Social Norms” or “Choosing Mass Media”).

Readability Readability scales describe (with various degrees of accuracy) the level that a reader needs in order to fully comprehend a text. Most such scales are based on the average number of words in a sentence and the number of syllables in a word. Even though Western reading scales were not a completely reliable method for judging ease of comprehension among the intended users, attention to the scales did ensure that the authors wrote simply and clearly. They did not talk down to the audience, but neither did they make things unnecessarily complicated. For example, the sentence “While the public needs to be informed via the mass media about the virus, this information must be complemented by peer education, in which trusted individuals from the same background as a target group encourage and enable them to change their behaviour” rates at a university

or post-graduate level. The same information can be given at a primary school level: “The public needs to learn about the virus from both mass media and trusted friends.”

Many of the intended users did not read English regularly. Thus, the authors avoided sentence construction and verb tenses that were difficult to decipher. Wherever possible, useful information was put in lists rather than paragraphs.

Essential Information In trying to keep each handbook short and useful, the authors constantly faced decisions about what information to include. Was background information needed? How much explanation was necessary for each step? Were examples needed for clarification? The final criteria were simple: if the reader needed the information in order to perform a task with confidence and ease, it was included; if the information was simply interesting, it was left out. Focus was on the “need to know,” not the “nice to know.”

Reader Involvement If the handbooks were to be real guides, the content had to actively engage readers. Consequently, each booklet was designed to lead a user to a decision. The user is frequently asked to consider lists of actions and to make decisions by checking off the items that pertain to his/her work. If a reader uses one of the handbooks as a guide and actively follows each page, by the last page he or she will have completed a task, such as writing a radio script, planning a communication strategy or pretesting a material.

Conspicuousness and Practicality In many field offices where bookcases are few and crowded, good materials languish on shelves,

unavailable to readers who cannot locate them easily among stacks of papers. FHI hoped to avoid that fate for its booklets by giving them brightly coloured covers that were not easily overlooked. (The colours also help users distinguish one BCC handbook from another. Eventually, the booklets became known by their colours by many users—for example, “the red book” or “the green book.”) Black spiral binding was chosen to enable readers to open and write in the handbooks. However, the main benefit of the plastic spiral binding was that the pages lay flat, making photocopying easy. In Kenya, for example, the Ministry of Health had 200 copies of the blue book made so that all health educators would have the same understanding of BCC principles and tasks.

DESIGNING THE HANDBOOKS

FHI relied on information from its regional and country staff and the words of project implementers to determine which BCC skills were most needed and which skills would have the most impact on behaviour change. Often the people in the field did not know exactly what was needed, but had clear ideas about what was not working: “People are tired of hearing the same old thing.” “Our peer educators keep leaving because they are discouraged—not seeing any progress.” “We find our leaflets in the market used as wrapping paper.” And, most troubling of all, many said: “People know about AIDS, but they just won’t change their behaviour.”

Field-level implementers of behaviour change interventions were the intended users of all the handbooks. Most were expected to be HIV/AIDS programme managers, BCC or IEC specialists, or other field staff, but different

handbooks had different audiences. The “teal book,” for example, was written for managers of sexually transmitted infection (STI) programmes or clinics to help them use BCC to improve services and relations with clients. In most cases, however, the introduction outlines what readers can expect to learn from the booklet rather than specifying who should use it.

The handbooks were rigorously pretested. As each draft was finished, ten copies were sent to each of four countries, where FHI staff distributed them to people who represented the intended users. (The countries differed for each handbook.) To ensure that all field implementers could benefit from the handbooks—not just those with higher education—we specified that most of the reviewers should not be managers or university graduates. Interspersed between each chapter was a coloured page containing five questions. The reader/pretester was asked to read one section at a time and then answer the five questions. This process of reacting to each short section separately provided meaningful feedback.

With as many as 16 sections in some books and 40 copies of each manuscript pretested, FHI sometimes received over 600 pages of pretest comments for one handbook. The pretest participants were thoughtful and thorough, and their comments helped authors clarify hard-to-understand concepts and use language more precisely.

Other BCC professionals were also asked to review the drafts. And copies of each draft handbook were sent to the AIDSCAP resident advisors and BCC officers, who were to serve as the bridge between the intended audience and the authors. More than once, their insights helped the authors rewrite or refocus an entire section.

THE HANDBOOKS

Assessment and Monitoring of BCC

Interventions (red book) A basic premise of the handbooks is that the readers learn by actively doing something. Since most of the intended users were in the midst of ongoing projects, the booklet entitled “Assessment and Monitoring of BCC Interventions” was developed first to help planners and implementers look at the effectiveness of their BCC interventions.

The red book presents a series of seven standards that are generally accepted as necessary principles of effective behaviour-change interventions. The user is asked to examine criteria to determine to what extent the project being monitored adheres to the standard. For example, Standard 4 reads, “A supportive environment needs to be created for HIV prevention and for the protection of those infected with HIV.” The criteria that help the user determine whether a project conforms to this standard require him or her to analyze many aspects of the project, such as the following:

1. What are the social, cultural, environmental, political and organizational conditions that may influence the target audience’s HIV/AIDS risk behaviours?
2. Does this intervention try to influence these conditions? For example, does it attempt to:
 - Support traditional and cultural values that encourage low risk behaviours?
 - Persuade government officials to change public health policies?
 - Influence organizational and corporate officials to discontinue discriminatory practices or policies?
 - Mobilize support among the general public to work for changes in public policy?

- Promote alternatives to risk behaviours?
- Protect human rights of all people affected by HIV/AIDS?
- Actively fight discrimination?
- Educate the whole community for care, compassion and prevention?
- Have any other impact—please describe.

How to Create an Effective Communication Project (blue book) Second in the series, the blue book was more ambitious. It was intended to show users exactly how to plan and design a behaviour change communication project. Starting with a section that helps users understand the factors that put the target audience at risk of acquiring HIV, it continues

with a series of questions that guide users to an understanding of the characteristics of the people who are most at risk. Next, the user considers which attitude and behaviour changes are desirable and describes specific behaviour change objectives. Throughout the process, users are asked to make decisions and note them on a planning chart, which is found in the appendix. The blue book also contains sections on how to develop effective messages and choose appropriate channels for delivering those messages. Finally, after carefully considering the risk factors, the audience, the objectives, the messages and the channels, a user puts them all together to create an effective and measurable communication strategy.

SIDEBAR 1

In Senegal, the BCC handbooks were used as an integral part of a workshop that launched the redesign of the AIDSCAP national strategy. NGO members organized themselves in groups according to geographical area and target audiences. After an initial session during which they shared their very different ideas about messages and activities, they realized that they needed a more systematic approach. Pages from the blue book (*How To Develop an Effective Communication Project*) were photocopied, and together each group tackled project design.

A planning chart in the appendix of the handbook provided the framework and forced the groups to clarify target audiences, risk behaviours and desired behaviours. Participants articulated their objectives and used them to focus on messages and approach. Each group also identified appropriate methods for formative research and made plans to conduct this research within the following month.

By the next meeting, representatives of each NGO had completed sections of the planning chart and had identified risk factors, primary and secondary target audiences, desired behaviour or attitude changes, core messages and communication channels. By working together on the communication strategy and following the guidelines in the handbook, they were able to develop a strong and coordinated implementation plan. It is doubtful that just reading this handbook would have had the same capacity-building impact. In this case, the NGO staff felt the need for a more systematic strategy, and the handbook appeared at just the right time. Using the handbook together for the first few chapters also seemed to motivate them. Once they discovered that it was easy to understand and follow, they had the confidence to continue. As one of the participants said, “This handbook simplified the presentation of something very complicated—the planning process.”

Behaviour Change Through Mass

Communication (green book) Health workers and NGO staff members who had no experience dealing with the media requested the next handbook. They asked for step-by-step advice on working with radio, TV, print and public relations workers to use mass communication for HIV prevention. As a result, the green book offers guidelines for:

- Approaching and working with TV, radio and print media staff.
- Writing short scripts for radio and TV programmes.
- Having scripts produced for radio and television.
- Getting stories printed in newspapers and magazines.
- Attracting more media coverage.

How to Conduct Effective Pretests

(purple book) The fourth handbook deals with materials development and conducting pretests. In addition to sections on pretesting methods and readability scales, it contains detailed instructions for organizing a pretest, including preparing the discussion guide and other materials, the test site and the participants. The purple book also includes sections on conducting focus group discussions and individual interviews for pretesting. Users have particularly appreciated the guidelines for analyzing pretest results.

How to Create an Effective Peer Education

Project (brown book) The information in the brown book was based on interviews with over 200 project managers, peer educators and peer beneficiaries in ten countries. It presents

advice from experienced HIV/AIDS BCC practitioners about:

- Activities that are appropriate for peer educators.
- Recruitment and selection of peer educators.
- Community acceptance and support for peer educators.
- Training topics for peer educators.
- Supervision and support for peer educators.
- The role of educational materials and condoms in peer education projects.

HIV/AIDS Care and Support Projects

(pink book) Perhaps the most ambitious of all, this handbook is a guide to project planning for organizations that may not have previous experience in care-related activities. Since care and support projects are relatively new undertakings for many implementers working in HIV/AIDS, the booklet uses questions and checklists to help users decide whether their organizations should work in this area. What kind of experience does your group have? Can this experience benefit an HIV/AIDS care or support project? Do you have the expertise, the staff, the time and the money to take on care and support activities? If users decide that they do want to undertake such a project, the handbook then guides them through 12 important steps, ranging from choosing a target audience to ensuring confidentiality.

Partnership with the Media (orange book)

This handbook grew out of the recognition that journalism workshops do not provide the entire solution to the problem of achieving credible, timely and relevant media coverage of issues related to HIV/AIDS. It is based on the premise that a true partnership with the media requires

a long-term relationship with people at all levels of the media establishment. The booklet provides suggestions for:

- Planning for events to be held with media professionals, including editors, station managers, producers and other “gatekeepers,” writers and school of journalism faculty members.
- Encouraging the development of a network of media professionals interested in HIV/AIDS/STI issues.
- Providing journalists with incentives for covering HIV/AIDS/STI issues.

Policy and Advocacy in HIV/AIDS

Prevention (grey book) This handbook was written for programme managers and others who operate outside the normal policymaking structure, but whose work is regularly influenced by the presence or absence of policy. It provides an overview of how to contribute to making policy an effective component of HIV/AIDS prevention. Although the book describes a process for policy development, readers are urged to adapt the guidelines to their own experiences and to the political dynamics of their countries and organizations.

Behaviour Change Communication for the Prevention and Treatment of STDs

(teal book) Behaviour change specialists and providers of STI services alike eagerly sought this handbook. It is intended to help programme and clinic managers design BCC components for STI control and prevention projects. The teal book provides suggestions and examples for:

- Assessing the STI beliefs, concerns and practices of clients and community members.

- Expanding the role of BCC activities in the clinic.
- Providing the education and understanding that STI clients need for behaviour change.
- Training health workers in the communication aspects of preventing and managing STIs.
- Involving the community in a BCC programme.
- Using the stages of behaviour change to develop appropriate BCC messages.

USING THE HANDBOOKS

The handbooks were initially disseminated to AIDSCAP implementing partners through the project’s country and regional offices. They were sent to AIDSCAP resident advisors and regional directors with a letter urging them to develop a country-specific dissemination strategy to get the booklets to the individuals who could put them to the best use.

Although the small user-friendly handbooks were well received by implementing agencies and donors, their use was not uniformly successful. Careful dissemination and follow-up proved to be key to effective use. In a few cases, a BCC officer simply distributed copies of a booklet and users were expected to refer to them if and when necessary. It is unlikely that this has resulted in a great increase in skills. In more successful cases, the handbooks were used for on-the-job training, as a curriculum for more formal training or as explicit guidelines for project development.

Many implementers have shared the handbooks with staff and field workers and have developed innovative ways to help ensure that the information provided is internalized and used. Managers report that they use specific chapters of the handbooks to help their staff

with particular problems. For example, in the brown book (*How to Create an Effective Peer Education Project*), the section on supporting and supervising peer educators can be used as a training and discussion tool with supervisors. It suggests ten different support activities and asks supervisors to decide which they plan to use or build upon. There are also six supervision suggestions that readers can use or adapt.

On the other hand, the purple book (*How to Conduct Effective Pretests*), with its clear instructions on preparing materials for pretesting, has been used primarily as a reference tool. Users say that they just refer to the handbook when they plan to do pretesting. They also report that the sample interview and focus group discussion questions have been particularly useful.

The green book (*Behaviour Change Through Mass Communication*) is used both as a reference and as a classroom teaching tool. Because it provides specific guidelines on what to consider when choosing radio, television or mass media to convey BCC messages, it has been useful as a reference for communication strategy planning. In other places, the entire handbook has been essential reading for a training-of-trainers course, with required homework based on the sections on how to write a radio or TV script.

In Laos and Cambodia, sections of the blue, green, brown and red books are used as support materials in training curricula, and each of the complete handbooks is given as a handout at the end of the course. As one trainer explained, “Most of the time I select only some chapters that I want to focus on, but I also introduce and go over all components in the book when I give it out at the end of the course. In that

way, participants can continue learning on their own.” Another trainer mentions that he uses the handbooks “to reinforce the concepts after training has ended. I leave copies as reference tools.” This same trainer has used the handbooks for communication training in development and health areas other than HIV/AIDS.

In yet another variation, one FHI field officer reported that she introduces or reviews one handbook at each of her monthly meetings with implementing agencies. She says that when people are given the opportunity to open a handbook and begin discussing the first few sections, they are more likely to take it home, read the entire booklet and use it as a self-teaching tool.

Funds were not available to conduct a formal evaluation of the impact of the handbooks on BCC skills and practice. However, the enthusiastic response to the series and anecdotal reports on its use suggest that the handbooks have made an important contribution to the BCC capacity-building efforts of FHI and many other organizations.

LESSONS LEARNED

The response to the BCC Handbook series shows that there is a growing need for practical publications such as these, which are aimed at field workers in field situations. FHI has had many requests for the handbooks and distributed more than 23,000 copies. Thousands more have been distributed by others as translations or photocopies.

FHI’s experience with the handbooks suggests that donors are willing to support the use of this kind of capacity-building tool. FHI produced all the handbooks in English and several in French and Spanish and received

hundreds of requests for them from donor organizations and their partners. FHI country offices and donors also translated many of the handbooks into local languages. In Indonesia, the Australian foreign aid agency, AUSAID, supported translation of some of the handbooks into Bahasa Indonesia. In Mozambique, Population Services International translated and printed all nine handbooks in Portuguese. UNICEF is in the process of translating and adapting the handbooks in Laos, Cambodia, Thailand and China.

The interactive format of the handbooks engaged readers in a decision-making process that helped them learn, apply and assimilate the information. Even though the assumption that readers would write answers in a workbook proved wrong—books are seen as too precious to write in—the questions in the handbooks are still a useful format for encouraging active learning, and they can be photocopied and used as true checklists.

Rigorous use of readability scales helped make the handbooks useful to a large audience of potential users with a wide range of education levels and language skills. The use of short words and sentences made the text clearer and more precise.

FHI's experience confirmed the importance of pretesting materials thoroughly. Although pretest results revealed that FHI's basic assumptions about format, content and style were correct, they also identified numerous opportunities to clarify concepts and explanations.

These user-friendly handbooks can serve as reference books. But, like most capacity-building tools, they are most effective as part of an ongoing, coordinated effort to strengthen

BCC skills. Whether they use the handbooks as part of a training curriculum, a planning exercise or informal inservice training, supervisors should take an active interest in the continued use of the books by staff to ensure that new BCC skills and principles become internalized and normative throughout their organizations.

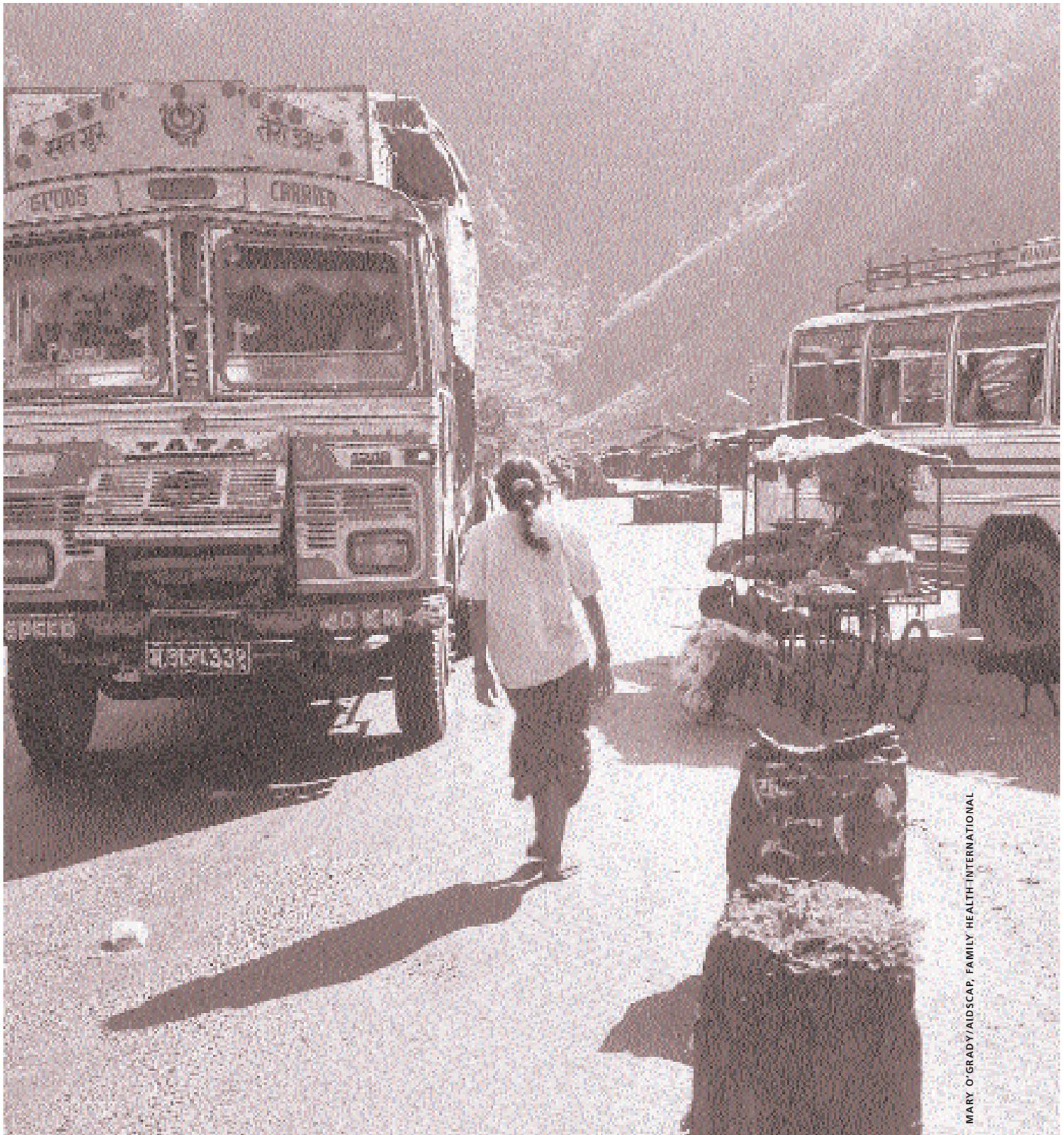
AUTHORS

Donna Flanagan, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA

Hally Mahler, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA

Bunmi Makinwa, Africa Regional Office, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Nairobi, Kenya

More HIV infections will be prevented sooner if programmes strategically select locations with the greatest potential for HIV transmission.



MARY O'GRADY/AIDSCAP, FAMILY HEALTH INTERNATIONAL

A BUSY HIGHWAY INTERSECTION IN NEPAL NEAR THE INDIAN BORDER PROVIDES AN ENTRY POINT FOR REACHING VULNERABLE GROUPS VIA CROSS-BORDER HIV PREVENTION PROGRAMMING.

INITIATING CROSS-BORDER HIV/AIDS-PREVENTION PROGRAMMES: PRACTICAL LESSONS FROM ASIA

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INITIATING CROSS-BORDER HIV/AIDS-PREVENTION PROGRAMMES: PRACTICAL LESSONS FROM ASIA

INTRODUCTION

Seroprevalence data from a number of countries in Asia show that there tend to be higher levels of HIV and sexually transmitted infections (STIs) in provinces with international border crossings than in other provinces.¹ Tens, sometimes hundreds of thousands of people cross these borders every year, stopping in nearby towns to rest and relax (see Appendix II). Studies conducted during the 1990s led to the growing recognition that border towns tend to be higher-risk environments for HIV and STIs, in part because of an atmosphere of remoteness from normal legal and cultural restrictions that encourages visitors to engage in risk behaviours they might not necessarily practice in their home communities.²⁻⁷

By 1998 a number of agencies in Asia had started implementing HIV-prevention programmes at border crossings to reach mobile populations in transit to other parts of the region. Implementing programmes in these border locations presents unique challenges that mainstream HIV/AIDS-control programmes do not regularly face. For example, multiple languages are used in cross-border sites; most of the population

at any given time is en route to somewhere else; and, fewer government health and social services are available in these sites than in provincial capitals or other trade towns not located on borders.

In March 1998 a workshop jointly organized and sponsored by Family Health International's (FHI's) Asia Regional Office, based on work performed during the AIDS Control and Prevention (AIDSCAP) Project, and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Asia-Pacific Intercountry Team (APICT) was held in Mae Sai, Thailand, to share experiences among agencies implementing cross-border programmes in Asia. Judging by the geographical sites represented by project staff, a definition of "cross-border" in the context of HIV prevention can be stated as "a land, sea or river connection between two countries where significant border crossing occurs."

The prevention programmes are usually carried out in linked settlements (see Table 1) populated by people who are involved in the cross-border trade. They target those who are travelling to places near or far in search of economic opportunity—a population largely unserved by mainstream HIV/AIDS programmes.

FIGURE 1

Examples of Linked “Cross-Border” Settlements in Asia

Type of Linked Settlement	Regional Example
Over Land	Poipet–Aranyaprattet (Thailand–Cambodia) Raxaul–Birgunj (India–Nepal) Bauwet–Moch Bai (Cambodia–Vietnam)
Over Sea	Merauke–Mahachai (Cambodia–Vietnam)
Over River	Mae Sai–Taichilek (Thailand–Myanmar) Huay Sai–Chiang Kong (Laos–Thailand)
Over Land And Sea	Sao Tong–Klong Yai (Cambodia–Thailand)

A “sister-city” approach to prevention programming is evolving in these linked settlements, based on the hypothesis that HIV-prevention messages and services will have greater impact if they are reinforced on both sides of a border. This assumption follows the basic communication principle of repeating messages through different media, but also reflects the understanding that public health problems such as HIV are not avoided by crossing a border.

This case study is a summary and synthesis of information from the agencies that have had actual experience in designing, implementing and evaluating cross-border HIV-prevention programmes. As a first attempt to chart the essential steps in mounting such a prevention effort, it draws on state-of-the-art experience from the projects that have pioneered this work and may serve as a practical guide to other agencies wishing to begin on their own. A much larger and wider effort will be needed in the coming years as the number of border crossings increases in Asia and elsewhere.

IMPLEMENTING CROSS-BORDER PREVENTION PROJECTS

1. Listing cross-border locations

Why? The number of border crossings in Asia seems to change by the month. While some close (temporarily), more open than close. With each new bridge, paved road or port, opportunities for cross-border movement increase. Therefore, it is important to try to establish a working list of international border crossings to serve as the “universe” of possible sites for a project. This list need not be exhaustive. Indeed, listing some unofficial sites might jeopardize the welfare of refugees. It should, however, include the major cross-border junctions where a significant number of people engage in daily economic activity across borders.

How?

- First, list the sites that meet the criteria for a cross-border location. Try to categorize the basic nature of the site from information available from common knowledge

(e.g., official/unofficial, land/sea/river crossing, large/medium/small size).

- Be creative about finding reliable sources of information. Include recent migrants, local government officials (particularly health officials) and representatives of nongovernmental organizations (NGOs) that may have development projects in border areas. Trips to the perimeter of the country are often useful and necessary. Look for published lists of cross-border sites (e.g., from the national immigration authority).
- Having an international airport should not be a criterion for selection because the higher-priority sites are land or water crossings. (In Asia, HIV is concentrated among the lower- and middle-income segments of society. Those who travel by air either have higher incomes or travel infrequently and are, therefore, at considerably lower risk of transmitting HIV to large numbers of people.)
- Cross-border sites are not only contiguous land borders; rivers or seas can connect “sister” port towns. Port cities that regularly receive international seafarers should always be included in a list. (However, “rest and recreation” sites that receive foreign navies a few times a year are not necessarily places where HIV flourishes and should not receive priority attention unless they meet other criteria described in this case study.)

2. Selecting sites for a formal assessment

Why? Once a pool, or “universe,” of cross-border sites is assembled, a subset needs to be selected for more in-depth assessment. The list of potential sites is usually too large to enable efficient assessment.

Selecting the preferred sites requires making a judgment on the relative importance of each site for the regional HIV epidemic—current or future. Please note that this step occurs before the on-site assessment. Thus, the selection of priority sites should be made based on secondary information that can be obtained easily.

How?

- In the absence of more specific data, sites with larger populations should be selected because they have greater potential for STI and HIV spread. This is because a local economy must reach a certain size in order to sustain overnight accommodations, commercial sex establishments and a wide selection of drinking establishments and to offer people some anonymity to engage in (usually) illegal activities—all hallmarks of cross-border HIV epidemics.
- If existing data show that a particular site has a tradition of nonmarital sex and a known STI or HIV problem, clearly that site is a priority for selection. Some of the key proxy information to look for is included in the following checklist:
 - Do people cross the border for commercial sex?
 - Is there a well-established nightlife or entertainment sector?
 - Are drugs and alcohol available or traded?
 - Is the site on a major truck route?
 - Is the site a major port for deep-sea fishing vessels or sea transport?
 - Is there evidence that women are welcomed aboard ships in port to engage in commercial sex (the “boat climber” format for commercial sex)?

- Do employers in the area want and employ migrant labour?
- Are there large numbers of soldiers or police in the area?
- Do men outnumber women?
- Are there legal differences between the two countries that stimulate cross-border movements (e.g., availability in one country of gambling, cheap alcohol, drugs, sexual services, pornography)?
- Is there a rapid change in the social environment that could create risk (e.g., sexual experimentation by youth, separation of families)?
- Are government welfare services or medical services weak?
- Is there significant trading of goods and services?
- Is the cross-border site a good-sized town and not just a “pass-through” point to another larger town?
- If a site has already been assessed within the past several years, reports of these assessments and their authors should be consulted as part of site selection and prioritization. Search for previously conducted studies about the sites that might be relevant (e.g., studies of drug use, trade, transportation, infrastructure development).
- A site that has some government or NGO HIV-prevention services may still be considered a priority if these services are weak or very limited in coverage. If a comprehensive prevention programme has already been mounted in a particular site, however, that site should be a low priority for new intervention.
- Sites that pose a security risk should be included and assigned relatively high priority in the list, because HIV tends to thrive in environments that encourage other forms of risk behaviour, such as gambling, organized crime, commercial sex and smuggling. Many of these activities occur in remote border areas because it is usually more difficult for authorities to police such sites. However, one must recognize the increased risk to project staff in such an environment and take this into account during design and implementation phases.

3. Conducting a preliminary rapid assessment and prioritization

Why? There are few agencies delivering cross-border prevention activities in Asia and not enough comprehensive programmes to cover all sites adequately. Thus, prioritization is particularly important in order to avoid wasted effort. More HIV infections will be prevented sooner if programmes strategically select locations with the greatest potential for HIV transmission. Some objective basis for this prioritization is needed to ensure that resources are directed to the most important locations. The data collected to make these decisions also will help funding agencies understand the need for and goals of cross-border projects.

What? The term “rapid assessment” is frequently used to describe data collection in a number of sites before a final location is chosen for an HIV-prevention project. Such an assessment need not be a complex and expensive behavioural survey. Enough is known about the context of HIV epidemics to allow efficient collection of

the relevant data from observation and interviews with a few key informants.

The main difference between rapid assessments and larger, more formal surveys is time. Depending on the site, a rapid assessment can range from one to two weeks.

In a rapid assessment, a trained team uses a set of methodological tools to efficiently gather information about a site. The methods may be qualitative, quantitative or both, but are often mostly qualitative. They include in-depth interviews, mapping, observation, collection of secondary data, taking photographs, videotaping and focus group discussions.

How?

- The rapid assessment should provide data on the number of sexual-risk access points, contextual features that support risk, general volume of persons in the cross-border area, the dearth or abundance of HIV/STI-prevention resources and political support for a prevention project.
- To the extent possible, use local people as data gatherers. This does not mean, however, that outside people cannot fully participate in the assessment.
- Training is particularly important when the local people have little or no experience in gathering data. Consider training needs when determining how long the rapid assessment will last.
- To the extent possible, conduct the assessment on both sides of the border.
- Consider what will happen in a cross-border site where you conduct a rapid assessment but do not decide to implement a project. How will it affect the people at the site?

Can the information collected during the rapid assessment be used advantageously to serve that community?

- Prioritize among sites that have been assessed. From the assessment results, an informed decision can be made about where to begin action among several potential sites. Clearly the sites with greater risk environment and fewer HIV-prevention resources should be given top priority.
- Appendix I provides one framework for conducting a rapid assessment. Another set of guidelines has been published by the UNAIDS AP ICT Task Force on Migrant Labor and HIV Vulnerability.⁸

4. Preparing the intervention programme

Why? The rapid assessment may provide the data necessary for prioritizing and selecting sites, but it will not yield enough in-depth information about the cross-border community to design a complete intervention programme. For this, a more involved pre-intervention technical assessment is needed.

What? Approaches designed to maximize the opportunity for community input include Participatory Rural Appraisal (PRA) and Participatory Learning and Action (PLA). Such approaches tend to be long term and in-depth. An agency that uses one of them should assume that it will start an intervention programme at the site—to justify the investment and also to be responsive to community expectations.

Several shorter-term methods have been used to design cross-border HIV interventions in Asia, including assessments by multidisciplinary technical teams. These methods are

focused, direct and rely on a small group of (usually outside) experts.

Some of the advantages and disadvantages of these types of approaches to designing interventions are described briefly below. Implementing agencies must weigh the advantages and disadvantages and select one approach or a combination of both. Field experience to date is not sufficient to recommend one method over another.

How? (1) *PLA: Participatory Learning and Action*. PLA evolved out of the participatory rural appraisal approach developed for analyzing agro-ecosystems. Many of the PLA methods are derived from social anthropology and include visualized information exchange among members of a community. For example, members of a community draw maps showing where people meet, and stones or other objects are placed on the maps to indicate areas of high and low HIV risk. A variety of other tools are used to gather information, including time lines of influential community events, family lines and trend analysis.⁹

In the context of HIV, the PLA technique requires particularly skilled guidance from facilitators because of the myths and prejudices that surround HIV/AIDS. While a participatory approach allows more community input, it can also allow those with discriminatory tendencies to dominate group discussion. The facilitator needs to guard against these tendencies and try to ensure that false or bigoted information is exposed and rejected by the group. Despite this hazard, the final result of a successful PLA exercise should be a more profound understanding of the dynamics of HIV/STI risk in the cross-border community,

more community investment in a solution and greater sustainability once external assistance ends.

(2) *Multidisciplinary technical assessment*.

In this approach an outside group of technical specialists visits a series of communities and, by reviewing data and holding discussions with local key informants, makes some determination of the level of risk in the environment. If team members consider the site worthy of a prevention programme, they recommend certain general strategies. Then local implementing agencies are given funding to operationalize those strategies.

While the factors that lead to HIV-risk behaviour are many and complex, the mechanics of prevention can be basic and straightforward. Therefore, having outside technical experts design a plan that applies behaviour change and STI-care strategies that have proven effective in other border areas can save valuable time in mounting a prevention effort.

Such early action may, in fact, be more important than long-term sustainability because of the explosive nature of HIV epidemics in Asia. The early period of very high infectivity (first three months after infection) followed by a long period of low infectivity means that a community can become saturated fairly rapidly unless the most susceptible sex networks are “immunized” by individual, group and structural interventions. On the other hand, if such immunization can be accomplished early in an epidemic, the result will be a rapid decline in new cases.

Thus, if HIV prevention is the primary goal of a cross-border project, a technical planning team might be more efficient than PLA. However, if long-term community health development is the goal, PLA may provide a broader base for future programming.

SIDEBAR 1

Nepal-India Project Creates Cross-Border Partnerships for HIV Prevention

One promising example of a cross-border HIV/AIDS prevention project began in 1995, when a clinic offering sexually transmitted infection (STI) treatment and other health services opened in the Indian town of Raxaul and started linking its services with those of a Nepali organization across the border.

This collaboration grew out of research conducted by Family Health International's (FHI's) AIDS Control and Prevention (AIDSCAP) Project, which found high levels of HIV-risk behaviour among truck drivers and their assistants along trucking routes in India and Nepal. Concerned about protecting its workers from HIV, the Transport Corporation of India (TCI) decided to establish the Raxaul clinic, one of a network of 16 clinics run by its Bhoruka Public Welfare Trust throughout India.

Raxaul was chosen as the site for the cross-border intervention because it is on the main road to Nepal's capital city of Kathmandu and consequently the most important entry point from India into Nepal and because of its proximity to AIDSCAP activities in the town of Birgunj. There the NGO General Welfare Pratisthan (GWP) was already providing HIV/AIDS and STI prevention outreach to truck drivers and their sex partners as part of the AIDSCAP programme along the major trucking routes in Nepal's central region.

Several major highways converge at Birgunj and Raxaul. Some 2,000 truck drivers pass through

these towns daily, often stopping for one or two days to load and unload trucks and to rest. The transient nature of life in such towns creates many opportunities for HIV-risk behaviour, but the open Nepal-India border also offers unique opportunities for cross-border interventions.

AIDSCAP's first cross-border project, funded by the United States Agency for International Development's (USAID) Asia and Near East Bureau (ANE), wove together the STI treatment and prevention services offered by the Bhoruka AIDS Project (BAP) in Raxaul with the outreach services of GWP in Birgunj. The staff of BAP, GWP and the Lifesaving and Lifegiving Society (LALS), a Nepali NGO that provides technical assistance in human resource development to GWP, worked together to match project goals, strategies and approaches. As a result, outreach workers from India and Nepal found it easy to coordinate their activities.

Frequent visits and communication among field staff were essential to successful collaboration. BAP, GWP and LALS staff members also participated in joint training workshops, and GWP invited BAP staff to participate in training sessions at its office in Hetauda, just an hour's drive north of the border.

Field workers from the three groups even crossed the border to work regularly with each other on Indian-Nepal outreach teams. BAP staff helped their GWP counterparts improve outreach to Indian men in Birgunj, while GWP educators talked to Nepali sex workers in Raxaul.

The Bhoruka AIDS Project was able to use or adapt many of the communication materials developed for the AIDSCAP programme in Nepal. Only a few changes (identified by focus group participants) were required to make the Nepal programme's logo, "Dhaaley Dai," acceptable to Indian audiences. Using similar materials created a seamless prevention environment at the Raxaul-Birgunj border, where thousands of people received consistent messages about HIV and STIs as they travelled back and forth.

Perhaps the most important aspect of the BAP-GWP collaboration was the joint STI referral system. Because people were often reluctant to visit Birgunj's only and highly visible STI clinic, GWP outreach workers used cards printed in Nepali and Hindi to refer men and women in need of STI services to BAP's general clinic just across the bridge. From 1995 to 1997, the clinic served an average of 50 clients a day. Almost one out of four clients receiving treatment was from Nepal.

GWP and BAP also worked together to organize a consultative board consisting of representatives of local organizations, clubs and government agencies. The board provides advice and keeps members informed about project activities, building vital community and government support for cross-border interventions.

The pilot project has not yet been evaluated. However, in surveys conducted to evaluate the AIDSCAP programme in Nepal, both sex workers

and their clients reported increased condom use. In fact, the proportion of sex workers who said that their most recent client had worn a condom increased from 35 per cent in 1994 to 61 percent in 1996, while there was no significant increase in reported condom use by sex workers in similar areas that had not benefited from the AIDSCAP programme. Nearly 82 per cent of clients with STI symptoms in the project area reported seeking treatment, compared to only 50 per cent in other areas.

Surveys of truckers in Raxaul also revealed some indications of behaviour change and an increased level of awareness about the risk of HIV. An analysis of the results, however, led to the conclusion that the Bhoruka AIDS Project alone was too small to have the necessary impact on HIV-risk behaviour and transmission among the large population of truckers and their partners along India's National Highway 28A.

Expanding cross-border prevention efforts to reduce HIV-risk behaviour among large mobile populations will require more of the kind of long-term international partnerships created in Raxaul and Birgunj. This collaboration continues with funding from the USAID's ANE Bureau and technical assistance from FHI, and it has been expanded to three additional border crossings between India and Nepal. It has also served as inspiration for a number of planned cross-border projects sponsored by other organizations along the India-Bangladesh border.

5. Implementing the interventions

Why? It is reasonable to ask why this additional section on implementing interventions is needed—why not simply apply the current state-of-the-art in HIV prevention to cross-border settings?

Because of the unique challenges of cross-border programmes described earlier, unique adaptations to the intervention strategy are required. The experience of the cross-border programmes in Asia provides important guidance in many areas that other guidelines may not address.

The next section lists some of these special attributes of interventions during the start-up phase of cross-border programmes. Since the implementation of these programmes in Asia is still nascent, it is premature to suggest lessons for successful (and unsuccessful) implementation.

How? (1) Forge local partnerships between agencies across borders. The most successful projects have started locally and gradually sought the support of national governments.

- Work with local agencies on both sides of the border. (See Sidebar 1.)
- Initiate contact at the provincial or district level first; *do not try to begin at the national level*. Build relationships between local NGOs before forging government-to-government collaboration.
- Plan to evolve toward a mixture of both government and NGO programme management.
- Include non-HIV programme areas of priority to local governments, such as assistance with repatriation of illegal aliens or orientation on immigration policies and differences in laws when crossing a border. Explore ways to incorporate these issues into the design of the intervention package.

- As projects mature, involve higher levels of governments.
- Inform and get approval from military/border police early.
- (2) Identify and engage the key stakeholders in cross-border towns/ports.
- Once local cross-border partnerships have been formed, move beyond implementing agencies to link the following on both sides, as appropriate:
 - private sector (clinics, pharmacies, transport companies, fishing companies)
 - commercial sex establishments (with consistent condom-only policies)
 - local border officials (customs/police)
 - immigration officials
 - port health officials
 - branch offices of the Ministry of Defence (reaching men)
 - publicity/media channels (local radio, television, advertisers)
 - mass organizations (political support, connections)
 - UN agencies (expertise, resources)
 - political parties (funding)
 - universities (evaluation, capacity building)
- (3) Establish a project advisory committee.
- Identify individuals on both sides of the border from the NGO, government and commercial sectors who can provide guidance and support to the implementing agencies.
- Include representative(s) from local organizations for migrant workers.
- Convene regular meetings of the advisory committee to review obstacles, progress and plans. (The advisory committee should be used as a “sounding board” to suggest what is realistically possible and what is not and to help interpret why activities do not proceed as planned.)

6. Evaluating the programme

Why? Evaluation is an essential component of all programmes, but it is particularly important for cross-border projects because of the special challenges they face. The high mobility of populations in border areas is perhaps the most formidable challenge, since effective behaviour change communication (BCC) requires repeated contacts. The many languages and dialects spoken in border areas may mean that BCC messages are not fully absorbed, or only by the full-time resident population. And the relative absence of social and legal controls in border areas means that risk is a way of life and that attempts to modify norms may have little impact on mobile populations.

These examples are just some of the attributes that distinguish border areas from the average provincial or district capital or trade town. The implication is that what worked elsewhere in HIV prevention may not fully apply in cross-border settings. Therefore, in this formative phase of cross-border programming, evaluation systems are needed to objectively monitor trends in self-risk perception and risk behaviour over many years. The information they provide will be useful to programme planners and implementers and to the funding agencies that are investing an increasing amount of resources in this strategy for regional HIV prevention.

What? The following bimodal approach to evaluating cross-border HIV-prevention programmes is recommended:

(1) Use quantitative data-collection tools to track risk behaviours over time among certain subgroups of the community.

(2) Use qualitative methods to assess the environment of risk in the community at large.

This approach is recommended because changes in risk behaviour have proved to be one of the more reliable indicators of prevention programme impact in Asia.¹⁰ While behaviour change itself does not necessarily protect one from HIV in all cases, there is a strong correlation between behaviour change and trends in STI and HIV in countries with extensive data.¹¹ Process data from programme implementation, such as number of persons reached, condoms distributed and posters displayed, are important for monitoring implementation. However, these data do not always provide convincing evidence of programme impact.

How? Monitoring changes in behaviour among a large population over time can provide reliable evidence that communities are changing in response to project interventions. Some of the recommended indicators include:

- self-reported number of sex partners in the previous six months
- self-reported patronage of commercial sex industry in the previous six months
- self-reported condom use with different types of partners
- self-reported STI symptoms and treatment-seeking behaviour
- self-assessment and assessment of others' risk of contracting HIV
- ability to identify effective methods to prevent HIV transmission.

Data collection to measure these and other indicators should be conducted just

before the prevention programme begins to establish a baseline and repeated once a year.

SIDEBAR 2

Subgroups at Risk of HIV Infection in Cross-border Areas

A behavioural survey should be conducted among different subgroups of the cross-border community, depending on their proximity to the HIV transmission network:

Highest risk groups

For example: full-time sex workers, motorcycle taxi drivers, border military or police, transport workers, boat crews.

Bridge between highest risk groups and general population

For example: border traders, freelance sex workers, travelling salesmen.

General population

For example: married women, adolescents.

The behavioural surveillance survey (BSS) approach, created by Family Health International, has been applied in a variety of settings in Asia and may be an appropriate tool for sub-regional programme evaluation of cross-border projects.¹² A core questionnaire and standard methodology already have been developed for the BSS and are described in several handbooks.^{13,14}

While the BSS presents quantitative data on risk behaviour in the cross-border population, other evaluation data are needed on the context of risk in the community. This is because some border towns have an

“atmosphere” of risk that facilitates reckless behaviour and, possibly, HIV transmission.¹⁵

Some of the contextual dimensions that should be investigated (using qualitative data collection methods) include:

- Interaction between the resident population and the mobile populations who travel through a border town
- Self-perception when in or outside the border area (e.g., sense of anonymity, freedom from legal or social controls)
- Behaviours and attitudes of powerful authorities that may encourage or discourage risk behaviour
- Increase or decrease in institutions and policies that encourage or discourage risk behaviour.

Manuals for using qualitative methods to collect data for HIV-prevention programmes are available.¹⁶

7. Leveraging Local Resources and Sustainability

Why? Despite the increased attention to Asia as the area with potentially more future HIV infections than any other region, it is very likely that grant funding for HIV-prevention programmes will continue to decline indefinitely. While loan funds may increase for some time, these funds will be managed by national prevention programmes that may consider border sites a lower priority than large cities. Thus, agencies planning new cross-border interventions need to include plans for sustainability right from the start. As data are being collected during the pre-implementation phase, special attention needs to be given to the capability of the community

to mobilize indigenous resources to eventually underwrite much of the prevention costs. If that capacity does not exist, it must be built as part of the intervention.

How? To invest in, and then sustain, HIV-prevention interventions can be particularly challenging in remote cross-border areas. Travel and communication costs are much higher on average for cross-border projects than for programmes in large cities and other more accessible areas. World Vision has attempted to address the sustainability challenge by integrating HIV prevention into its general development work along the border between Thailand and Myanmar. This integration achieves some economies of scale. Other programmes are considering a “prevention marketing” strategy to deliver prevention materials and supplies to at-risk mobile populations through social marketing. Cost-recovery is possible through the collection of modest clinic fees, as is done on the India-Nepal border. However, the most successful HIV-prevention work is achieved through sustained interpersonal communication with trained outreach workers, and this usually requires outside support.

CONCLUSION

While HIV has spread rapidly in some Asian countries, it appears that the pervasive urban and rural epidemics that many countries in sub-Saharan Africa are experiencing will not materialize in this region of the world.¹⁷ Nevertheless, for future decades HIV will continue to be a serious public health threat to Asians. Accordingly, regional prevention programmes need to concentrate their limited resources in the areas most vulnerable to

HIV/AIDS epidemics. Analysis of the distribution of HIV in parts of Asia suggests that areas with busy land-border crossings and international fishing ports have higher levels of STI and HIV than other trade areas. Because of the volume of people who travel to and through these towns and ports, the implications for widespread transmission of HIV are enormous. Similarly, the implications for cost-effective reductions in new HIV infections are also great.

An increasing number of NGOs and funding agencies are recognizing this border-crossing epidemic-spread phenomenon and are steering resources to the geographical perimeter, instead of the centre, of societies. The March 1998 Mae Sai meeting of the agencies with the most experience conducting this work in Asia was remarkable for the commonality of approaches and strategies that had evolved independently. This case study outlines the essential elements of a cross-border programme based on the practical experience of NGOs that implement such programmes. This experience can be summed up in a few simple words: “Select carefully, start locally, plan broadly.”

AUTHORS

Tony Bennett, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Bangkok, Thailand
Kathleen Henry, Sidebar 1, AIDSCAP, Family Health International, Arlington, Virginia, USA

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APPENDIX I

RAPID ASSESSMENT: GUIDELINES FOR CROSS-BORDER PROJECTS

Introduction and Rationale Using statistical methods, epidemiologists have determined that mobility is an independent risk factor for HIV infection where HIV is prevalent. The same relationship should hold for other STIs, even where HIV is not prevalent. Thus, it is important for prevention programmes to develop services for mobile individuals.

Regional HIV-prevention programmes in Asia are becoming more interested in mobile populations because these individuals may not have equal access to national prevention programme services. In addition, population movement in Asia is on the rise, due to the expanding infrastructure of paved roads, bridges and ports. This increased movement is expected to increase the spread of HIV.

By virtue of their movement, mobile populations are difficult to reach with sustained interventions for STI diagnosis and treatment and interpersonal communication to assess risk and choose behavioural options to reduce personal risk. Mobility is also a vague term, since everyone in society is mobile to some degree. For the purpose

of this discussion, the following distinction is made. Mobile populations are of two types:

- (1) Migrants, who change residence (legally or illegally) for a significant duration (many months or years).
- (2) Other mobile populations, such as those with mobile occupations, who do not change their formal residences.

Although both groups are vulnerable to HIV/STI due to lack of access to quality prevention services—and the social disruption of moving—it is proposed that the second group plays the more significant role in fuelling the regional HIV epidemic. This is because certain HIV “breeding grounds” in the region are disproportionately located in cross-border market towns and international fishing ports. These cross-border junctions serve as gathering places for Asian men and women with mobile occupations and cash incomes. While migrants may pass through these locations only once, those with mobile occupations pass through them regularly and repeatedly.

Despite the substantial investment in HIV/AIDS prevention resources in Asia, few of these resources reach the cross-border sites because of their remoteness, the lack of recognition of their epidemiological

significance and the priority national AIDS programmes place on serving mainstream populations. In addition, the need for programmes that cross borders means that these sites fall into a political vacuum, outside of the mandate of most national and bilateral programmes. Recently, however, regional HIV-prevention programmes are beginning to design prevention projects for mobile populations—especially those that cross national boundaries. To inform the design process, these projects need more information on the context of risk and the potential modes of intervention.

This case study defines a proposed methodology for conducting a rapid assessment of cross-border locations originally prepared in response to a request by the APIC/UNAIDS Task Force on Migrant Populations and HIV Vulnerability.

Data Collection: Community Context

The epidemiological data suggest that some contextual factor or set of factors render cross-border sites “flammable” for HIV. Thus, a rapid assessment must collect certain information on the general community setting in order to help sketch a risk profile. This information should enable planners to prioritize sites for the pilot projects that are to follow the assessments. The major method of data collection is key informant interviews with individuals who have a broad knowledge of the site and have been in residence for some time. In addition, the team will use observation and mapping to describe the locations and interaction of various establishments or sites that facilitate sharing of sex partners.

Key Informant Interviews

Key government administrative officials

- chief district officer, mayor
- chief of police
- chief of immigration
- chief government health officer.

Knowledgeable long-term residents

- retired governor, district chief, mayor
- beauty salon owners (female)
- bar or nightclub owners.

The items for the discussion guide should be adapted for different types of informants, and not all questions should be asked of each respondent. Reliable information on the following core items should be obtained:

- age of town; factors behind development status
- number and location of ports, landing docks
- number and location of bus depots, truck stops
- number and location of fresh markets
- number and location of health service outlets (including pharmacies)
- number and location of places with overnight accommodations by price/room
- number and location of places that serve hard liquor
- number and location of commercial sex access points by type (e.g., brothels, karaoke lounges, massage parlours)
- number and location of places that sell/distribute condoms
- number and locations of parks, locations for “cruising” for commercial sex partners and men who have sex with men
- number of gambling dens
- local slang terms for above locations, commercial sex, STI, drunken behaviour

- size of population (of sexually active age):
 - in residence
 - in transit
- passing through without staying overnight
- male-to-female ratio (of those of sexually active age).

Based on this information, the data collection teams will begin to construct a crude map of the site and plot the key landmarks. Next, a thorough walk-through is conducted to fill in locations of other sites that were overlooked by the key informants. Photographs should be taken during the day and night of important gathering places where risk behaviour or commercial sex negotiation take place; STI service outlets; and border crossing junctions, such as bridges, checkpoints, ports and piers.

Data Collection: Populations of Special Interest

It is necessary to have some concept of hierarchy of risk to ensure that the most vulnerable are the focus of the assessment. Time does not allow a general survey and evaluation of risk for all persons in cross-border communities. Besides, much is already known about vulnerability in the Asian context. Although behaviour is the most important determinant of risk, certain occupations create circumstances leading to very high risk of infection.

Occupations for Men: These include occupations in which there are prolonged periods in close proximity with other male co-workers, followed by a short burst of freedom to socialize with women (e.g., deep-sea fisherman, logger, miner, military recruit).

Occupations for Women: These include occupations in establishments whose primary customers are men (e.g., brothel

worker, masseuse, karaoke lounge hostess, barber shop attendant, snooker hall marker, dance hall hostess).

Secondary levels of risk are associated with the following:

Men: Occupations involving itinerant travel, such as trader, salesman, transport worker or border police.

Women: Wife or girlfriend of the men in any of the male occupations described above.

A rapid assessment of such short duration must rely on key informants who know about the populations of special interest described above. It is not necessary to conduct sample surveys of these populations to measure knowledge and behaviour. Their vulnerability is already well established. Instead, the data collection team should collect information from individuals who have resided in the cross-border location long enough to have a good understanding of population movements, gathering places and prevention opportunities. Approximately one person each should be interviewed from the following groups:

- older sex worker who has been in town at least one year (one for each of the predominant linguistic groups, or about 3 persons)
- fishing boat captain (in port towns)
- foreman (logging, mining, construction, fishery company)
- daytime market vendor (female)
- nighttime market vendor (female)
- local commuter transport worker: motorcycle taxi
- local commuter transport worker: cycle, rickshaw
- local commuter transport worker: boat or ferry.

The discussion guide will vary by type of key informant, but the essential information from all groups should lead to a composite impression of the risk environment of the town at large.

The core components of the discussion guide should include the following content:

- size of the population of coworkers, peers
- frequency of turnover (average duration of stay)
- common destinations when leaving this site
- trend toward increase or decrease in population of peers
- common languages spoken in group
- most pressing need/hardship of group right now (financial, legal, environmental, health, etc.)
- previous STI/HIV-prevention services received (when, what type, by whom)
- current need for prevention services by type (STI, condoms, information, incentives to change behaviour)
- sources of condoms (with price range)
- sources of STI treatment (with price range)
- interest in becoming a peer educator/leader
- recommendation of other key informants.

Data Collection: Service Infrastructure

To obtain more information on the health-seeking behaviours of the mobile populations and the range of services available, both STI and non-STI certain key informants will be interviewed, such as the following:

- private clinic physician (one male, one female)
- pharmacy drug seller (one male, one female)
- government health office official (one male, one female)
- traditional healers.

The information to be collected from these individuals includes, but is not limited to, the following:

- most common complaints/conditions of patients seen
- any patients with STIs or concerns about STI, by type
- about how many persons with STI-like complaints seen per week or month
- what service is provided to these individuals
- local terms used for different STI-like conditions
- how STI is diagnosed
- how treatment is prescribed
- the most common treatment for (1) genital ulcer, (2) genital discharge, (3) abdominal pain
- need for additional training on STIs
- need for additional equipment/supplies for STI management; who should provide these
- most popular service outlets for STIs (by name and location)
- volume of sales of over-the-counter STI drugs by type
- volume of sales of post-coital contraceptive (Postinor)
- demand for abortion
- volume of sales of condoms by brand, price per piece.

Data Collection Team Composition

The research team may vary in size and other parameters but must include the following attributes:

1. literate, multilingual speakers of the predominant languages used in the site

2. male and female data gatherers (minimum: one each) with quantitative and qualitative data-collection skills
3. team supervisor (one minimum)
4. local counterpart (ideally, one female and one male)
5. time enough to spend overnights in the site inclusive of one Friday-Saturday night combination.

Field logistics It is proposed that the assessment be conducted over a period of six consecutive days. A team of five individuals should be able to collect the requisite data in that time. The assessment report should be prepared in the week immediately following the assessment and should include maps and photographs to illustrate the context of the risk dynamics of the site.

Essential equipment and support services include:

- evidence of previous contact with local officials and official, written permission to collect data in the site
- a one-page description of purpose of visit and names of team members and organizational affiliation
- most recent road maps of the districts and provinces surrounding the site
- discussion guides with topics for key informant interviews
- checklists to aid in mapping site locations
- grid paper for map sketches
- notepads for field notes
- tape recorder, tapes, spare batteries
- camera, print film, spare batteries
- locally-rented transportation and driver.

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APPENDIX II

TABLE A

Selected Border Crossings in Asia*

(Note: All crossing points are official or officially endorsed)

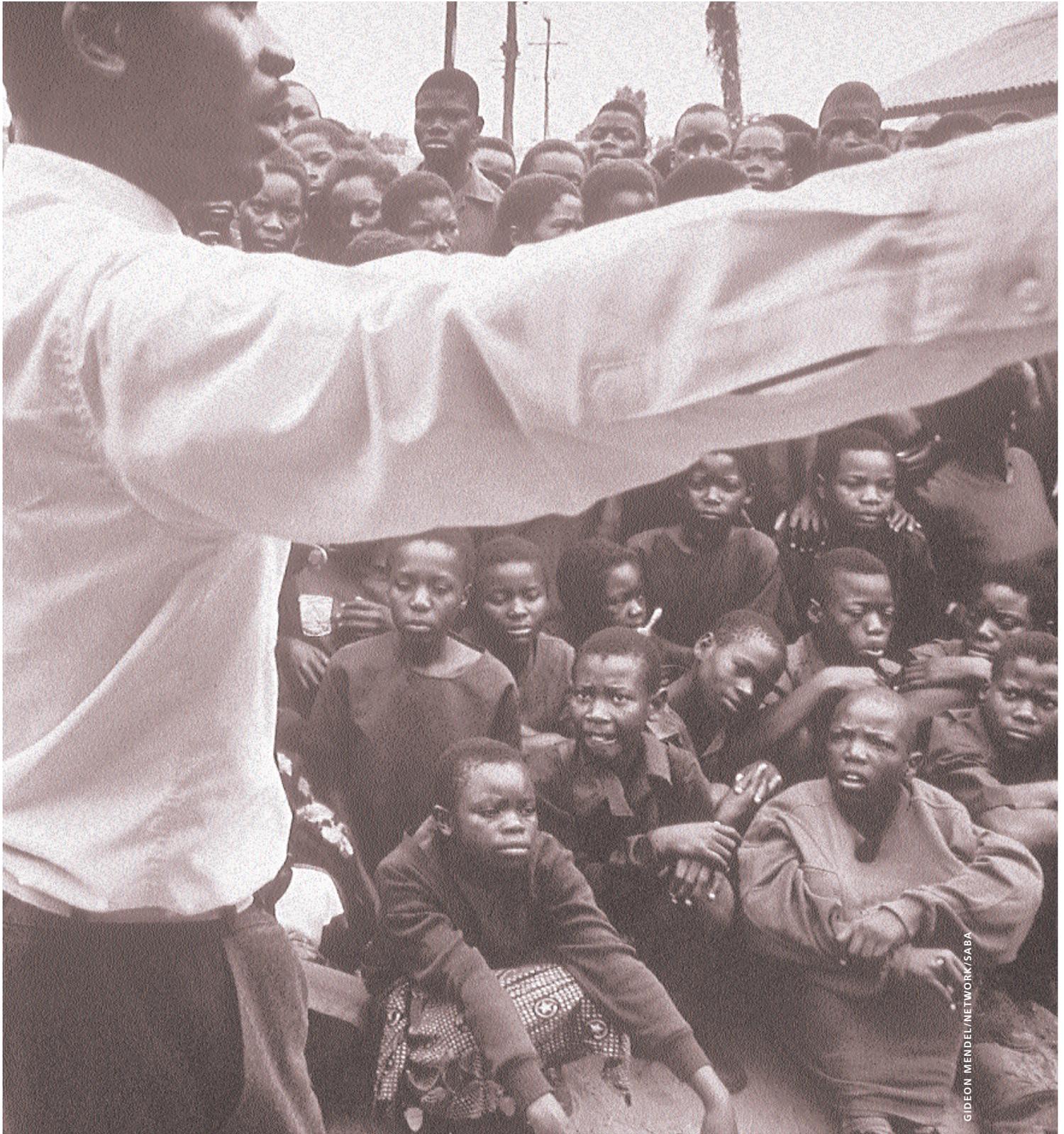
Names of "Linked" Border Towns	Type of Crossing	Estimated Person-Crossings Per Year
Thailand-Laos		
Chiang Khong-Huaysai	River ferry	
Chiang Saen-Huaysai	River ferry	
Nongkhai-Vientiane	Bridge	830,000 (1996)
Nakorn Panom-Savannakhet	River ferry	
Chong Mek-Pakse	River ferry	350,000 (1996)
Cambodia-Thailand		
Choam Ksan-Nam Yin	Land	
Samrong-Kap Choeng	Land	
Polpet-Aranyapratet	Land	
Koh Kong-Klong Yai	Land, speed boat, sea vessel	300,000
Kompongsum-various ports	Sea vessel	
Thailand-Myanmar		
Mae Sai-Takilek	Bridge	Hundreds of thousands
Mae Sot-Myawadee	Bridge	Tens of thousands
Ranong-Kawthawng	Ferry and land	Tens of thousands
Thailand-Malaysia		
Satun-Padang Besar	Land	
Sungaikolok-Kota Baharu	Land	
Cambodia-Vietnam		
Svay Rieng-Tay Ninh	Land	110,000
Takeo-Chao Doc	Land	
Kompongsum-various ports	Sea vessels	

TABLE A (CONTINUED)

Names of "Linked" Border Towns	Type of Crossing	Estimated Person-Crossings Per Year
China–Laos		
Mengla–Mohan	Land	
Jiangcheng–Phongsaly	Land	
Laos–Vietnam		
Savannakhet–Quang Tri	Land	22,000 (trucker-trips)
China–Myanmar		
Ruili–Muse	River vessel	
Mengding–Chin Shwe Haw	River vessel	
China–Vietnam		
Dongxing–Mong Cai	Land	
Pingxiang–Dong Dang	Land	Approximately 2 million
Tianbao–Ha Giang	Land	100,000 (1995)
Jingping–Jinshuihe	Land	124,000 (1995)
Hekou–Lao Cai	River vessel	200,000 (1990)
Nepal–India		
Birgunj–Raxaul	Land	
Nepalgunj–Bharaich	Land	
Biratnagar–Dharbanga	Land	
India–Bangladesh		
Calcutta–Benapole–Jessore	Land	
Silchar–Syhlet	Land	
Bangladesh–Myanmar		
Chittagong–various ports	Sea vessels	
Mongla–various ports	River and sea vessels	
Philippines–Indonesia		
General Santos City–Manado	Fishing boats	
Indonesia–Thailand		
Mereuke–Samut Prakan	Fishing boats	

*Much of the information in this table is derived from the Asia Research Centre for Migration publication *Maps of International Borders between Mainland Southeast Asian Countries and Background Information Concerning Populations Movements at those Borders* (February 1998).

Since both traditional and modern systems of health care coexist within communities and serve the same target populations, collaboration between the two not only enhances the services being provided by each system individually, but also ensures transparency and trust benefiting individuals and the community as a whole.



GIDEON MENDEL/NETWORK/SABA

A CROWD OF YOUNG PEOPLE IN TANZANIA LISTEN ATTENTIVELY TO A HEALTH EDUCATOR WHO SERVES AS A ROLE MODEL WHILE EXPLAINING THE NEED TO PRACTICE HIV PREVENTION BEHAVIORS.

PARTNERSHIP WITH TRADITIONAL HEALTH PRACTITIONERS IN HIV/AIDS PREVENTION AND CARE: THE TANGA EXPERIENCE IN TANZANIA

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PARTNERSHIP WITH TRADITIONAL HEALTH PRACTITIONERS IN HIV/AIDS PREVENTION AND CARE: THE TANGA EXPERIENCE IN TANZANIA

INTRODUCTION

The HIV/AIDS pandemic continues to grow in Tanzania, taking a heavy toll on the population despite the intervention measures in place since 1985. By the end of 1997, for example, there were an estimated 520,000 AIDS cases in Tanzania, although only 103,185 had been officially reported to the Ministry of Health. In 1999 about 1.2 million Tanzanians were estimated to be living with HIV, and HIV prevalence among the general population stood at 10 per cent. Prevalence rates among women attending antenatal clinics in some parts of the country in 1999 were as high as 44 per cent. As in other sub-Saharan countries, HIV is mainly transmitted through heterosexual intercourse in Tanzania, with young adults between 15 and 24 years of age being more vulnerable than other age groups.

The impact of the pandemic is severe and affects all social and economic sectors of Tanzanian society. The burden of the disease will also result in a decline in productivity, slower growth in gross national product (GNP), increased health care costs, high infant and child mortality and a growing number of orphans. By the year 2000, more than 1 million children in Tanzania will have lost one or both parents to AIDS.

Most recent statistics from government hospitals show that up to 50 per cent of all the beds in some hospitals are occupied by patients with AIDS-related illnesses. This situation has created a high demand for hospital supplies and services, and many health care facilities are unable to cope with the level of services needed.

THE RESPONSE

Since 1983, when the first AIDS cases were reported in Tanzania, various programmes and plans have been instituted to address the pandemic, with varying but limited results. Following official recognition of the AIDS epidemic in 1985, for example, the Tanzanian government formed a two-year Short-Term Plan (STP). This was followed by a five-year Medium-Term Plan I (MTPI, 1987–1992) and the establishment of the National AIDS Control Programme (NACP) to coordinate its implementation.

During the implementation of MTPI, the government recorded a number of achievements. These included strengthening public health services to ensure safe blood transfusions, management of sexually transmitted infections (STIs), care for people living with HIV/AIDS (PLHA), as well as raising the level of

HIV/AIDS awareness to an estimated 95 per cent of the Tanzanian population (NACP Quarterly Epidemiological Report, 1990).

However, despite these achievements, MTPI implementation remained largely the responsibility of the Ministry of Health, with little involvement from other sectors, including other government agencies, institutions, nongovernmental organizations (NGOs) and businesses. This narrow approach denied communities the opportunity to create and carry out the kind of multisectoral and community-based interventions that have proved to be effective in responding to the HIV/AIDS pandemic. Realizing this crucial shortcoming, the Ministry called for a multisectoral response from all government, private, bilateral, nongovernmental and other donor organizations in implementing the second Medium-Term Plan, MTP II.

THE TANZANIA AIDS PROJECT (TAP)

One of the bilateral responses to the call for multisectoral collaboration in AIDS prevention came from the United States, through the United States Agency for International Development (USAID) Mission in Tanzania. This response came in the form of a five-year (1993 to 1998), \$20 million support project, later known as the Tanzania AIDS Project (TAP). TAP was awarded to Family Health International (FHI) and implemented through its AIDS Control and Prevention (AIDSCAP) Project, in collaboration with several other international organizational partners, including Population Services International (PSI).

The goal of TAP was to contribute to government efforts to reduce the HIV

transmission rate and thereby lessen the social and economic impact of HIV/AIDS on Tanzanian society. The purpose of the project was to increase the level of HIV-prevention practices and ensure the provision of adequate support services to AIDS orphans and families affected by the HIV epidemic.

The project created a network of regional NGO clusters to introduce and coordinate a package of interventions aimed at promoting safer sex through individual behavior change, by reducing people's number of sexual partners and encouraging consistent and correct condom use. Project activities promoted access to condoms, early diagnosis and treatment of sexually transmitted infections (STIs), and care for people living with HIV/AIDS (PLHA). The NGO cluster network, which operates in ten out of 20 regions in the country, works in close collaboration with the Regional and District AIDS Control Coordinators, as well as the regional, district and community leadership.

Through this cluster network, the NGOs have trained resource persons involved in peer education, home-based care and counselling, orphan care and support, and care for PLHA. These training activities also involved traditional birth attendants and traditional healers in the care and support of PLHA, in collaboration with modern health care practitioners (MHPs).

This collaborative undertaking brought together the country's traditional health care practitioners (THPs) and MHPs in a working partnership that is unprecedented in the history of health care delivery in Tanzania. This case study highlights some of the partnership's distinctive features and its impact on health care provision for PLHA in the Tanga region.

THE TANGA AIDS WORKING GROUP (TAWG)

Collaboration between THPs and MHPs in the Tanga region began during implementation of the Village Health Project (VHP), established in Pangani district in 1989. This project provided health care services for PLHA and tested the efficacy of various traditional remedies. Attracted by the project's efforts, MHPs and key public health researchers began to focus their attention on traditional health practices in Tanga.

The interest in traditional health care services was fuelled in part by the growing frustration among MHPs in trying to treat a variety of ailments among the PLHA who were frequenting their health facilities. The lack of drugs in most of the health facilities was equally frustrating to the PLHA who then resorted to seeking alternative care from the THPs. Capitalizing on the already growing interest for collaboration between the two groups of practitioners, the VHP organized a series of meetings to devise mechanisms for putting the partnership in place. During these meetings a spirit of mutual respect and trust was forged between the two groups of practitioners as they shared experiences. For example, the THPs came forward with detailed information on the health problems they were comfortable managing and acknowledged their shortcomings in addressing those, in their opinion, that were better handled by MHPs. Similarly, the MHPs shared their experiences by highlighting cases where their clients with AIDS-related problems showed great improvement after seeking alternative treatment from THPs.

This initial openness and candid attitude among the two groups of practitioners levelled the ground for a serious partnership that quickly spread throughout the region, leading to the

formation of an NGO known as the Tanga AIDS Working Group (TAWG) in 1992. TAWG's main mission is to promote HIV/AIDS/STI prevention and to provide social support and care for PLHA and their families.

TAWG's popularity has continued to grow over the years, with a total membership of 94 practitioners, and includes 60 traditional healers and birth attendants and 34 health workers, ranging from medical doctors, nurses, and counsellors to home-based care workers. The TAWG joined the TAP NGO Cluster Network in 1995, which enabled the two groups of practitioners to benefit from TAP support. With a three-year technical assistance and financial support grant from TAP, TAWG was able to provide extensive care services to PLHA in the three selected districts in Tanga region.

PROJECT METHODOLOGY

In collaboration with TAP, TAWG held a series of meetings to sensitize local government leaders and health care providers on the need for partnership between the traditional and modern health care sectors. The main objectives of these meetings were to:

- Update participants on the status of the HIV/AIDS/STI epidemic in the district.
- Share information on the intervention efforts of the National AIDS Control Programme (NACP) in collaboration with local NGOs.
- Share experiences and establish a sustainable mechanism for MHP/THP collaboration on HIV/AIDS prevention and care for PLHA.

Following these sensitization meetings, training workshops were held for THPs. The overall objective of these workshops was to provide them with information about HIV/AIDS/STI

and equip them with basic skills in home-based care and counselling for PLHA and their families.

Among others, the following issues were highlighted during the training:

- The importance of using appropriate diagnostic procedures and maintaining sterile equipment
- Recognition of a life-threatening condition (i.e., cerebral malaria) and the need for early and timely referrals of these clients to a health care facility
- Importance of maintaining good hygienic practices and other protective measures when attending clients.

The primary training material was a manual specifically developed by the TAWG to address the information needs of THPs and their supervisors. The training process encompassed a number of adult learning methodologies, including the Learner Centered Problem Posing Self Discovery Action Oriented (LEPSA) approach, lectures, group work, role-playing and drama.

To ensure the quality of the services provided by the THPs and the overall sustainability of this initiative, two trainers were assigned to monitor and supervise THPs in the field. The trainers made regular visits to the worksites of THPs, where they observed them in action. Based on these observations, hands-on training was provided to the THPs: harmful practices were corrected and good ones were reinforced. As a backup, 17 other supervisors were selected from the Association of Traditional Health Practitioners (Chama cha Waganga na Wakunga wa Jadi Tiba Asilia Tanzania, or CHAWATIATA) and trained in monitoring and supervising THPs in their workplace.

RESULTS

Over the three-year funding cycle, TAWG trained a total of 120 THPs in three districts out of five in the region, including Tanga, Pangani and Muheza. Out of these, 60 were traditional birth attendants (all women) and 60 traditional healers (16 were men). Eighty of these THPs came from the Pangani district, the locus of this initiative. This team of practitioners not only became a major resource in the provision of care for PLHA, but also a source of HIV/AIDS/STI information, education and counselling both for their clients and the public in general.

The respect and trust established between the two groups of practitioners during the sensitization seminars, and the training activities that followed, enhanced the collaboration between the two groups in delivering HIV/AIDS/STI prevention and care services to their clients. Collaboration between the two groups also has resulted in increased mutual understanding of each other's medical concepts and practices. This understanding and frequent consultation between the two groups has enhanced the cross-referral process for clients, facilitating holistic health care provision.

Since most THPs and health care facilities were already well known in the community, organizing client referral services between the THPs and MHPs was easy to accomplish. Through this system, THPs referred more than 1,600 people to the modern health care facilities for HIV counselling and testing over the life of the project. Similarly, MHPs referred some 5,400 clients to THPs for counselling after the initial pre- and post-test counselling at their health facilities.

This cross-referral system not only reinforced the partnership between the two groups, but also enabled them to build on each other's strengths and weaknesses. For example, the realization by the MHPs of their limitations in providing effective treatment for various ailments related to AIDS led some of them to start providing herbal remedies known to treat opportunistic infections among their clients and to keep records of the observed changes over time. These records were jointly reviewed with their THPs counterparts and future follow-up procedures were recommended.

Following this teamwork, substantial information on the effectiveness of these local remedies slowly started emerging. Available data from the TAWG document showed that a number of traditional remedies were reported

to provide effective treatment for various ailments experienced by PLHA. These include "muogola," which is both antifungal and an antibacterial drug known to treat diarrhoea and improve appetites, thus leading to weight gain among PLHA. Others include "mkusu," which is also potent for fungal and bacterial treatment and is known to treat candida albicans and "mvuti," which is also antifungal and antibacterial and functions more or less like "muogola." The most powerful of all is the "zingiri," which like the others is antifungal and antiviral and treats a number of problems including oral thrush, skin lesions, tinea versicolor and tinea capitis, as well as herpes zoster.

All these medicines are extracted from various local trees and, depending on the condition of the patient, are provided independently or in

SIDEBAR 1

Relieving HIV Symptoms Through Traditional Remedies

To demonstrate the effectiveness of traditional remedies, TAWG volunteered the following data on "Case Four" of their clients:

"Carolina, a 29-year-old single mother, is reported to have been suffering from prolonged fever, diarrhea, malaise and occasional outbreak of oral thrush. She visited a number of public and private health facilities in Tanga, where she was repeatedly told that she was suffering from malaria. On each visit she was either given malaria drugs or other drug combinations, which did not improve her situation. On sharing her frustrations with a friend, she was advised to go for an HIV test, which she did

after a long agonizing period of decision-making. Her worries were finally confirmed when she got the results of her test. She was HIV-positive."

"On sharing the news with her friend, she was advised to go see Salehe Waziri (the THP working with TAWG). Mr. Salehe put her on a combination of herbal medicines, which took care of most of her ailments in three months. She later, however, developed oral thrush, which was also attended by Mr. Salehe. Carolina has been on Mr. Salehe's drug combination for more than a year now, and she remains healthy taking care of her eight-year-old daughter."

combination. The majority of these medicines, with the exception of the ones for treatment of herpes zoster that are applied topically, are taken orally in combination with liquid such as porridge (with the viscosity of tea). Instructions for utilizing these medications are simple, and most patients have no problem in adhering to them.

Furthermore, TAWG, in collaboration with other researchers, have capitalized on home-based care and counselling services and the existing working relationship between the THPs and MHPs to initiate studies aimed at assessing the efficacy of traditional herbs and remedies for AIDS-related illness. These studies are a continuation of those supported by the Tanzanian government through VHP. Although more time is needed before conclusive results can be measured through these studies, preliminary findings as described above show the great potential of these traditional remedies for treating various AIDS-related problems.

Apart from providing treatment for various AIDS-related ailments at their workplace, the THPs also carry out home-care visits, where they provide care and counselling for the whole family. Supervised by TAP-trained home-based care workers, the THPs made 2,731 home visits during the three-year period, providing services to more than 237 PLHA and their families. Contrary to the usual and expected reluctance by PLHA and their families to open up to outsiders, the THPs appear to have been accepted, mainly due to their traditional role in the community. Although tangible statistics are lacking on the impact of the services provided through this partnership due to absence of baseline data, anecdotal information shows that a good proportion of patients are benefiting from the services.

These include patients who otherwise would have been frequenting the health facilities for care of one ailment or another.

Further, following the training, the THPs acknowledged that their skills and confidence in addressing AIDS-related issues had been enhanced. They reported increased satisfaction with their role in the community, because they were now addressing HIV/AIDS/STI issues with authority. In turn, they said that members of the communities were giving them more recognition and respect. Thus, in addition to providing counselling and home-based care services for PLHA, the THPs used their new skills to educate the community in HIV/AIDS/STI prevention methods.

During the project, THPs reportedly conducted 1,241 educational sessions on HIV/AIDS/STI, both at health care facilities and at selected community sites. These sessions, usually accompanied by video or drama shows tailored to address local HIV/AIDS/STI information needs, reached 19,294 people in the community.

Finally, the training provided to the THPs also helped in humanizing the HIV/AIDS messages being communicated by both the MHPs and THPs. By communicating consistent, educational messages to their clients, THPs and MHPs have been able to reduce the myths and misconceptions about HIV/AIDS/STI that were prevalent in their communities. In addition, the THPs used their workplaces as outlets for socially marketed “Salama” condoms, distributed by PSI. Over the project’s two years some 320,000 Salama condoms were sold through the cluster consortium in Tanga, including the ones sold by THPs, showing there was significant demand for this HIV-prevention method.

SIDEBAR 2

Enlivening AIDS Understanding Through Community-Based Drama

Most of the drama shows developed in Tanga were written in collaboration with the target communities, usually following a "community diagnosis" of the social problem at hand. Based on the identified problem(s), the community resource persons, in collaboration with the THPs and assisted by relevant technical resources from other NGO clusters, came up with a drama to address the information needs in the community. The drama was performed by men and women selected from the community, thus making it more realistic.

The dramas focused on a number of social problems contributing to HIV infection, including alcoholism, commercial sex, migrant labour and infidelity. Community reactions to the locally adopted films as well as most dramas developed and performed in collaboration with the THPs were overwhelming. For example, after watching the video show, "Poa Mambo Bado," translated from the English-language film "More Time," one youth had this to say:

"I think the film has a lesson for the whole family: it has a lesson for mothers on dealing with issues of sexuality and HIV/AIDS with their teenagers, a lesson for youth on alcohol and AIDS; and even more important, it has a lesson for both parents and youth to talk openly about condoms and AIDS."

Similar reactions to the drama shows were observed. For example, after watching one of the locally staged drama shows, one elderly woman made the following remark:

"We need to be honest with our kids. This problem (rape) is quite real in our community. Women in our community have gone too far, losing their control due to alcohol. And the poor youth appear to be taking advantage of them, without knowing what they might encounter at the end."

One young person had a different reaction to the same play:

"The drama we just saw is a reflection of what is exactly happening in our community now. Personally, I think we need to be more open and candid about our actions. Some of the youth here have been taking advantage of drunken women by raping them just as it was depicted in the drama. This behaviour is likely going to expose them to the risks of HIV infection. I am sure those who are involved in this kind of behaviour learned something from this play because it was quite real."

BEST PRACTICE CRITERIA

This initiative presents a rare and successful collaboration between THPs and MHPs in Tanzania to provide care and support services for PLHA. The project's evolution is a reflection of the health care workers' response to the increasing demand by community members for HIV/AIDS/STI prevention and care services that built on locally available resources in an innovative and sustainable manner.

Relevance Historically, THPs have been the primary source of health information and care for communities in sub-Saharan Africa. Strategic collaboration between THPs and MHPs in HIV/AIDS/STI prevention and care services highlights the inherent ability of both types of health care workers to respond to the challenges arising from the HIV/AIDS pandemic, and underscores the need to forge new partnerships to address such challenges.

Effectiveness/Impact Since both traditional and modern systems of health care coexist within communities and serve the same target populations, collaboration between the two not only enhances the services being provided by each system individually, but also ensures transparency and trust benefiting individuals and the community as a whole. The success of efforts to promote collaboration between modern and traditional health care practitioners, strengthen the AIDS care and counselling skills of THPs and support their use of effective remedies demonstrates that such partnerships can make an important contribution to the response to the HIV/AIDS pandemic.

More people are now receiving holistic care though this collaborative effort, while others are being referred as needed. During the lifetime of this project, for example, 2,731 home-based care visits were made to PLHA by THPs, saving the health care system an estimated total of US\$10,500. This amount, which may seem small in an industrialized country setting, is significant given the low level of funding available to hospitals in Tanzania.

Replicability The coexistence of two parallel health care systems (traditional and modern) facing the same challenges presented by the HIV/AIDS epidemic is found in all communities in Tanzania. Therefore, the Tanga experience can easily be replicated elsewhere. What is needed is NGO initiative in taking a coordinating role and bringing the two systems together through true collaboration and mutually advantageous partnership, endorsed by the government and community leadership.

Sustainability Establishing the partnership between the THPs and MHPs in Tanga necessitated the substantial involvement of the local community leadership. The initial sensitization meetings created a solid foundation of stakeholders interested in and capable of sustaining community support for this initiative. From the beginning, the parties involved (i.e., government, THPs, MHPs and community leadership) had an opportunity to share experiences, providing a common understanding of the magnitude of the challenges the HIV/AIDS pandemic was presenting to their community. Based on this understanding, consensus was reached on what should be done and what should be the role

of each key player. Community involvement in the identification of the THPs for training further enhanced community ownership of the project and increased the prospects for future sustainability.

LESSONS LEARNED

Through this unique collaboration between the Tanzanian AIDS Project and modern and traditional health practitioners, the Tanga AIDS Working Group learned the following lessons:

- Sensitization of THPs and MHPs as well as community leadership is essential for establishing a shared understanding of the magnitude of the HIV/AIDS pandemic in a region and the roles and expectations of key stakeholders in addressing it. Sensitization efforts emphasizing common challenges and goals builds mutual trust and enables a serious partnership among the stakeholders to be established. By embracing common challenges, community ownership is enhanced and sustainability in HIV/AIDS prevention and care services becomes viable.
- Tailored training on HIV/AIDS/STI for THPs and MHPs is essential, not only for imparting the needed information and skills related to daily practice, but also for validating service needs by the community and enhancing confidence in addressing issues within their social context.
- The existence of local remedies for treatment of opportunistic infections provides the basic ingredient for home-based care services provided by MHPs and counsellors, gives holistic meaning to their work and increases its value to the provider as well as the recipient.

- Collaboration between the THPs and MHPs combined with the availability of cross-referral services saves money for the health care sector and eases the burden of hospital visits and hospitalization for patients, communities, and health care systems as a whole.
- Involvement of THPs in identifying community-based needs for behaviour change intervention leads to culturally grounded messages that are relevant, sensitive and have greater potential for influencing behavior change.
- Partnership between the MHPs and THPs not only facilitates holistic provision of care for PLHA, but also provides a viable platform for multidisciplinary studies on the safety and efficacy of traditional remedies.

CONCLUSION

As HIV/AIDS continues to take a substantial toll on the Tanzanian population, communities are slowly feeling the impact of the costs for caring for PLHA, burial services and support for AIDS orphans. People with AIDS-related illnesses occupy more than 50 per cent of hospital beds in referral hospitals. This has created a high demand for hospital supplies and services, which the Tanzanian government cannot afford to supply.

The integration of traditional health care practices into the modern health care system comes at a time when most hospital facilities in Tanzania are lacking the most basic drugs, including aspirin, paracetamol (Panadol), antibiotics and anti-diarrhoeal medicines, which are vital to treat various ailments suffered by PLHA. Traditional practitioners,

therefore, constitute a community-based resource with great potential for HIV/AIDS/STI prevention and care for PLHA. This potential, however, can only be realized through sensitizing MHPs, THPs and community leaders on the need for effective partnerships in addressing the HIV/AIDS pandemic.

The partnership described in this case study developed from the community demand for increased services and the MHPs recognition and acknowledgement of the importance of the services provided by THPs. This recognition and eventual partnership of the two health care systems reflects a long process in responding to the call made in 1989 by the former World Health Organization (WHO) Director General Dr. Halfdan Mahler:

“For too long, ‘traditional’ and ‘modern’ medicine have followed their own separate paths in mutual antipathy. But their aims are surely identical—the improvement of human health and, hence, improvement of the quality of life.”

AUTHORS

Justin K. Nguma, AIDS Control and Prevention (AIDSCAP) Project, Tanzania AIDS Project (TAP), Family Health International, Dar es Salaam, Tanzania

Penina Ochola, AIDSCAP Project, Family Health International, TAP, Dar es Salaam, Tanzania

Fermina Mberesero, Tanga NGO Cluster, TAP, Tanga, Tanzania

Abdalah Mohammed, Tanga NGO Cluster, TAP, Tanga, Tanzania

Mngao E. Mathias, Tanga NGO Cluster, TAP, Tanga, Tanzania

Gilbert Lutwaza, AIDSCAP Project, Family Health International, TAP, Dar es Salaam, Tanzania

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As a “captive population” that travels internationally and regularly interacts with local populations, the military provides an extremely efficient infrastructure in which to spread information transnationally, promoting behaviour change among its forces as well as to the surrounding populations.



RYAN BEILER/IMPACT VISUALS

AIDSCAP'S CIVIL-MILITARY PROJECT ON HIV/AIDS CENTERED ITS HIV PREVENTION OUTREACH ON MEMBERS OF THE MILITARY SUCH AS THIS HONDURAN SOLDIER HOLDING AN M-16 RIFLE.

THE CIVIL-MILITARY PROJECT ON HIV/AIDS: AN INTERNATIONAL JOINT VENTURE FOR HIV/AIDS PREVENTION

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THE CIVIL-MILITARY PROJECT ON HIV/AIDS: AN INTERNATIONAL JOINT VENTURE FOR HIV/AIDS PREVENTION

INTRODUCTION

Military personnel are at least twice as likely as their general population counterparts to be infected with a sexually transmitted infection (STI), even in peacetime.¹ Why are they so vulnerable, and what are the factors putting them at greater risk than others? While there are no absolute answers to explain the behaviour of each and every individual, several factors make military personnel highly vulnerable to STIs, including HIV. They tend to be young, sexually active men who are garrisoned away from home. Freed from the strictures of their normal social environments, they may engage in risk behaviours they would not practice in their home communities. In many areas where military personnel are stationed, commercial sex is readily available. Moreover, the military environment promotes a feeling of invincibility, inviting risk behaviour based on aggression and an action orientation, as well as “military readiness,” or the need to be ready for life-endangering attack.

At the same time, military bases are vigilant about regimenting strict protocol and procedures that promote rigidity in attitudes, preferences and actions while personnel are on the job. Sex can provide a release from these stressful working conditions and from the loneliness

of being away from home. Likewise, time off duty also can prove to be stressful when there is pressure from military peers to acquire an STI to prove one’s manhood. Tragically, this type of orientation and practice can have deadly consequences when the sexually transmitted infection acquired is HIV. Despite this risk, an environment providing an open invitation to “work hard, play hard” can be too much to resist, especially where heavy peer pressure and loneliness collide.

The reality of high-risk sexual behaviours for the men and women who practice them is that HIV transmission is as much as ten times more likely to occur in the presence of an untreated sexually transmitted infection. When military personnel are deployed to areas that are already socially disrupted, this overall instability, combined with easy access to commercial sex, promotes even riskier behaviour than normal: during wartime, the risk to military personnel of acquiring an STI can be 100 times that of civilians in a normal setting.² Moreover, when local residents or troops themselves are infected with HIV, the presence of military personnel who have multiple sex partners and frequently engage in commercial sex can enable HIV infection to run quickly through existing

sexual networks in communities, multiplying the infection rate exponentially.

Thus, the conditions that enable HIV to become endemic in such settings make civilians and the military equally vulnerable to infection. Further, when HIV-positive troops return home to their wives or other sex partners on leave or after they have been discharged, they carry HIV with them. If these individuals don't adopt safer sex practices, the virus also can be spread into their home communities.

Origins of the Civil-Military Project

Because of the explosive HIV/AIDS pandemic growth during the 1980s, a number of military and civilian leaders decided by the early 1990s that the response of armed forces around the world had been inadequate. The military had long been documented as a population playing a significant role in the spread of STIs, yet military commanders were resistant to dealing with the implications of the new pandemic. Sexual behaviour, gay issues, condom use, religious mores, gender sensitivity and HIV testing and screening were all controversial issues by the late 1980s. If each of these issues was not handled appropriately through clear and enforceable policy within the overall military "command and control" structure, even greater controversy could be provoked, threatening the future career paths of even the most seasoned military "top brass."

To further complicate the situation, most countries lacked epidemiological data and surveillance systems to show how widespread HIV prevalence was within the ranks of the military. With resources already spread too thinly and no existing collaboration and informa-

tion exchange between armed forces and civilian national AIDS control programmes, no clear solution was in sight.

As early as 1992, however, a number of civilians and high-ranking military officers from countries in several regions of the world began to recognize the increasing threat of the HIV epidemic in the civil-military context. Their early discussions were given sharper focus by a survey of NATO countries on policies and practices related to HIV testing, management of people living with AIDS, medico-legal aspects of the epidemic and current HIV seroprevalence. The outcome of that survey was presented at the IXth International Conference on AIDS in Berlin, Germany, in August 1993. Delegates from 27 nations met in a satellite seminar of the conference at the invitation of the United Nations Development Programme (UNDP) and several U.S. government agencies to discuss HIV/AIDS-related issues specific to the military. This meeting proved to be momentous in making participants aware of their mutual goals and of the need to work together to help stem the spread of HIV in the ranks of the military and in the communities where troops were deployed. A consensus statement emerged from the seminar that has continued to provide direction for the civil-military initiative.

Some of those who had attended the Berlin seminar met a second time in Marrakech, Morocco, during the VIIIth International Conference on AIDS and STDs in Africa (ICASA) in December 1993. This "international interest group," as they called themselves at that time, began to lay plans for more concerted action in the military sector. The group met again in June 1994 at the XXXth International

Congress on Military Medicine in Augsburg, Germany, where they initiated a proposal to formally establish the Civil-Military Alliance to Combat HIV and AIDS. The following November, the steering committee of the alliance held its first meeting in Washington, DC, USA.

Forming the Joint Venture To continue and expand the civil-military focused activities and provide more of a management structure to implement the ambitious plans of the new group, the United States Agency for International Development (USAID) funded Family Health International's (FHI's) AIDS Control and Prevention (AIDSCAP) Project to manage the initiative through the Civil-Military Project on HIV/AIDS. The project was in essence a joint venture designed in conjunction with several founders of the newly formed Civil-Military Alliance to Combat HIV and AIDS, based at various agencies in the United States, Europe and Africa. In addition, the Project's organizers targeted several key policy-makers in sub-Saharan Africa and Europe and at the U.S. Department of Defence to help build international awareness of this new initiative.

The worldwide network of individuals forming the Civil-Military Alliance became the main informal implementing body of the Civil-Military Project on HIV/AIDS in various countries. Through AIDSCAP funding, one half-time staff director was appointed to help guide the project's activities toward meeting its objectives and to provide a networking bridge with the alliance.

By providing access to its membership for Civil-Military Project activities and information dissemination, the alliance's global network served as the main platform to help meet the

Civil-Military Project's mandate: to collect, analyze, share and disseminate information on HIV-prevention methods; foster civilian-military collaboration to stem the spread of the HIV/AIDS pandemic; discuss possible collaborative prevention and care scenarios; and, develop additional civilian-military networking opportunities on HIV/AIDS-related issues.

The synergy between the project's mandate and avid transnational interest in the new alliance enabled this joint venture to grow much more quickly than anyone had expected. Fortunately, this rapid growth was based partly on the excitement and commitment of various individuals representing both the civilian and military realms from six key countries: Belgium, Chile, Italy, Uganda, the United Kingdom and the United States. Yet it was also based on the international recognition of the urgent need for militaries to take a much more active role in promoting HIV prevention in their forces, especially in HIV hot spots in east and southern Africa and South-East Asia. Likewise, people who had firsthand knowledge of the effects of military cantonment on their communities were extremely concerned that HIV-prevention awareness and behaviour change start to occur among forces both in their own countries and worldwide.

PROJECT DESCRIPTION AND ACTIVITIES

The Civil-Military Project on HIV/AIDS focused on three main activities in conjunction with the alliance during the project's three-year life span: (1) organizing training workshops and small conferences for civilian and military populations; (2) publishing a newsletter focusing on the need for HIV prevention in the military and the status

of project activities; and, (3) operating a resource centre to compile and maintain information on HIV/AIDS-related issues, salient issues involving military populations and background resource information relating to events and activities sponsored by the project.

Training and Networking Seminars The project held a number of training seminars on HIV prevention. A five-day training seminar brought together military and civilian delegations from seven sub-Saharan African countries—Botswana, Kenya, Malawi, Tanzania, Uganda, Zambia and Zimbabwe—in Harare, Zimbabwe, in June 1995. With substantial organizational assistance from the Economic Development Institute of the World Bank, the seminar was coordinated by part-time Civil-Military Project staff and alliance members with AIDSCAP assistance on site.

In September 1995, a five-day training seminar for senior civilian and military delegates from Bangladesh, India, Indonesia, Malaysia, Nepal and Thailand was held in Cha Am, Thailand, with substantial sponsorship by the World Bank, along with assistance from the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Department of Peacekeeping Operations (UNDPKO) and U.S. Department of Defence staff. Convening this seminar just prior to the Third International Conference on AIDS in Asia and the Pacific (ICAAP) in Chiang Mai, Thailand, made it possible for a large number of international participants to attend both the seminar and two panels on “AIDS Prevention in Military Populations” at the Chiang Mai conference.

The Civil-Military Project on HIV/AIDS held its first seminar in Latin America in

November 1995 in Santiago, Chile, with representatives from civilian and military groups from Argentina, Bolivia, Brazil, Chile, Honduras and Peru. This two-day seminar was organized around the Tenth Latin American Congress on Sexually Transmitted Diseases and the IV Pan American Conference on AIDS. And in December 1995 a series of more informal symposia was held throughout one day in Kampala, Uganda, during the IXth International Conference on AIDS and STIs in Africa (ICASA). These symposia focused on issues of commonality in preventing the spread of HIV in civilian and military populations in sub-Saharan Africa.

At the request of the Minister of Defence of Malawi, one of the countries in sub-Saharan Africa hardest hit by AIDS and with the fewest resources, the Civil-Military Project, the alliance, UNAIDS and UNDPKO jointly sponsored a special policy seminar on HIV/AIDS and the military for 13 countries in east and southern Africa held in Mangochi, Malawi, in April 1996. The participating countries were Botswana, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Swaziland, Tanzania, Uganda, South Africa, Zambia and Zimbabwe. To build on both the need and the opportunity, the project partners planned visits by Malawian participants to countries with greater experience in implementing HIV/AIDS-prevention programmes in military populations, including Uganda, Zambia and Zimbabwe.

One realization this seminar and earlier ones served to highlight was the lack of policy presentation skills by most of the military participants. Military secrecy was such that there was little formal policy exchange between military and civilians on social, behavioural

and health-related issues, and there was no existing forum for advocacy addressing joint interests. Thus, the seminars underscored the need to strategically use the opportunity the Civil-Military Project provided for this type of exchange. They also demonstrated that the civilian sector could actively help military leaders influence national and international policy by providing prevention materials and initiating the training-of-trainers skills transfer that was lacking in many militaries at the time.

In February 1996 the Civil-Military Project supported a seminar focusing on HIV in the military for North Atlantic Treaty Organization (NATO) and Partnership for Peace countries, which was held in Brussels, Belgium. The following July a special roundtable session on “HIV/AIDS in the Armed Forces” was held at the XIth International Conference on AIDS in Vancouver, Canada. Five of the six presenters at the Vancouver roundtable had participated in previous Civil-Military Project seminars and were affiliated with the Civil-Military Alliance. In addition, the roundtable session was co-chaired by the director of the Civil-Military Project on HIV/AIDS who was also the alliance’s international co-chair for 1996–97, presenting an advantageous opportunity to spread information about the Civil-Military Project and the alliance to representatives of the regions not involved so far.

Returning to sub-Saharan Africa, the Civil-Military Project sponsored the “Third African Regional Seminar on HIV/AIDS Prevention in Military Populations,” held in Windhoek, Namibia, for 15 English-speaking countries in the region over five days in March 1997. Participants in the seminar included civilians and military members representing

Angola, Botswana, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The participants committed themselves to establishing a sustainable mechanism to promote information exchange, facilitate technical and training collaboration and support cooperation. Their objective was to build on their established sense of community through coordination and networking, with a minimum of infrastructure. Among the initiatives they approved for the following two-year period was the appointment of a part-time regional coordinator from their experienced alliance ranks. Zambia agreed to initially host the regional coordinator’s office.

In September 1997 the Civil-Military Project held two small seminars on HIV/AIDS in the military for audiences in the United States. The first, held in Washington, DC, focused on military policy. The second seminar was held in New York City for donor agencies and private foundations to present the known status of HIV/AIDS in military populations and the achievements of the Civil-Military Project as well as next steps for the alliance after the project ended. As its final event the following month, the Civil-Military Project and the alliance cosponsored a special panel on HIV/AIDS and the military at the International Congress on Military Medicine in Beijing, China.

Overall the seminars described above hosted more than 660 participants from over 40 countries. In addition, more than 1,000 civilian and military observers attended the various seminars and coordinated events. Among the participants in the seminars were surgeons general, cabinet-level government ministers, army generals, medical commanders, military

SIDEBAR 1

An illustrative example of the results of just one of the Civil-Military Project's seminars is shown by some excerpts from the conclusions and recommendations formulated by the participants in the civil-military "AIDS Prevention in Military Populations" seminar held in Harare, Zimbabwe, in 1995. Excerpted from the *Observations and Common Findings* section are two key points:

1. "The continuing progression of the HIV epidemic in the world and in our own countries is a matter of real concern and demands our vigorous attention. Of particular concern is the impact of the epidemic that we are witnessing in our armed forces, their families and their communities. This concerns the prevalence of sexually transmitted diseases (STDs) as well as infection with HIV and the number of cases of AIDS.
2. We recognize the vulnerability of women and youth to HIV/AIDS infections and we feel that measures should be taken to address this situation. We affirm the importance of empowering women and youth, in the military and in the civil society, to be able to make choices about sex and sexuality in HIV and STD prevention."

From the *Conclusions and Recommendations* section are the following salient excerpts:

1. "We believe that our inter-country cooperation should include both civil-military working relationships, as well as military-to-military cooperation. Specifically we recommend the relevant institutions in our countries to:

a exchange policy documentation, field operational manuals, standard operating procedures, medical manuals, and other relevant documentation related to STDs and HIV in military populations; and

b generate and exchange learning and training materials, training processes and programmes, and train-the-trainer manuals that deal with STDs and HIV prevention, counselling and care."

And, from *The Way Forward* section, these excerpts further underscore the need for collaborative approaches and support the reason for initiating the project itself:

1. "We believe these recommendations can make an essential contribution to the challenge our nations face in the fight against AIDS. Our national military readiness and our common well being depend on this.
2. Furthermore, as neighboring countries in a region so hard hit by the epidemic, we cannot continue to "go it alone," and believe that inter-country initiatives are now appropriate."

These excerpts highlight the considerable importance given by the participants to the civil-military initiative, why it was embraced so readily and why participants continued its fundamental organizing principle so sustainably by establishing their own regional mechanism to continue the project's mandate after it ended in 1997.

nurses, heads of national AIDS programmes and leaders and members of nongovernmental organizations (NGOs) and local community-based organizations (CBOs) where the events were held.

Publications and Resource Center More than 26,000 copies of 12 quarterly Civil-Military Project newsletters (including three issues in French and two in Spanish) were published and disseminated worldwide, reaching more than 105,000 readers. Among the printed materials disseminated at the seminars were HIV/AIDS-prevention programme guidelines and manuals; programme assessment and evaluation tools; a methodology to measure the cost of interventions; guidelines on coordinating inputs from donor and cooperating agencies; and, a position paper to guide policy dialogue on civil-military collaboration for HIV/AIDS prevention and mitigation in sub-Saharan Africa.

In addition, the Civil-Military project developed a questionnaire that was disseminated, with additional support provided by UNAIDS and members of the military in Belgium, Italy and the United States, to project seminar attendees and to members of the Civil-Military Alliance in 120 countries around the world. Analysis of the results of the responses to the 40 questions provided the basis for a global summary report disseminated within the January 1997 project newsletter. Some 42 per cent of the countries queried responded to the survey, with 98 per cent of them reporting that they had an HIV-prevention education programme of some kind and 88 per cent reporting that they had developed formal prevention policies. However, only 56 per cent said their programmes consisted of more than annual educational sessions and

only 54 per cent responded that they had a focus on individual education, which generally proves to be more effective and produces longer-lasting results.

Among the many recommendations resulting from the survey are the following, which focus specifically on civil-military cooperation:

- Inclusion of the military as an integrated sector within national AIDS prevention programmes. Sharing of existing national health care funding and facilities, epidemiological data, and HIV-prevention materials and techniques.
- Adoption of a long-term multisectoral approach to HIV prevention and counselling and to AIDS care, within and between the military and civilian sectors, stressing the importance of defining the disease not only as an immediate medical emergency, but also as a permanent but surmountable challenge to national security and socioeconomic development. In particular, strengthening the first line of defence against the disease by ensuring the dependable availability and accessibility of condoms to all members of society, both civilian and military, together with an inculcation of young adolescents into a common culture of consistent condom use.
- Greater attention paid to HIV/AIDS mitigation in civil-military relations through a careful coordination of the employment and staged release into society of HIV-positive military personnel, with life-extending alterations of public beliefs, values, attitudes and patterns of behaviour within as well as outside socially accepted norms concerning HIV and other STIs.

Proceedings from each workshop also were published and disseminated to targeted military and civilian audiences around the world. In addition, materials from the Civil-Military Project's Resource Centre were exchanged with individual researchers, planners, trainers and policy-makers in North America, Africa, Asia, Latin America and the Caribbean.

Another realization that gradually emerged over the project's first two years was that the materials and techniques used in the seminar presentations were largely transferable to other contained populations, such as prisoners, seafarers and stevedores (port workers), and other transportation workers, including commercial pilots, truckers and bus drivers. Since that time, some of the project's materials have been adapted for use with these other groups.

THE EFFICIENCY OF MOBILIZING THE MILITARY

As a "captive population" that travels internationally and regularly interacts with local populations, the military provides an extremely efficient infrastructure in which to spread information transnationally, promoting behaviour change among its forces as well as to the surrounding populations. Moreover, military commanders actively try to protect their troops in order to maintain the overall strength of their fighting force. Indeed, it is the responsibility of the military leadership to make its forces aware of the existing situation on the ground, militarily and societally, wherever they will be deployed. Consequently, the military sector provides a sophisticated and dynamic information-dissemination channel, including air drops

and ground supply networks when ground forces are deployed, that could be highly effective internationally if it were used to transmit HIV/AIDS-prevention and care information and methods to local populations.

Building on Existing Resources The Civil-Military Project's implementers used the convening capacity of the regional and global AIDS conference as a platform for organizing specific civil-military events. This saved project funds because most participants travelled to the civil-military events through their organization's or country's sponsorship for the main conference. It also allowed project events to draw participants who normally would not have been able to attend a seminar organized by a group with no prior track record of international significance.

In sub-Saharan Africa, which was the main geographical focus of project efforts because it is the global epicentre of HIV prevalence and because its military groups lacked adequate training in HIV/AIDS prevention, the Civil-Military Project organizers took a regional approach to planning events. In maximizing the reach of limited seminar resources by inviting participants from several different countries, the project not only saved significant money, but also facilitated cross-fertilization among the civilian and military sectors. Indeed, the project used seasoned military, NGO and United Nations agency staff to make all the presentations in the seminars. No new or additional presenters were hired to supplant the existing expertise among associated Civil-Military Project implementers and alliance members.

OVERALL EFFECTIVENESS OF THE INITIATIVE

The Civil-Military Project on HIV/AIDS was funded initially to carry out activities only in sub-Saharan Africa. However, because the project was building on broader international relationships among military and civilian decision-makers that had been established by representatives from several regions at the first seminar in Berlin in 1993, it was determined in 1995 that project efforts would be expanded, where possible, to include workshops and networking meetings in other regions. What's more, the dissemination of the newsletter supported by the project since its inception was already global. From then on, the regions where project-funded activities could take place included Asia, Latin America and the Caribbean, and Europe as well as Africa.

A great advantage of the Civil-Military Project on HIV/AIDS was that it was inclusive rather than exclusive in its approach to involving civilians and the military, women and men, nongovernmental organization as well as government agency representatives, members of local community groups where events were held, people living with HIV/AIDS (PLHA), and potential donors who might help expand the project's efforts or make funds available for additional outreach activities. This embracing of communities helped the project gain momentum and gave it exposure to some national- and community-level public- and private-sector gatekeepers who would not have been aware of the initiative otherwise.

Promoting Healthy Lifestyles Given the growing recognition of the need for civilians and military to work together

on HIV/AIDS prevention, more countries have expressed interest in becoming involved with civil-military activities and in using the approaches and materials crafted during the life of the project. As HIV prevalence continues to rise in many non-industrialized countries, increasing attention is being paid to the groups at highest risk of becoming infected with or transmitting the virus. Members of the military who do not practice safe sex fall into both categories. In addition, even more policy-makers, nationally and internationally, are becoming concerned with the behaviour of military personnel, their involvement in the spread of HIV into some formerly low-prevalence rural areas, and the need to maintain the overall health of members of the military to safeguard national defence readiness as well as regional security.

Nevertheless, the most important aspect of the work done through the Civil-Military Project was the promotion of healthier life-styles for both military and civilian populations, as well as humane treatment for all PLHA. The information and strategies transferred through this project were the only information that some individuals attending civil-military events had received on HIV prevention. Clearly, there is a need to disseminate HIV-prevention information as widely as possible and to continue to keep both populations in touch with state-of-the-art prevention and care practices and human-rights issues.

Three HIV/AIDS prevention strategies presented during seminar discussions that remain relevant to military populations include:

1. “Safe zones,” whereby military garrisons would work with local nongovernmental or community-based organizations to launch local behaviour-change communication campaigns promoting STI/HIV-prevention behaviours upon which existing community norms could be remodelled.
2. One hundred per cent condom-only brothels, the world’s most successful national initiative to date, first formulated for one province in Thailand and then made a national mandate enforced by the Thai government in the late 1980s. Based on this initiative, Thailand was the first country in the world to show falling HIV prevalence, among its military conscripts in 1993.
3. A military code of conduct based on healthy behaviour and fundamental human rights and equity promoted by the project’s organizers and civilian and military presenters. Fundamental to the safe zone and 100 per cent condom strategies the Civil-Military Project endorsed, this code builds on the positive aspects of individual responsibility the military employs.

Monitoring and Evaluating Project Progress

While the project’s evaluation strategy did not involve utilizing outcome data, FHI did use monthly process indicator forms to monitor the project’s progress. Among the indicators used were the creation and ongoing functioning of the project’s resource centre, numbers of newsletters published and disseminated, numbers of HIV/AIDS prevention materials packets produced and disseminated at conferences, and the number of regional workshops held. By the end of the three-year project, all the initial target

numbers for these indicators had actually been tripled or quadrupled by the project’s implementers, with some additional funding assistance provided by UNAIDS and the World Bank. Yet despite this assistance, there had been no expectation that the project would achieve such extraordinary success.

An indicator of the Civil-Military Project’s success is that the activities in which the Civil-Military Alliance is involved in 1999 are still expanding, as well as the groups to which it is reaching out. Seafarers, who have been mentioned as having much in common with military because of their international mobility, attitudes and tendency to engage in risky behaviours, are another population to whom the Civil-Military Alliance has promoted the need for HIV-prevention initiatives internationally.

ETHICAL SOUNDNESS OF PROJECT DESIGN AND IMPLEMENTATION

The voluntary participation of government agencies as well as militaries in the Civil-Military Project on HIV/AIDS made it a free and open forum for expressing diverse views, discussing strategies, plans and constraints under equitable conditions, and addressing conflicts and unresolved issues in a sympathetic and positive setting among peers. Many of the issues surrounding HIV prevention are complicated and, likewise, many of the issues surrounding military planning and behaviour are complex. Providing an open forum for dialogue in which progress can be made on these issues through an approach of solidarity was a cornerstone of this project, which credits the members of the Civil-Military Alliance for mandating this principle.

Moreover, the Civil-Military Project on

HIV/AIDS started with a basic human-rights orientation. The organizers acted as role models for participants by displaying non-accusatory attitudes and highlighting shared responsibility. When conflicts arose or a need for confidentiality was expressed in small working groups, these requests were respected and honoured. Efforts were made to enable all participants to express their views and to reach group consensus on any determinations and recommendations.

Presentations during workshops were made by experts in each field who were at least basically familiar with the living and working conditions of the participants. Individual viewpoints were considered valid because they were based on actual life and work experience rather than indoctrination in unrealistic and unattainable modes of behaviour.

Maintaining Confidentiality Project organizers respected the need for militaries to keep information on HIV prevalence and incidence in their forces secret for reasons of national security. Since much information regarding military capability and readiness is considered secret for security reasons, there was an understanding among the project's organizers that some questions were "off limits" and would be divisive rather than collaborative to pursue through group discussion. While this issue was never explicitly discussed, all workshop participants seemed to understand and support the need for complete openness where possible, yet respected the military need to restrict some statistical information on the extent of HIV/AIDS in their forces.

Although the project's organizers and the individuals in charge of civil-military workshops were as responsive as possible to the media

requests they received, at the same time respect for the project's working process, the necessarily low profile of some workshop participants and the military need for sensitivity to national and regional security were maintained. Local workshop organizers scheduled a few media interviews and proactively educated local media representatives in advance on any sensitive issues they were expected to pursue.

A confrontation on such issues occurred only once, outside the actual workshop setting, when a member of the media tried to use the convening of a civil-military group to prod the release of information that might lead to a front-page story in a newspaper. This situation occurred during the first seminar jointly organized by the World Bank in conjunction with the Civil-Military Project on HIV/AIDS, the Civil-Military Alliance and the World Health Organization (WHO) in Harare, Zimbabwe, in June 1995. At that time, a journalist who had barged into the workshop environs was accorded an interview afterwards with a delegated workshop participant, which seemed satisfactory. There was even national television coverage of the convening of the Harare workshop, showcasing the participation by military and civilian representatives from seven east and southern African nations.

Unfortunately, since then, controversy over military confidentiality in regard to HIV-prevalence information appearing in the news media has intensified. On 1 April 1999, the *New York Times* ran a piece mentioning the launch of a new daily newspaper in Harare, *the Daily News*. The report said, "Its publication comes after a number of journalists for independent weeklies were arrested, and some reportedly tortured,

for reports about Zimbabwe's military readiness.”³ Based on press accounts of high HIV prevalence in Zimbabwe's military, the debate over confidentiality of military HIV/AIDS statistics has gained increasing international attention.

Gender Bias in the Military Another issue that has a long history in militaries in nearly every country is gender bias. Because women have not been given the same status or the same staffing, advancement and training opportunities as men in the military culture, the Civil-Military Project's leadership made special efforts to involve women in planning and implementing project activities. Moreover, because sexual transmission of HIV is a sensitive issue for both women and men—whether they are members of civilian or military populations—the involvement of women in various levels of the project was proactively sought.

Women maintained oversight responsibility for the project itself on behalf of Family Health International (FHI), the organization supervising the Civil-Military Project's implementation. The individual who directly supervised the project for FHI was also involved in planning seminar activities, and one or more women were invited to be presenters or co-chairs in the seminars held in various regions. In addition, participation by women in the seminars was openly sought, and the number of women participating as well as observing was tracked in the monthly process indicator forms as part of the project's ongoing monitoring and evaluation. What's more, strategies were devised to address the topics discussed in a gender-sensitive manner.

Overcoming Stigma The Civil-Military project made special efforts to deal with all the issues surrounding HIV infection sensitively. Each workshop participant's HIV status was unknown, unless an individual chose to make his or her status known to the group as a whole. This did occur once during the Civil-Military Workshop held during the IX International Conference on AIDS and STD in Africa (ICASA) in Kampala, when a civilian woman disclosed her HIV-positive status. However, this level of personal openness was rare.

The *modus operandi* during workshop sessions supported the need for HIV-positive military members in most countries to keep their status secret as long as possible to maintain employment equity and full benefits as well as receive humane interpersonal treatment. Unfortunately, despite some progress made on human-rights issues in some countries, as of 1999 the stigma and inequity associated with being HIV-positive remain more or less universal worldwide.

An excerpt from an article in *SafAIDS News* in March 1999 sums up the degree to which stigma surrounding AIDS continues in sub-Saharan Africa, despite the region having the highest HIV prevalence in the world: “...AIDS has remained a symbol of stigma frequently evoked in the continent's ethnic, racial and religious conflicts, perpetuating the notion that AIDS defines the ‘other.’” Because of this ongoing inequity and its threat to a truly civil society, the Civil-Military Alliance and many AIDS projects underway around the world are actively attempting to change social norms to defeat stigma everywhere it exists.

Involving Local Communities The Civil-Military Project on HIV/AIDS workshop held in Kampala in 1995 was the first effort by the project to broadly include any interested participants in workshop events and discussions, many of whom were from local Ugandan communities. Somewhat to the organizers' surprise, the first time this wide-open approach was taken in a conference forum with strong local community representation, the events proved to be greatly popular and, thus, unusually successful. Very sensitive and open attitudes were expressed generally, and especially towards one woman living with HIV, who was particularly courageous in discussing her status with such a diverse international group, including representatives from many African, European and North American countries.

The civilians attending the civil-military sessions in Kampala put great emphasis on the need to share as much information as possible between civilian and military groups in the region and to actively open dialogue and coordinate HIV-prevention-related events in the future. Most of all, they stressed the need to continue the new network and, where possible, to include local community members in any future events or workshops held in sub-Saharan African countries.

An unusually warm relationship quickly arose among members of both the military and civilian groups during the day of events in Kampala. In fact, the mood of the events was almost one of jocularly despite discussion on such a serious topic. Perhaps this togetherness was rooted in the fact that this was the first time an open session for both military and civilian populations was held at an international AIDS conference in Africa. Whatever the reason, while this workshop

did not disseminate an enormous amount of technically specific information on HIV-prevention methods and model programmes, it certainly produced a momentum among participants and project personnel to maintain the new openness and involve local civilian populations in the initiative as widely as possible.

To continue the momentum fomented in Kampala, the Civil-Military Project made greater efforts to involve local NGOs and community-based organizations (where they were active) in activities surrounding any civil-military workshops and events, if not in each and every specific workshop activity.

Promoting Voluntary HIV Counselling and Testing Another attitudinal norm priority among project organizers and alliance members was to promote HIV counselling along with HIV testing where HIV testing was part of an HIV-related programme in a military population. A representative of the U.S. armed forces who made presentations at most of the Civil-Military Project workshops in sub-Saharan Africa and South-East Asia put particularly strong emphasis on the importance of this aspect of HIV programming.

The Civil-Military Project supported the stance that all military and civilian populations should be aware of the need for health-seeking and prevention-related behaviour, regardless of the results of each individual's HIV test. Quality pre- and post-test counselling is essential to help individuals understand the implications of knowing one's HIV status—positive or negative—and act responsibly in the future. Given the current lack of appropriate care for PLHA in most countries of the world,

the need for individual counselling before and after HIV testing for members of sexually active age groups, whether they are members of military or civilian populations, cannot be underscored enough.

RELEVANCE OF THE PROJECT TO HIV/AIDS PREVENTION

The Civil-Military Project on HIV/AIDS initially targeted sub-Saharan Africa in 1994 for its activities. At the time 66 per cent of all adult (ages 15 to 49) HIV infections, 73 per cent of the total reported AIDS cases and 74 per cent of the total AIDS deaths reported in the world had occurred in this region. Strikingly, the female-to-male ratio of HIV infections at that time was 1:0.87, showing that more women than men were infected with HIV in sub-Saharan Africa.

An example from Zimbabwe illustrated the need to focus on HIV prevention among military populations: 10 to 20 per cent of Zimbabwean civilians were infected with HIV, while some 50 per cent of Zimbabwean soldiers were estimated to be HIV-positive. In Congo, AIDS was identified as the cause of 34 per cent of military deaths and the probable cause in another 35 per cent. However, the Civil-Military Project organizers felt there was a need to reach out to all communities—civilian and military—and to as many populations as possible in designing and implementing an effective civil-military initiative.

The Aftermath of the Rwandan Conflict

The year the Civil-Military Alliance and the Civil-Military Project emerged, 1994, was the same year the world witnessed the disintegration of the government and civil society in Rwanda, with widespread genocide and hundreds of

thousands of refugees crossing borders into then-Zaire, Tanzania and Uganda. Members of the military and others in Rwanda formed militia groups, raping and decimating the remaining local populations in many parts of the country.

Before the rampant violence broke out in Rwanda, Hutus were charging that they were afraid that Tutsis would infect them with HIV. Clearly, HIV/AIDS was a major national issue prior to the outbreak of hostilities. At one military camp in Rwanda, 70 per cent of the soldiers reported being more afraid of HIV than of war. This fear was hardly groundless: pre-war estimates of HIV infection among Rwandan soldiers varied from 45 per cent to 60 per cent, with even higher rates among officers. Rwanda was a hot spot for HIV transmission during this period of anarchy, which continued sporadically into 1995. Moreover, during the period of civil strife in Rwanda, there were reports that rape had become a weapon of war. Women often were told that they were about to be infected with HIV before they were raped by Rwandan soldiers.

Based on Family Health International's firsthand knowledge of the high prevalence of HIV in Rwanda through its work in the country before the carnage, the first HIV/AIDS prevention project specifically designed for refugee camps was initiated by FHI's AIDSCAP Project, in collaboration with CARE International, Population Services International and John Snow, Inc., in the Ngara camps in northwestern Tanzania in August 1994. Hundreds of thousands of Rwandan refugees, including former soldiers in the Rwandan Army, resided in these camps, which sprang up over a matter of a few weeks in a former nature reserve just over the Tanzanian border. Reports suggest that former soldiers

who had become refugees helped spread HIV in the refugee camps, where there were also a considerable number of reports of violence against women.

When a new government was fully established in Rwanda in 1995, HIV/AIDS was recognized as a significant public health problem in the country. Subsequently, FHI's AIDSCAP Project, which had launched the Civil-Military Project on HIV/AIDS several months earlier, was the first external NGO invited back into Rwanda to work. According to Rwanda's new health minister, even though the fighting had stopped, in March 1995 nearly 2 million Rwandan refugees remained in refugee camps, where rape as well as forced marriage continued, further continuing the spread of HIV.

Learning from Angola Another country in sub-Saharan Africa, Angola, provided an historic global lesson in HIV vulnerability to and transmission by members of the military. In 1992, the WHO warned that the 150,000 demobilizing military personnel in Angola could spread HIV when they returned home to their families and workplaces. Indeed, the WHO's prediction proved to be true: HIV/AIDS was reported to be the second most prevalent disease among Cuban soldiers who returned home after serving in Angola. In 1995, the WHO surmised that after 20 years of fighting in Angola, thousands of soon-to-be demobilized government and UNITA rebel troops as well as aid workers were at risk of being infected with HIV. According to the Washington, DC-based Centre for Strategic and International Studies (CSIS) at that time, "the infection rate is so high among African soldiers that they have a greater risk of dying from

AIDS than from warfare. It is estimated that at least 100,000 Angolan and rebel troops—half of the fighting force—are infected with HIV."

Leadership by Uganda Thus, in 1994 the need to target military personnel for HIV/AIDS-prevention awareness in countries surrounding Rwanda that were undergoing stress due to refugee influx, as well as other countries in Africa, was urgent. Taking on the cloak of African leadership, the Minister of Defence in Uganda became an exemplary role model as the first African military policy-maker to focus the attention of other African militaries on taking action against the spread of HIV/AIDS. While his stance was based partly on courage and genuine humanitarian goals, it was also based on the reality in the Ugandan military: 75 per cent of Ugandan soldiers who died within one year of leaving military service died from AIDS-related illness.

Despite Uganda's strong national leadership and the outspokenness of both its defence minister and president about HIV/AIDS in their country, three years later the country was having problems with the way some military personnel were treating fellow staff found to be infected with HIV. One day in January 1997, when 1,000 military recruits were assembled at the Mbarara Military Training Wing, the names of the 114 HIV-positive recruits—including 21 of the 27 women recruits—were read out in front of the whole group as being "medically unfit to join the army," based on blood samples taken four months before. A leading Kampala newspaper, *New Vision*, wrote in an editorial later that month, "Even as army recruits, these young people have relatives and friends, and

as human beings they deserve sympathy and respect...it is one thing to be diagnosed HIV positive and completely another not to be a useful member of society even when not serving in the army.”

Joint Venture Rationale: Protecting the Health of Communities The Civil-Military Alliance and Civil-Military Project’s organizing strategy of including military and civilian population representatives in all its activities was initiated basically because there had been no prior effort to bring together these populations, both suffering the effects of an intensifying global pandemic. There was a strong recognition by individuals in some militaries and government ministries as well as in civil society that more could be achieved by mobilizing the two communities to approach the HIV transmission issue in tandem than through separate initiatives. Such collaboration would also focus the attention of the military on protecting the health of the local communities in which they were residing, thus increasing the viability and sustainability of community prevention efforts.

In many countries, members of the military serve as role models for boys and young men in the community. Therefore, by actively promoting safer sex practices, the military can also promote community norms for safer sex and other HIV-prevention behaviours. The result will be lasting positive health and behavioural effects for the military and their families and for local populations, and even subsequent generations in areas of military deployment as well as home residence.

As sex partners who can be infected by members of the military, civilian women need to be respected and treated with the human

dignity each individual deserves. Many women living in the communities surrounding military bases either work at the bases or regularly mingle, including sexually, with military personnel garrisoned in the area. Sometimes these sexual contacts are a means of personal or familial survival. If the women become HIV-positive, their children can be infected with HIV through mother-to-child transmission or be orphaned when their mother dies from AIDS or AIDS-related illness.

Women who are sexually active with members of the military deserve to be given the opportunity to establish and maintain relationships where safer sex is the norm. Communities, as well, have a stake in protecting their members from life-threatening illness and the risk of HIV exposure through sexual, blood or other routes of transmission that can be avoided through the practice of responsible preventive behaviours.

The rationale for involving both the civilian and military sectors in Civil-Military Project activities was to actively share, through the mutual training opportunities the seminars provided, as much HIV/STI transmission and prevention information and materials as possible. The seminars would be used as a multiplier mechanism through the training of trainers in technical and programmatic strategies for HIV prevention and in advocating appropriate HIV/AIDS/STI policy approaches, depending on which area seemed more urgent and useful to each audience. In fact, it was found that the participants in seminars generally needed both types of information to further disseminate to different audiences for the purposes of individual prevention or policy making.

Forming New Strategic Alliances In order to reach out to as many relevant international agencies as possible, the Civil-Military Project and alliance members proactively sought collaboration with the UNDPKO in 1995. Within its peacekeeping policy requirements, UNDPKO recommends that all militaries supplying United Nations peacekeepers train these troops in HIV/AIDS prevention, that voluntary or mandatory HIV screening be employed prior to deployment, and that military personnel infected with STIs, including HIV, should not be deployed. UNDPKO, to which many sub-Saharan African nations supplies troops, supported several of the project's seminars by sending medical staff presenters who shared their materials and statistics with participants.

Ensuring Primary Prevention The majority of members of the military are heterosexual men, a population generally underserved by HIV-prevention interventions to date. Most of the HIV/AIDS-related attention to military populations has been devoted to policies and testing, whether voluntary or mandatory. While policy and testing are important, especially to the military where physical health is a principal prerequisite for service, these issues do not encompass the overarching need for individual awareness of appropriate measures for primary prevention of STI, including HIV infection. Testing assists in focusing individual efforts on secondary prevention (transmitting STI/HIV to others), but there is an urgent need for all military personnel to incorporate safer sex practices into their daily behaviour for the purpose of primary prevention of STIs, including HIV.

Based on the experience of the Civil-Military Project, the project's implementers recommend the following five key strategies to reduce vulnerability to HIV/AIDS among civilian and military populations:

1. Foster a positive social environment conducive to value change so that changes in sexual behaviour can result.
2. Make a serious attempt to stabilize HIV infection rates and offer to support HIV-positive individuals and their dependents.
3. Minimize the short-term psychological, social, economic and political effects of the HIV/AIDS pandemic on individuals, communities and civilian and military institutions.
4. Counter long-term reductions in standards of living, productive capacities and civil order.
5. Design innovative yet realistic programmes that contain adequate funding provision to maximize their impact on both military and civilian populations.

SUSTAINABILITY OF CIVIL-MILITARY COLLABORATION

After the first two years of successful networking by the Civil-Military Project, a number of additional donors started to provide funds for the civil-military activities the project was convening. The newly organized Joint United Nations Programme on HIV/AIDS (UNAIDS) began to provide funding in 1995 to enable a larger number of sub-Saharan African countries to be represented in project seminars and other events in the region, as well as to allow some

attention to be devoted to other regions, including Asia and Eastern Europe. UNAIDS also provided the expertise (half-time) of one of its Geneva-based physicians to assist the project and the alliance in meeting their mandate as capably as possible. Further more, UNAIDS provided funding for a multi-country francophone African civil-military seminar to take place in the October 1997 after the Civil-Military Project had ended.

Subsequently, under the auspices of the expanded Civil-Military Alliance to Combat HIV and AIDS, the Ford Foundation in the United States began funding some related civil-military activities, and UNAIDS increased its support to the alliance substantially. In addition, the European Union has funded some alliance activities. Perhaps most impressively, on the basis of its leadership and its successful collaboration with UNAIDS, the Civil-Military Alliance was awarded the status of a United Nations Collaborating Centre in 1998.

Several countries have started their own national versions of the Civil-Military Alliance. These include Zambia, which formed an alliance managed by one of the regular presenters at Civil-Military Project workshops in Africa, a female colonel in the Zambian Army. This alliance was based on joint interest reached through consensus in the last Civil-Military Project-supported seminar held in sub-Saharan Africa in 1997. The following year, the colonel gave a presentation entitled “Enhancing training capacities through regional military networking in countries of eastern and southern Africa,” at the XIIth International AIDS

Conference in Geneva, Switzerland, primarily focused on the accomplishments and legacy of the Civil-Military Project on HIV/AIDS. South Africa has also formed its own national alliance, using the networking approach of the Civil-Military Alliance and the activities of the Civil-Military Project on HIV/AIDS as models.

In the United States, USAID, which supported the Civil-Military Project activities and funded research performed by the alliance, continues to focus on military populations as critically important to solidifying progress on international HIV/AIDS prevention behaviour as a normative practice worldwide.

Finally, FHI continues to informally support the activities of the Civil-Military Alliance to Combat HIV and AIDS. During its implementation of the USAID-funded AIDSTECH Project (1987-1991), FHI worked directly with the armed forces in Ghana, starting in 1989. During its subsequent AIDSCAP Project (1991-1997), which launched the Civil-Military Project on HIV/AIDS as a global dissemination vehicle, FHI also worked with the Rwanda Patriotic Army after the war ended and with the Zimbabwe National Army and Airforce of Zimbabwe. FHI is again working directly with the armed forces in Ghana through its five-year USAID-supported Implementing AIDS Prevention and Care (IMPACT) Project, also funded by USAID, which was formed in 1997 a few months after the Civil-Military Project on HIV/AIDS ended.

It is hoped that these individual country efforts as well as the global efforts continuing through the Civil-Military Alliance will coalesce into even more productive interaction among civilian and military populations and lead to

mutual recognition of the commonality of all HIV-prevention efforts: to save lives and improve the well-being of all populations. In mid-1999, the urgency of these international multidisciplinary civil-military joint ventures cannot be emphasized enough. In 1994, the year the Civil-Military Project began, the projected number of HIV infections by the year 2000 was 40 million. That number was surpassed before the end of 1998: in December of that year, UNAIDS estimated that a cumulative total of 47 million people had been infected with HIV. In mid-1999 it is estimated that by the end of the 2000, well over 50 million people will have been infected with HIV since the pandemic began. Clearly much greater and more coordinated attention to HIV/AIDS prevention is needed from all sectors, civilian and military alike.

AUTHORS

Mary O’Grady, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Arlington, Virginia, USA
Norman N. Miller, The Civil-Military Alliance to Combat HIV and AIDS, and Dartmouth Medical School, Hanover, New Hampshire, USA

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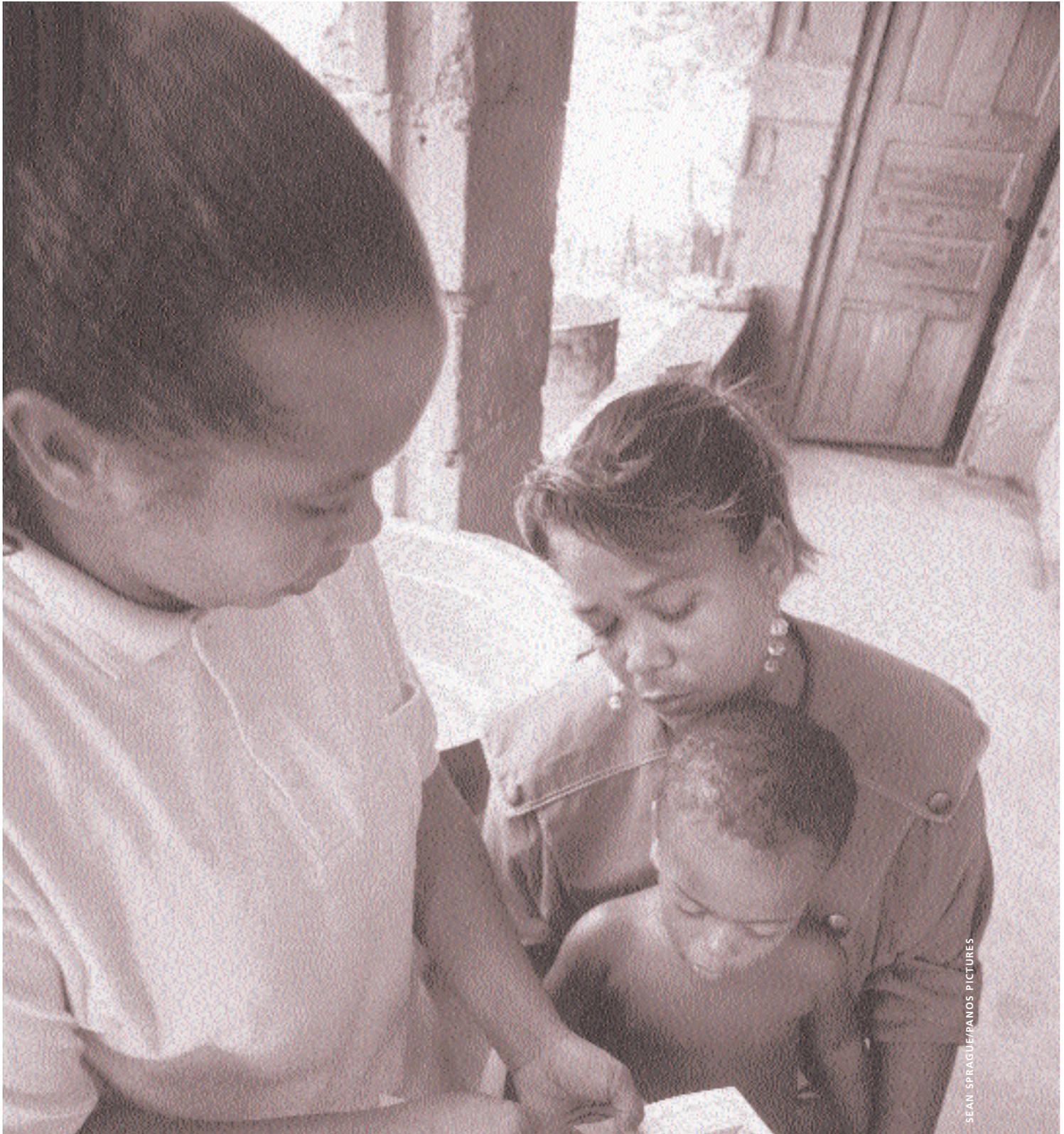
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It has been clearly demonstrated that timely and adequate treatment of STIs during the first patient visit can have a significant impact on the transmission of HIV.



SEAN SPRAGUE/PANOS PICTURES

SYNDROMIC MANAGEMENT TRAINING PROVIDES HEALTH WORKERS WITH THE ABILITY TO TREAT COMMON SEXUALLY TRANSMITTED DISEASES IN PLACES SUCH AS THE RURAL DOMINICAN REPUBLIC.

SYNDROMIC MANAGEMENT TRAINING: PAVING THE WAY FOR THE ADOPTION OF SEXUALLY TRANSMITTED INFECTION TREATMENT NORMS IN THE DOMINICAN REPUBLIC

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SYNDROMIC MANAGEMENT TRAINING: PAVING THE WAY FOR THE ADOPTION OF SEXUALLY TRANSMITTED INFECTION TREATMENT NORMS IN THE DOMINICAN REPUBLIC

INTRODUCTION

Epidemiological analysis of the spread of HIV infections has shown that the primary route of HIV transmission in the Dominican Republic (DR) is sexual. Classic sexually transmitted infections (STIs), which manifest symptoms in the genital area and include syphilis, gonorrhoea, chancroid, herpes, and genital ulcer disease and HIV infection not only share the same predominant mode of transmission, but there is increasing evidence that the presence of an STI increases the transmissibility of HIV infection.

Prior to 1995, the DR public health sector took primarily a clinical approach to diagnosing and treating STIs. In some other health centres, diagnosis and treatment of STIs was based on the etiologic approach because of limited laboratory facilities and non-specialized physicians. There were no adequate national treatment norms, and a system for contact tracing was limited to only one reference centre in Santo Domingo, the capital city. Drugs for treatment were scarce and, when available, were very expensive. STI treatment protocols centred on antibiotics, for which many drug-resistant strains have emerged.

Based on this situation, syndromic management of STIs emerged as the most effective strategy for HIV/AIDS prevention in the DR.

It has been clearly demonstrated that timely and adequate treatment of STIs during the first patient visit can have a significant impact on the transmission of HIV. Thus, training service providers in syndromic management of STIs was crucial in decreasing the spread of HIV in the country.

PROGRAMME DESCRIPTION

In 1994 the local university, Instituto Tecnológico de Santo Domingo (INTEC), and the Dominican Dermatological Institute's STI Centre (CETS) entered into a partnership to implement a training programme on the syndromic management of STIs.

INTEC is considered one of the best universities in the Dominican Republic. It provides postgraduate research and continuing education, has one of the most complete libraries in the country and is linked with several computer networks. In the area of health, it is affiliated with the Federación Panamericana de Facultades y Escuelas de Medicina (FEPAFEM) and the Association of Universities of Public Health Administration (AUPHA), among others. The faculty of health has coordinated development and training programmes in community health with the Inter-American Foundation

and the Pan American Health Organization (PAHO), and it has coordinated health administration training with AUPHA and community health development with UNICEF.

CETS, on the other hand, is a national reference centre and laboratory for HIV/AIDS/STIs and is the foundation for important investigations carried out in the country. CETS has extensive experience in clinical education in STI. Medical and bioanalysis students from principal Dominican universities receive their theoretical and practical training in diagnosing and treating STIs at CETS. In addition, residents in dermatology and gynaecology must spend a three-month rotation in its STI clinics. The institute also has experience in providing speciality and continuing education courses in STIs.

INTEC's role in this project was to coordinate and manage the programme, supplying the necessary training facilities, audiovisual equipment, library and administrative services. CETS coordinated and supplied the necessary laboratory facilities for the clinical training.

This 18-month programme was implemented during 1995–1996 with technical guidance from the University of Washington, Seattle, Washington, USA. Funding and technical assistance was financed by the United States Agency for International Development (USAID) through its AIDS Control and Prevention (AIDSCAP) Project, implemented worldwide by Family Health International (FHI).

The programme had the official endorsement of the National AIDS Control Programme (Programa de Control de Enfermedades de Transmisión Sexual y SIDA, or PROCETS),

the Dominican Union for STI Control (UDOCETS) and the Dominican Medical Association (AMD).

Programme Goals, Objectives and Target

Audience The purpose of the programme was to improve the quality of STI services by training clinicians in the syndromic management of STIs, assuring that supplies and equipment necessary for prompt diagnosis and treatment were available and training non-clinical service providers to encourage STI care-seeking activities, partner referral and medication compliance. While clinics are not usually the most popular places to seek treatment for STIs due to reasons of confidentiality, among others, they were identified as the starting point for this initiative because they were providing STI services to the sub-populations targeted by AIDSCAP and the Dominican non-governmental organization (NGO) implementing its HIV/AIDS prevention programme in the country.

The programme aimed to train 300 clinicians, 500 non-clinicians and 15 laboratory technicians. Clinicians included physicians, nurses, other health care professionals and paramedical personnel providing patient care; non-clinicians consisted of social workers, health promoters, educators, counsellors and NGO staff working in these capacities.

Course participants (clinicians and non-clinicians) were those providing services in support of the NGO programmes financed by AIDSCAP. Other participants were those servicing PROCETS STI clinics, as well as those affiliated with family planning organizations supported by USAID and the Dominican Republic government.

PROJECT DEVELOPMENT AND IMPLEMENTATION

The first task accomplished by INTEC-CETS in developing the training programme was to design course contents and supporting materials. Several physicians from the private and public sectors, who had been trained in syndromic management of STIs and training-of trainers-techniques at the University of Washington, were selected to carry out this task. This training took place in 1993 through the sponsorship of AIDSCAP and the Infectious Disease Society of America. Other noted Dominican professionals, such as psychologists, educators and counsellors were recruited and integrated into the team. The multidisciplinary nature of this group of experts allowed for the development of an integral and cross-speciality training programme.

Courses for clinicians included: human sexuality, STI/HIV epidemiology in the DR, syndromic management of STIs, counselling as part of case management, and training techniques. These courses consisted of one week of theoretical training and one week of hands-on experience in clinic, laboratory and counselling-service provision.

Courses for non-clinicians included didactic training on the clinical manifestations of STIs and HIV/AIDS, counselling, human sexuality and training techniques. The focus of these courses, however, was to enable non-clinicians to recognize STIs and refer people for treatment, stressing messages of prevention and partner notification.

As noted previously, courses for clinicians and non-clinicians were structured to be training of trainers. This enabled them to share what they learned with their colleagues at their home

institutions in the future. Course materials were provided to support this replication.

Some of the programme's training materials were based on existing materials from the World Health Organization (WHO), the Nepal Medical Association and the universities of Nairobi in Kenya and Manitoba in Canada. These materials were reviewed and validated in geographical areas where the training sessions were to take place to assure quality, readability and usefulness in these settings.

Materials produced for clinicians included: a manual describing the complete training course, an implementation guide, a videotape of the course, a set of slides and transparencies used during the course, a pocket-sized card with clinical symptoms and treatment for clinicians describing five major syndromes, informational brochures and updated materials on STIs, condoms, STI drugs, etc. Materials developed and delivered to non-clinicians included a course manual and implementation guide, and supporting information on STIs, condoms and educational intervention techniques.

After the training programme was completed, an STI service referral guide was developed and distributed among all the participants. It includes a list of clinicians and non-clinicians who participated in the training programme and other noted health professionals in the DR utilizing the syndromic approach to STI management in order to facilitate referrals to appropriate and high-quality STI services in the country.

Training sessions were held in five different sites of the country, Santo Domingo, Puerto Plata, Santiago, Barahona and La Romana, where clinical facilities were adequate for training in

CETS clinics. This also facilitated access to training by clinicians established in those geographical areas.

Six months after the initial training, both clinicians and non-clinicians received a second training. The purpose of these “refresher” courses was to update participants on HIV/AIDS issues, given that the knowledge of HIV and the epidemic parameters is continually evolving, and obtain feedback from them on the challenges and constraints they had encountered during the period following the training.

EVALUATION METHODOLOGY

Qualitative and quantitative methodologies were used in this programme to assess progress in achieving its objectives. Progress was assessed using process, outcome and impact measures.

Process Evaluation Evaluation of this training programme was ongoing. Pre- and post-tests were conducted among participants during the initial training as well as the refresher course. The following areas were covered: knowledge of STIs, ability to utilize syndromic management techniques and the use of flowcharts.

Evaluations were also conducted among course participants to assess the overall quality of the courses. This included facilitator performance, schedules, adequacy of physical installations, etc.

Materials produced for training and/or dissemination were always validated with the target audience through focus group discussions during the production process. Their suggestions were incorporated into and guided the final production of materials.

Outcome Evaluation A midterm evaluation conducted in September 1995 showed that participants had attained significant improvements in knowledge about STIs and syndromic management as an approach. This evaluation showed that 84 per cent of participants had total comprehension of the course content.

RESULTS/TANGIBLE OUTCOMES

Training Programme The overall goal and objectives of the STI algorithm training programme were completed and surpassed in a timely and effective manner. A total of 325 clinicians were trained through 15 courses, and 529 non-clinicians through 21 courses. Sixteen laboratory technicians were also trained through the programme. Additionally, 35 refresher courses were offered to clinicians and non-clinicians.

As a result of this specialized training, 25 clinics and posts are participating in STI diagnosis, treatment and prevention using the syndromic management approach.

To improve the ability of participating institutions to deliver adequate STI services, the project strengthened and established CETS clinics of the Dominican Dermatologic Institute (DDI) as the reference clinics for both the referral of complicated cases and as STI-training sites. Furthermore, personnel on all levels of care were educated in the appropriate use of the treatment referral system, which included a telephone guide listing all those involved in providing STI treatment based on syndromic management.

The programme successfully established a standardized methodology for diagnosis and treatment of STIs as an HIV/AIDS-prevention method without relying on elaborate laboratory techniques. Trained service providers have

implemented these new skills throughout the DR where the existing health infrastructure is limited.

One of the biggest challenges of the programme was overcoming the strong resistance by participants to any training. In the DR, there is no tradition of continuing education, especially among physicians. However, the innovative and participatory training techniques used in the programme helped overcome this resistance. Most of those who participated became advocates of STI syndromic management.

The programme itself has evolved into sustainable postgraduate training totally coordinated by INTEC, with a continued link with the DDI's STI Department. The programme also received widespread recognition during presentations made on it at the 10th Latin American Congress on STDs and the IVth Pan American Conference on AIDS in Santiago, Chile, in 1995, and the XIth International Conference on AIDS in Vancouver, Canada, in 1996. Technical assistance provided by the University of Washington throughout all stages of the programme was undoubtedly key to the project's success.

The programme also generated the following important activities and results, which are described in detail:

STI Drugs This programme generated negotiations with the National Essential Drug Programme (PROMESE) for the inclusion and availability of adequate STI drugs. Supplies of drugs as specified for the syndromic approach have been made available at the 410 popular pharmacies, and official drug lists have been modified accordingly. Some health centres have even begun to establish a prepackaged therapy kit for the five syndromes.

National STI Guidelines One of the greatest achievements of this programme was that it opened the way for the adoption of STI syndromic management at a national scale in the Dominican Republic. The country's health authorities have endorsed syndromic management as the national approach for diagnosis and treatment for STIs. National guidelines for syndromic management of STIs were developed and are going through a final revision before implementation.

Other Ministry of Health (MOH) departments have acknowledged the importance of implementing the syndromic management approach to STIs in the Dominican Republic. Such is the case with the Epidemiological Surveillance Department at the MOH, which has changed its data collection system to register syndromes instead of etiologic diagnosis.

BEST PRACTICE CRITERIA

Relevance The DR is a resource-constrained country with a growing HIV/AIDS epidemic and limited technological resources at all levels of the public health system. The adoption of syndromic management as the official approach for diagnosis and treatment of STIs by the Ministry of Health (MOH) is of particular importance. This approach allows for improved STI services, thus making an impact on the HIV/AIDS epidemic.

Efficiency The project was strategic in using national resources efficiently to support implementation. The infrastructure for the theoretical and clinical training consisted of the existing facilities at CETS and INTEC. Training sessions were carried out in five different geographical areas of the country. This not only minimized

the travel and per diem costs for participants, but optimized exposure to different groups and cemented the validity and appropriateness of the training in the country. The existence of adequate and appropriate clinical facilities in these training sites as well as the opportunities for expanding local STI service delivery were also considered when selecting the training sites.

Effectiveness and Impact This programme has had profound impact in expanding the knowledge and skills level of all the trainees. Furthermore, at the time of production of the referral guide over 80 per cent of those trained were actively involved in providing STI management using the syndromic approach.

Even more important is the snowball effect of this training programme: it generated the national STI treatment guidelines (published in 2000), the development of a referral guide and the inclusion of STI syndromes in the newly revised national epidemiological reporting system. Also, the programme has become sustainable through the incorporation of training into the university's portfolio for continuing medical education and the official requirement to include syndromic management training in every project with STI services, regardless of the funding source.

To attain long-term impact related to biological indicators resulting from STI service improvement it is important that the training course be permanently replicated throughout the MOH public health care infrastructure and through residency programmes such as gynaecology and obstetrics, urology, dermatology, etc. Meanwhile, the MOH's National AIDS Control Programme (PROCETS) is currently planning to support the continuation of these courses nationwide. It will

also disseminate the national STI treatment guidelines based on syndromic management.

Due to a lack of resources, assessing the biological impact of this programme was not planned as part of the project. However, a second algorithm validation study may be useful in providing information on the use of the syndromic management approach to STI treatment in the Dominican Republic adopted by PROCETS based on this initiative. Without a doubt this training programme has made an impact on the spread of HIV in the DR, despite not having had the opportunity to put a system in place to quantify such impact.

Sustainability INTEC has fully incorporated syndromic management training into its medical curriculum, and it gave academic credits to physicians who completed the training. The project is now sustainable at a low cost since the materials have been developed and produced in Spanish already, and a cadre of trainers have been trained to train others. In addition, both INTEC and CETS have furthered their institutional links with other projects, based on this initial joint venture with the AIDSCAP Project.

Through the technical assistance provided by the University of Washington, a considerable transfer of expertise and skills took place in the DR and remains with Dominican professionals who are committed to improving STI services in the DR. The training programme not only trained a core group of highly capable professionals, but also helped to develop a committed group of advocates to assist with overcoming the obstacles to institutionlizing syndromic management as an appropriate STI treatment approach in the Dominican Republic.

From day one of this initiative, it received the support of PROCETS. Further, after the AIDSCAP Project ended in the DR, PROCETS reached agreement with a Dominican NGO to further STI syndromic management outreach and clinical service provision in the country.

LESSONS LEARNED

The institutionalization of the syndromic management approach to STI treatment requires a long-term commitment and continuous support. Institutional support is necessary to overcome health care provider resistance to obtaining additional training in a country where continuing medical education is not customary.

The routine dissemination of current, local data on STI trends can be instrumental in maintaining clinician interest in STI programmes. High turnover of clinic personnel is an additional reason why continual training is necessary to maintain adequate STI management services.

Syndromic management training also needs to be implemented for pharmacy clerks to be able to provide appropriate STI treatment to individuals not seeking clinical services.

Algorithms and risk assessments for the syndromic management of STI can be effectively modified for individual countries. STI monitoring needs to become a regular programmatic service provided by a good referral facility to observe and direct appropriate action to the development of antibiotic resistance as well as maintain national standards for adequate treatment of these infections.

Systematic STI data collection to guide decisions is key to developing more solid programmes and gaining physician endorsement

and involvement with continuing this programme successfully in the future.

AUTHORS

Martha Butler de Lister, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Santo Domingo, Dominican Republic

Tanya de Morales, AIDSCAP Project, Family Health International, Santo Domingo, Dominican Republic

Miguel Suazo, Intec University, Santo Domingo, Dominican Republic

Rafael Alcantara, Instituto Dermatologico Dominicano, Santo Domingo, Dominican Republic

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In resource-constrained settings, a local drug seller can play a pivotal role in selling and dispensing essential drugs to the public in need and thus play an important dual role in furthering STI and HIV prevention.



MARY O'GRADY/AIDSCAP, FAMILY HEALTH INTERNATIONAL

A YOUNG HIV PREVENTION OUTREACH WORKER IN NEPAL REFERS WOMEN TO PHARMACISTS WHO CAN PRESCRIBE TREATMENTS FOR SEXUALLY TRANSMITTED INFECTIONS BASED ON THEIR TRAINING IN STI DIAGNOSIS AND TREATMENT.

CHEMISTS SERVING THEIR COMMUNITIES TO PREVENT SEXUALLY TRANSMITTED INFECTION TRANSMISSION IN NEPAL

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CHEMISTS SERVING THEIR COMMUNITIES TO PREVENT SEXUALLY TRANSMITTED INFECTION TRANSMISSION IN NEPAL

INTRODUCTION

Since 1994 the Himalayan Kingdom of Nepal has been the focus of a number of innovative HIV/AIDS and sexually transmitted infection (STI) interventions with funding from U.S., European and multilateral development agencies. International and local nongovernmental organizations (NGOs) have also committed significant resources to HIV-prevention initiatives—all in collaboration with the national HIV control strategy.

Nepal is recognized as a nation well situated for a potential HIV/AIDS pandemic in Asia. Sandwiched between China and India, Nepal remains a nation of limited economic opportunities, with an undeveloped national infrastructure. Nepal's economy is intertwined with that of its southern neighbour, India, in trade, employment and regional migration. Such migration includes the ongoing flow of male labourers and the trafficking of young women from the hills of Nepal to the large urban centres of India, including for commercial sex.

While HIV prevalence continues to grow at an alarming rate in pockets of southern Asia, a number of organizations actively work to prevent a national health catastrophe in Nepal. One of these, the Nepal Chemists and Druggists

Association—the nation's largest membership association of retailers—has tested an STI/HIV prevention model that may be relevant to other health providers, health service associations, national-level pharmacy organizations or retail-sector organizations interested in community-level STI/HIV prevention. This case study examines the country context, the epidemiology, the pilot project, the results and the lessons learned and best practices from the Nepal Chemists and Druggists Association's STI/HIV/AIDS Prevention Education Strengthening Initiatives for Chemists Project, which was implemented from January 1995 to December 1996 in Nepal's Central Development Region.

BACKGROUND

HIV and STIs in Nepal Nepal's first AIDS case was detected in a foreign visitor in 1988. By early 1993, the Nepal government reported a total of 124 HIV infections. As of January 1995, this number had increased to 235 infections, and in December 1996, Nepal's National Centre for AIDS and STD Control (NCASC) reported a total of 468 HIV infections and 82 AIDS cases in the country. The majority of infections are detected in people aged

20 to 29, and sexual transmission is the predominant mode of transmission.

Nepal's HIV/AIDS coordination agency, the NCASC, has maintained a national HIV sentinel surveillance (HSS) system since 1991. Through 1996, HSS data indicated relatively low HIV prevalence (averaging one per cent or less) among the highest risk groups (STI patients). Since then, a study by the NCASC and the European Union's University of Heidelberg STD/HIV Project reported an HIV prevalence of 0.2 per cent among women attending antenatal clinics in four urban sites. The Nepal Red Cross reported the 1996 HIV-prevalence rate among blood donors to be close to 1/1000 (39/42,500), a three-fold increase over the rate calculated from the previous year's blood donor data. With these trends, the Nepal data suggest that the HIV epidemic in Nepal is growing, but at a slower rate than HIV epidemics in other regions of South and South-East Asia.

Based on Nepal's limited data, HIV projections for Nepal indicate up to 10,000 HIV infections as of late 1994, increasing to 15,000–20,000 in 1996. Estimates for 2000 among the adult population range from a conservative projection of 22,012 to a moderate projection of 44,024 and a high scenario of 88,047.

Like its HIV surveillance system, Nepal's collection and reporting of STI data remain weak. Prior to the threat of HIV/AIDS, Nepal's public health system had paid little attention to the epidemiology of STIs. As a result, no national STI reporting or surveillance system is in place. However, a number

of project-based surveys show high STI rates among high-risk groups, particularly female sex workers. STIs reported in Nepal include both ulcerative and non-ulcerative STIs: gonorrhoea, syphilis, chancroid, genital herpes, genital warts and granuloma inguinale. Urethritis and genital chlamydial infection are commonly reported by both public and private clinics. The common term for all STIs (ulcerative and non-ulcerative) is "bhiringi."

Health care delivery in Nepal: the traditional approach Nepal is ranked as one of the world's most impoverished countries. With a 1996 population of 21 million, Nepal is growing at a rate of 2.4 per cent per year. Per capita income is US\$200, and the nation's literacy rate is 28 per cent. Nepal's economy is largely rural and agricultural, and 91 per cent of the population resides in rural areas. The country's health care delivery system inversely reflects its national urban-rural bias. Nepal's urban minority—particularly those living in the capital city of Kathmandu—have access to the nation's highest quality health services. Kathmandu and the major cities of Biratnagar, Birgunj, Nepalgunj, Pokhara, Mahendranagar, Bhairahawa, Butwal and Bharatpur offer a range of government and private-sector curative and preventive care services. In 1996 Nepal had a total of 114 hospitals, 4,848 hospital beds and 852 licensed physicians. Although theoretically there is one physician per 25,000 population, in reality, more than 95 per cent of physicians practice exclusively in urban areas. To help meet the needs of the rural majority, the Ministry of Health operates health posts and sub-health posts staffed by

paramedics, staff nurses, nurse-midwives and other community health workers.

Overall, Nepal's rural primary health care is substandard. Management is weak, staff shortages continue, employees are under-skilled, and the system is plagued with grossly inadequate equipment and budgets. In addition, the government often experiences acute shortages of essential drugs in the rural areas. Rural patients travel long distances by foot or public transport to reach a health post and, once there, wait hours for service. The ratio of health posts is one per 27,450 population.

Public use of government health facilities in Nepal is generally high because most people cannot afford private-sector services. Private practitioners do offer services in clinic settings, but the only patients using these services are those able to afford the clinician fee plus laboratory and treatment costs. In general, men and women seeking STI services in the public sector visit these providers only as a last resort. Few patients seek routine STI treatment in health posts or district hospitals. The government's best quality STI services are provided by venereological/dermatological specialists working in the skin/VD departments in central or regional hospitals, but even these facilities fail to attract large numbers of patients. Generally, cases seen in the skin/VD clinics are difficult-to-treat patients. Patients able to afford quality services prefer to visit a specialist in a private clinic.

In Nepal men and women with STI symptoms prefer to seek services in informal or private settings. These may include a private venereologist, a general practitioner,

a chemist or an informal practitioner. Some prefer to self-treat or to seek advice from friends or relatives and use allopathic medicines, herbal medicines or other home remedies. Many Nepalese women ignore their STI symptoms and continue living with chronic STIs.

STI health-seeking behaviour A number of donor-funded HIV/AIDS and STI projects have conducted qualitative and quantitative research on issues of STI/HIV knowledge, attitudes, related practices and associated health-seeking behaviour among those at risk.

In 1994 the Kathmandu-based organization New ERA conducted a baseline study of female sex workers (FSWs) and their clients working along Nepal's major national highway to survey STI/HIV knowledge, attitudes and practices. Key findings showed that of clients visiting an FSW in the previous year, 68 per cent reported making such visits on at least three occasions. Thirty-four per cent of the clients reported condom use during their most recent sexual contact, and 35 per cent of FSWs reported condom use during their most recent sexual encounter with a client. Three-quarters of the clients and 53 per cent of the FSWs understood HIV transmission. Only one-third of the clients, but more than half of the FSWs, claimed no knowledge of a measure of protection from HIV. Among those reporting exposure to condom advertisements, 57 per cent of the clients and 31 per cent of the FSWs were aware of the protection condoms provide against STIs. Sixteen per cent of clients reported using condoms with their wives, and half of them

said they used condoms with other female sexual partners. More than three-quarters of the clients and 55 per cent of the FSWs reported seeking treatment when they experienced STI symptoms. For both clients and FSWs, the preferred source of treatment identified was a private clinic or a chemist shop (pharmacy).

In 1996, the NCASC's University of Heidelberg STI/HIV Project conducted an ethnographic study of community perceptions and attitudes toward STIs and HIV/AIDS among labourers, students, police, health personnel, businessmen, rickshaw pullers and housewives in two district capitals. The study found a high awareness of "bhiringi" and HIV/AIDS among the respondents, as well as an understanding of the role of multi-partner sex in the transmission of HIV. Respondents were also queried on where they preferred to seek treatment for "bhiringi." Overwhelmingly, chemists, shopkeepers and paramedical providers were identified as the preferred treatment source. These services were reported to be more friendly and convenient. Only in the event of unsuccessful treatment did respondents seek hospital-based services.

Another study performed by New ERA in 1995, *A Qualitative Study of Chemists Shops on the Land Transportation Routes from Naubise to Janakpur and Birgunj*, assessed the quality and quantity of STI services provided by chemists in 34 chemist shops serving rural-highway clients. The chemists reported that approximately 60 per cent of their STI customers in the previous month were male and 40 per cent

were female. Sixty-eight per cent of STI customers would visit the chemist shop without a physician's prescription. Chemists reported dispensing a variety of drug treatments for STIs, including quinolones, penicillin, norfloxacin and alkalizing agents for genital discharge, and antiseptic ointment, penicillin injection, norfloxacin, ampicillin and ciprofloxacin for genital sores. Half of the chemists reported providing advice or counselling to their STI customers, including advice on proper condom use.

AN ALTERNATIVE STI SERVICE DELIVERY OPTION: NEPAL'S COMMUNITY CHEMIST

Nepal's non-formal health delivery sector offers an important alternative health delivery channel for the treatment and prevention of STIs. With at least 8,000 chemist shops nationwide, Nepal's retail pharmaceutical sector boasts a chemist shop–customer ratio of 1:2,600. Large numbers of chemist shops are found in urban communities, and most rural communities have at least one chemist shop.

In a Nepali village, people tend to first go to the neighbourhood chemist for family health services. A chemist shop is convenient, friendly and more affordable than other health services, and it provides timely service. The local chemist dispenses drugs with a prescription or directly, based on his or her knowledge of allopathic medicine. Often the community chemist is the first and only point of encounter for modern health care in a Nepali village.

To become a registered chemist, one must successfully complete a 72-hour, 21-day

continuing education programme, “Orientation Course for Drug Retailers and Wholesalers,” managed by the Nepal Chemists and Druggists Association (NCDA) on behalf of the Ministry of Health’s Department of Drug Administration (DDA). This course is open to secondary school graduates and provides basic pharmaceutical knowledge, including common drugs, drug storage and management, drug doses, proper dispensing practices, adverse reactions and contraindications, and drug ethics/law. The course does not address issues of sexuality, safer sex or STI prevention and treatment. As sexuality and sex education have only recently been integrated into Nepal’s secondary school curriculum, the majority of the country’s estimated 21,500 chemists have limited understanding of STIs and sexuality issues.

Approximately 65 per cent of Nepal’s chemists are full-time chemist shop owner-operators. These chemists serve customers on a full-time basis and are usually assisted by a spouse, sibling or other immediate family members. Rural chemist shops operate for 10 to 12 hours per day, and urban chemist shops are usually open up to 15 hours per day, with several shifts. Generally the primary chemist is available during the busy early morning hours and the late afternoon or evening. Often female chemists or assistants work the slack mid-day sales period. This time slot, when the chemist’s wife is available at the sales counter, is usually the preferred time for women to visit a chemist shop.

About 35 per cent of Nepal’s chemists work the profession in a “moonlighting” capacity during the afternoon and evening hours after

the close of their day-jobs at local health posts, hospitals or NGO clinics, where they may work as paramedics, nurses or physicians. As these “chemist-providers” have completed specialized public health training, they are regarded as Nepal’s most highly skilled chemists. However, many still lack basic training in STI prevention. Moreover, while the chemist-providers are working at their full-time jobs, their pharmacies are staffed by family members or employees who may or may not have any public health or chemist training.

Rural chemist shops in Nepal sell a stock of general allopathic medicine. Approximately 23 per cent of the medications are produced domestically, with the remainder imported from India. Chemist shops sell complementary health and nutrition products and maintain the distinction of being the primary sales outlet for condoms (including the Nepali socially marketed condom brands *Dhaal* and *Panther*, as well as other Asian imports).

Chemist shops are generally located in commercial centres nationwide. In small urban communities, chemist shops are usually located near government health facilities and transport-commercial hubs (bus stations, rickshaw stands or the central bazaar). In rural communities, the shops are found in the central bazaar or alongside a main access road or walking trail. Chemist shops remain open 7 days a week and are known to provide a variety of services, including drugs by or without prescription, informal advice and counselling and consultation-examination.

Chemist “consultations” are free of cost to the customer (the chemist’s remuneration being the profit from drug sales), thereby

making a visit to the chemist more affordable than a consultation with a private doctor. In a larger urban community, a physician or paramedic will often operate a small clinic inside or adjacent to a popular chemist shop.

The retail drug business offers a lucrative business opportunity in Nepal. When government drug supplies run out at the community health post, the chemist is the only available source of allopathic medicine in the area. Chemist shops in mountainous regions often serve a vast geographical area, with a multitude of customers from distant mountain villages. Not surprisingly, retail drug management is both a financially rewarding and popular occupation. Shop owners often serve a dual role as health provider and commercial/social leader in Nepali villages.

The chemist shop in Nepal remains a unique public health service delivery site. It serves as a private-sector alternative to government services, with a reliable drug distribution network and accessible, consumer-friendly services. However, although health sector policy makers recognize the opportunities and advantages of Nepal's retail drug sector, a number of weaknesses and constraints remain to be addressed. A Nepali chemist's first priority is his or her business interests: maximizing sales and profit. Chemists have the reputation of over-dispensing medicines to ignorant customers and selling ineffective medicines and health products. Nepali chemists often fail to use opportunities to educate their customers at the shop counter, such as sharing simple health-promotion messages or actively promoting the sale of inexpensive socially marketed condoms.

A PILOT INTERVENTION TO STRENGTHEN DISPENSING PRACTICES OF COMMUNITY CHEMISTS

Recognizing the need and the potential for improving chemists' dispensing of STI medications and STI/HIV prevention services to Nepal's high-risk communities, the Nepal Chemists and Druggists Association joined forces with the NCASC and Family Health International's AIDS Control and Prevention (AIDSCAP) Project in 1995 to pilot an intervention, the "STD/HIV/AIDS Prevention Education Strengthening Initiatives for Chemists Project." The NCDA project was one of numerous targeted interventions in a mutually-reinforcing HIV-prevention strategy managed by AIDSCAP with funding from the United States Agency for International Development (USAID).

The primary objectives of the NCDA project were to strengthen the role of chemists in the prevention and control of STIs, including HIV/AIDS, particularly as educator, emergency case manager and condom promoter to customers at risk.

Also recognizing the potential role of chemists in STI/HIV prevention and control, the NCASC and the Department of Drug Administration (DDA) provided the NCDA the authority to pilot an untested approach, the training of chemists in the government-sanctioned STI case-management method. In 1994 the NCASC completed and distributed its first national STI case-management guidelines. The Nepal Medical Association (NMA) was one of the first national health organizations to develop a training curriculum for physicians based on the national guidelines. The NMA

training package and the lessons learned from training physicians served as the starting point for developing a practical approach to train community chemists.

Developing the curriculum The NCDA began by appointing a project steering committee, or technical advisory group (TAG), to guide the development and technical quality of the training curriculum and programme. While the NCDA had more than a decade of experience managing its 21-day drug orientation course, the association lacked specific expertise to develop and manage an STI-prevention and treatment initiative. The TAG was appointed at project start-up and continued to serve in a critical advisory role throughout the life of the project. TAG membership included:

- the director of the Department of Drug Administration
- the director of the National Centre for AIDS and STD Control
- the president of the Nepal Medical Association
- Nepal's senior dermatologist/venereologist
- the senior professor of pharmacology from the national university
- additional supportive physicians
- training/curriculum specialists
- AIDSCAP's STI advisor
- AIDSCAP programme management staff
- NCDA staff and member-volunteers.

To better guide curriculum development, the TAG next identified a curriculum development committee to actually draft the tailored curriculum focused on the needs of Nepali chemists. Using the Nepal Medical Association's

field-tested "STD Case Management Training Package for General Practitioners" as the base, NCDA's Curriculum Development Committee began a lengthy process of developing and refining a comprehensive but understandable curriculum for community chemists with secondary- or post-secondary-school education. The draft curriculum was reviewed and critiqued by the TAG, revised and translated from English into Nepali. Finally, the curriculum was pretested with a group of 20 chemists in Kaski district, which is outside the project intervention area.

The pretest of the draft training package was a critical step in curriculum development. Material understood by health care workers was not understood by chemists. The chemists also found the language of STIs—primarily sexual terms and descriptions—difficult to comprehend and discuss freely. Following the pretest, the curriculum was again revised and organized into a training package complete with training workbook, modules, overheads and a handout manual.

NCDA's training aimed to strengthen the dispensing practices of chemists in STI-treatment services and prevention education utilizing the Ministry of Health's official national STI case-management guidelines. The syndromic approach recommended in these guidelines allows health care workers during a single visit to effectively manage patients who have STI symptoms without sophisticated laboratory tests, specialized skills or equipment.

The NCDA initially identified the syndromic approach section of the curriculum as "The Three Major STI Syndromes and

Medicines.” Members of the TAG representing Nepal’s medical community felt that the proposed curriculum presented the authority of prescription. To satisfy the concerns of the medical community, the Ministry of Health and the NCDA negotiated a compromise among all the concerned parties with a change in the title of the session to “Three Major STI Syndromes and Medicine Prescribed by Doctors.” Effectively, this was a simple but workable compromise between the physician’s rule of prescription and the NCDA’s motto of training.

Training of trainers To manage a training programme covering a 450-kilometre-long geographical area in the Central Development Region, the NCDA hired a project coordinator from within its own ranks. A full-time administrative assistant also was hired. Everyone else who assisted in project implementation was hired as a short-term consultant or provided voluntary assistance free-of-charge to the project. The core NCDA trainers were a team of three “master trainers” with years of pharmaceutical and orientation-training experience.

Initially, all the trainers lacked specific STI-training expertise. This is because the NCDA felt it best to develop the capabilities of its own membership to deliver training among NCDA peers at the district level to ensure the sustainability of this education programme within its association.

Prior to the launch of the field training, the NCDA master trainers organized a four-day “training of trainers” (TOT) residential workshop to orient and train new “novice trainers.” Key topics in the TOT curriculum

included training methodology, curriculum content and practice training sessions. The majority of the novice trainer candidates were chemist-providers and NCDA zonal branch leaders from the Central Development Region. The NCDA’s objective was to train these local leaders to serve as peer trainers alongside the master trainers throughout the pilot project.

Planning Planning and logistics management were crucial to the success of the field training. The NCDA began by conducting a survey of all potential chemist participants to be invited to the workshops. While the NCDA zonal branches maintain membership lists for their respective zones, the NCDA felt it necessary to update these lists and also to identify other chemists (non-NCDA members) serving the public in the intervention communities.

The chemist survey provided the information needed to effectively plan the training workshops. It enabled NCDA to:

- locate appropriate training sites (halls, hotels or public buildings)
- identify transportation options
- schedule training sessions in accordance with local needs (considering weather conditions, holidays and local business standards).

The curriculum The NCDA’s final training curriculum was developed with the primary objective of improving the dispensing practices of chemists in STI treatment services and STI/HIV-prevention education. The final approved curriculum covers seven major topics in a two-day training format.

SIDEBAR 1

Outline of the Nepal Chemists and Druggists Association Curriculum

Unit 1 Introduction To Workshop

- Part A
 - Introduction to the Project
 - Objective of the Training
 - Part B
 - Objective of the Introduction Session
 - Group Introductions
 - Introduction to Curriculum
 - Ground Rules
 - Pretest
-

Unit 2 Introduction To Sexually Transmitted Infections

- Male and Female Reproductive Anatomy
 - What Are STIs?
 - Signs and Symptoms of STIs
 - STI Syndromes
 - Consequences of STIs
 - Relationship Between STIs and HIV/AIDS
-

Unit 3 Introduction To HIV/AIDS

- What Is HIV/AIDS?
 - How HIV Is Spread and How It Is Not Spread
 - Signs and Symptoms of HIV/AIDS
 - Some Facts About HIV/AIDS
 - Why the Focus on Chemists
 - The Wildfire Exercise
-

Unit 4 Communication Skills And Health Education

- Part A
 - Attitudes and Beliefs
 - Behaviours that Can Make a Client Feel Uncomfortable
 - Communicating Effectively with Clients
 - Part B
 - Basic Health Education Messages (The 4 Cs)
 - Ways to Improve Patient Compliance
 - Reasons for Noncompliance with Drug Treatment
 - Ways to Improve Clients' Health Consciousness
 - Assisting Clients with Partner Notification
-

Unit 5 Three Major STI Syndromes and Drugs Doctors Prescribe to Treat Them

- Part A The Three Major STI Syndromes
1. Urethral Discharge in Men
 2. Vaginal Discharge in Women
 3. Genital Ulcer Disease in Men and Women
- Part B Drugs Prescribed for the Treatment of STIs
- Part C Contraindications and Potential Side Effects
- Part D A User's Guide to Client Education Checklists

Unit 6 Condoms And Social Marketing

- Advantages and Disadvantages of Condoms
- Correct Condom Use and Condom Demonstration
- Shelf Life of Condoms
- What Is Social Marketing?
- The Social Marketing Approach
- The Role of Chemists in Social Marketing

Unit 7 Ethical And Correct Drug Dispensing Practices

- Inappropriate Behaviours Related to Drug Use
- Inappropriate Behaviours of Drug Retailers and Wholesalers
- Inappropriate Behaviours of Consumers
- The Problems of Antibiotic Resistance
- Consequences of Antibiotic Resistance
- Factors that Encourage Inappropriate Drug Dispensing Behaviours

Unit 8 Closing

- Post-test
- Evaluation
- Certificate
- Closing
-

In addition to improving chemists' dispensing practices, the training package seeks to encourage the individual chemist to improve the quality of health education communication provided to his or her STI customers and to other non-STI pharmacy customers. The chemists learn to stress the "Four Cs."

SIDEBAR 2

The Four Cs

Compliance

Educating customers on the importance of completing the entire dispensed treatment.

Counselling/education

Providing basic information on STI/HIV transmission.

Contract Tracing

Encouraging STI customers to inform their sexual partners of a suspected STI and to seek immediate treatment.

Condom

Educating customers about condoms and condom use.

The curriculum provides detailed information on the three most common STI syndromes in Nepal: urethral discharge in men, vaginal discharge in women and genital ulcers in men and women. The chemists are introduced to the Nepal-specific syndromic flow charts adapted by the NCASC from the World Organization's (WHO's) standard STI flow charts. The training sessions includes information about common

etiologies and complications, instructions on the use of the flow chart, a clinical slide show and simple case-study discussions.

The NCDA training workshop also introduces chemists to the national STI case-management guidelines. Chemists are advised to sell only the drugs recommended in the guidelines to their STI customers. When in doubt about a physician's STI treatment prescription, the chemist is urged to consult the national guidelines as the definitive treatment protocol. Another important message included in the training package is a section on professional ethics and the obligation of chemists to refer customers to a qualified physician or health care provider when in need.

Training participants Over the two-year project, the NCDA trained a total of 579 chemists who participated in 22 two-day workshops in the Central Development Region. The chemists trained represented a majority of the chemists situated alongside Nepal's major cross-country highway, as well as key chemists located close to bus stops and urban health facilities or in high-risk urban communities in Nepal's busy cross-border towns.

Of the total chemists trained, 89 per cent were male and 11 per cent female. Sixty-nine per cent work as full-time chemist-owners, and approximately 31 per cent fill dual roles as full-time health care providers in the formal health care system and part-time chemists in a shop.

While the NCDA target was the private, non-formal health sector, it is important to

note that the government health system was a direct beneficiary of NCDA's skills development programme. Twenty-two per cent of the training workshop participants were full-time Ministry of Health staff.

Evaluation of the NCDA pilot: a simulated client survey Since few chemist STI intervention projects have been attempted in developing countries and even fewer studies have been conducted to assess the impact of such interventions, a determination was made during project design to conduct an external evaluation of the NCDA pilot. New ERA, a Kathmandu-based non-profit research organization with long experience in social and public health research, was contracted to manage this evaluation on behalf of the NCDA and AIDSCAP. The simulated client method of data collection (or "mystery shopper") approach was used to assess changes in chemists' dispensing practices, condom promotion, partner notification and physician referral for the syndromic treatment of men with urethritis.

Due to the nature and sensitivity of the subject matter, all parties agreed that a direct survey methodology would be an ineffective means of assessing the intervention. The simulated survey provided an alternative method of gathering information on sensitive issues in difficult field settings. Pre- and post-intervention surveys were conducted in late 1995 and early 1997 respectively. Ten research staff served as the simulated clients. Their job was to visit chemist shops and to meet only with male chemists to seek treatment for complaints representative of urethral discharge.

Each simulated client was trained to "act out" the same scenario during each visit. The simulated client conversation guideline was the following:

I am a married male. About 2 weeks ago I had unprotected sex with a "friend." One week ago I noticed a thick white discharge from my penis. I have also experienced a pain and burning sensation while passing urine. I do not have any sores or itching. I have had sex with my wife since this contact with my "friend."

The simulated clients were instructed to purchase all of the medications and items (condoms or other pharmaceutical items) recommended by the dispensing chemist, but were specifically instructed to request only part of the recommended dosage. The simulated clients were also instructed to avoid any and all injections or physical examinations. The researchers were trained to carefully monitor the chemist's reactions to determine whether the chemist was at all suspicious of the "mystery shopper."

Immediately after the chemist-client interaction, the simulated client was interviewed by a research colleague in a private location using a semi-structured questionnaire. Information recorded in the questionnaire included:

- the name of the drugs dispensed
- the price of the drugs
- the drug doses
- the chemist's reaction to the request to purchase an incomplete treatment
- any encouragement to purchase a condom

- any other questions asked by the chemist of the client's symptoms
- further communication concerning treatment, condom promotion, partner notification, advice on STI/HIV or referral to a physician.

A total of 160 chemist interactions were included in the survey. New ERA selected its baseline survey chemists from a stratified random sample generated from the NCDA's list of targeted chemists and shops. Chemists identified for the post-survey were those included in the baseline survey and positively identified as NCDA trainees by NCDA

records/photo documents. Due to the timing of the training workshops, chemists included in the post-survey had been trained by the NCDA anywhere from one to nine months prior to the survey.

New ERA analyzed the data using the Statistical Package for the Social Sciences (SPSS). Data on the drugs sold to the simulated clients were coded according to antibiotic and non-antibiotic categories. The appropriateness of the dispensed drugs was then determined according to the NCASC and WHO treatment guidelines.

The simulated client survey found that

SIDEBAR 3

Key Findings of New ERA's Simulated Client Survey

- About 81 per cent of the chemists in both the baseline and follow-up surveys suggested medications to treat STIs.
- Approximately 45 per cent of the chemists in the post-survey suggested the correct medications and correspondingly correct dosages for urethral discharge, compared to less than 1 per cent in the baseline survey.
- In the baseline survey only 14 per cent of the chemists suggested condom use to their customers. This increased to 23 per cent in the follow-up evaluation. The proportion of chemists actually selling condoms remained low, with no change after the training.
- While only five per cent of the chemists in the baseline survey suggested STI treatment for sexual partners, after training partner referral increased to approximately 21 per cent.
- Only three per cent of the chemists in the baseline survey advised their customers to consult a physician if not cured by the recommended STI treatment. Following training, physician referral increased to 16 per cent.
- The average cost of the suggested medications decreased from 193 rupees in the baseline survey to 137 rupees in the evaluation survey.
- Chemists' retention of the training curriculum content and the prevention education messages substantially decreased after a period of three months following the training. This suggests a need for refresher and complementary training initiatives by the NCDA.

the proportion of the chemists recommending the correct drugs or treatment regimen to a client with complaints of urethral discharge increased from less than one per cent to 45 per cent. This is a particularly important result because effective STI treatment has been shown to reduce the transmissibility of HIV. Clearly the training also had a positive impact on chemists' communication and counselling of customers. At the same time, the training had little impact on the sale of condoms along with STI medication.

Overall, the results indicate that STI services provided by community chemists can be significantly strengthened with targeted, short-term training interventions. As a professional network and support organization for retail chemists nationwide, the NCDA has an obligation to continue providing its continuing education in STI treatment and prevention. Moreover, the NCDA and the chemist community play a crucial role in the response to HIV/AIDS in Nepal.

LESSONS LEARNED AND BEST PRACTICE CRITERIA

The Nepal Chemists and Druggists Association's experience as a significant STI and HIV/AIDS prevention partner in Nepal has been an enormous challenge for the association. From the beginning, the NCDA used every opportunity to test approaches, implement revised activities, and then stop and assess its small successes as well as its failures. The following summary of key lessons learned by the NCDA and associated best practices should be considered by any organization planning an educational intervention with retail drug sellers.

Promoting STI/HIV/AIDS Prevention through Non-Clinical Service Outlets

Case management of STIs exclusively through clinical settings is not possible in a resource-constrained nation such as Nepal. Using the NCDA's network of community-level retail drug sellers to manage STI cases at the first point of encounter proved to be a successful alternative.

Soon after HIV/AIDS was reported in Nepal, public health planners in Nepal recognized the importance of promoting STI case management through all potential public and private-sector channels. In resource-constrained settings, a local drug seller can play a pivotal role in selling and dispensing essential drugs to the public in need and thus play an important dual role in furthering STI and HIV prevention.

Forging Linkages for Efficient Programme

Delivery It would have been impossible for the NCDA to conduct this pilot project alone. To succeed the NCDA had to adopt a strategy for strengthening the association's relations with knowledgeable groups already working in the sector. These included NGOs, other health professional organizations, government organizations and Nepal's top STI experts. The NCDA worked very hard to cultivate its relationships with the Nepal Medical Association and national STI specialists by directly involving them in programme planning, curriculum development, pretesting and field-based training.

Project resources were used strategically and effectively by NCDA project planners and managers. The NCDA also contributed

significant resources—particularly senior-level volunteers—from within the association during the development and implementation stages. In addition, the NCDA tapped a variety of high quality material and technical assistance resources for use in curriculum development and training. Instead of “reinventing the wheel,” the NCDA adapted materials developed by the Nepal Medical Association, NGOs and association colleagues. The NCDA relied heavily on the contributions of public health educators and practitioners experienced in STI and HIV control during the design and monitoring phases of the project. Likewise, at project completion the NCDA shared its final training curriculum with the National Health Training Center and other health-sector associations and projects interested in STI syndromic management.

Adding Value through International Technical Assistance Programme planning and content development was shaped and influenced by hands-on technical assistance from international STI experts. AIDSCAP’s STI advisor and other seasoned professionals were crucially important in guiding the technical content, evaluation techniques and the application of complementary experiences from other Asian countries.

Sanctioning the Syndromic Approach Nationally The sanctioning and promotion of the national STI case-management guidelines by the Ministry of Health, the WHO, the Nepal Medical Association and other national public health leaders paved the way for NCDA to pilot a new and innovative approach to private-sector STI-service delivery.

Giving Full Consideration to Professional Interests As the NCDA is a professional, membership organization comprised of a variety of members from the pharmaceutical business community, it was vital that association and membership interests and priorities were given careful consideration in programme design. At the local level, chemists can serve as influential leaders on issues of health, commerce and social welfare. At the national level, change in association leadership can have a positive or negative effect on programme strategies and association investments. For example, a newly elected association president may consider STI training to be insignificant in regard to an association’s business interests. Issues such as these must be addressed in programme design and over the longer term for effective and sustainable programme implementation.

Using Marketing and Attention to Detail to Attract Training Participants Initially, it was extremely difficult to cultivate much enthusiasm among community chemists to participate in a two-day training workshop on STIs and HIV/AIDS. Sitting in a training hall for two days means a significant loss of sales. Once the NCDA’s training reputation was established, however, the training was regarded as a valuable skill-building opportunity. In some districts the NCDA had a waiting list of interested candidates.

For training workshops to be successful, it is essential that close attention be given to each and every aspect of a workshop in addition to technical content. Such aspects include session scheduling, start-up time, the availability of public transport or need for accommodation,

proper lighting and air conditioning, the need for back-up power, refreshments, quality materials as hand-outs, and other attractive educational materials and giveaways.

Targeting Content Culturally Acceptable to the Community At the completion of the pilot project, the NCDA convened a special workshop for all the active novice trainers to assist the association in finalizing the end-of-project training package. Participants revealed that the two most important training modules were: (1) the one on STI syndromes; and, (2) the “Wildfire” Exercise. The module on STI syndromes provided the core technical content of the workshop, while the wildfire exercise served as the essential “ice-breaker.” This simple exercise opened the chemists to the “reality” of STI transmission and awakened them to the reality of STIs and HIV in Nepal. With this understanding, training participants were able to put the remainder of the workshop into an appropriate perspective.

Improving Training Quality through Pictorials and Visual Aids The NCDA had never used supplementary communication materials, colour slides, films or visual aids in its 21-day basic training course for chemists. To reduce costs, the materials for the STI training were presented in a black-and-white text with simple overheads and condom demonstration displays. Over the course of the project, NCDA added a number of supplementary reproductive health aids, flip charts and a short colour slide presentation of actual STI clinical cases. These new communication materials and aids were instrumental in capturing participants’

interest and adding reality to the training. The colour pictorials/illustrations were particularly helpful to the full-time chemists who lacked opportunities to examine patients first hand, and exemplified the phrase “A picture can say a thousand words.” In future, the NCDA plans to expand its training package with a colour photo/illustrative section identifying the common STIs.

Promoting Condom Sales and Use Chemists in Nepal have been involved in the sale of the national socially-marketed condom, *Dhaal*, for the past 20 years in support of the national family planning programme. Initially the chemist curriculum included a full session on the condom, including: (1) advantages and disadvantages of condoms; (2) proper condom use; (3) an interactive condom demonstration; and, (4) a discussion on the benefits of social marketing and the Nepal Contraceptive Retail Sales (CRS) Company’s role in managing this national effort.

The results of the simulated client survey and the reaction of the participants both demonstrate a need to further strengthen the condom curriculum. The linkages between use of condoms and disease prevention were not fully understood, even by the more experienced chemist-providers. Improved understanding of these linkages can be promoted by making at least two changes: distinct improvements in the condom curriculum and the active participation of social marketing experts in the training.

In Nepal, it is recommended that the Nepal CRS Company managers/salespersons fully participate in each and every workshop

as condom resource persons. The Nepal CRS Company can also make better use of the workshops from a marketing and sales perspective. Besides serving as a resource on condoms, CRS representatives can provide special condom marketing products to each of the participants and later follow up the training with individual promotional sales visits.

Considering Gender and Other Sensitive

Topics The distribution of female chemists in Nepal's Central Region ranges from 30 per cent in some districts to less than 5 per cent in the more conservative districts along the Indian border. In some communities, it is not acceptable for a woman to work alone in a retail shop serving male customers. Programme planners were not sure how male and female chemists would interact with one another in workshops focused on sensitive issues such as sex, condoms and STIs, so NCDA arranged both single-sex and mixed-sex workshops.

The results were very interesting. The dynamics of the mixed groups provided the best overall learning environment. In the single-sex sessions, for example, it was often difficult to convince the male or female participants to focus on the content of the condom discussion and demonstration sessions. With mixed groups, the participants were more serious and focused on the subject matter. Once these group dynamics were recognized, every effort was made to maximize the number of female participants to improve the gender balance.

Training Immediate Family Members In a small community, local women know the best time to visit a chemist shop to purchase

personal items or seek sensitive advice—when the chemist's wife is sitting at the sales counter. As many shop owners employ their wives, sisters or brothers to assist with drug sales, it is essential to try to train all key sales staff (from one family). However, the training of family members representing the same drug retail establishment presents its own challenges. For example, an elder brother's presence severely limits a younger sister's ability to fully absorb and later apply sensitive sexual subject matter. It is therefore preferable to train immediate family members separately.

Strengthening Programmes through

Evaluation The use of external evaluation to assess the effects of the NCDA pilot prevention project has proved to be an invaluable asset. The results of the simulated client survey have provided the implementing agency, the managing agency, the donor and Nepal's Ministry of Health with essential information to lend critically important support to the approach. The evaluation findings also served to legitimize the value of the NCDA pilot in the eyes of the national public-health community. Perhaps most important, the data provided clear information on the constraints of the curriculum and directions for future improvements, including the strengthening of key sections of the curriculum, increased use of the local novice trainers and the need for frequent follow-up/refreshers training.

From an ethical perspective, the application of a special evaluation component provided the NCDA with the necessary ammunition to overcome vocal criticism of the effort by a group of public health sceptics. While the

health ministry sanctioned use of the approach among trained community chemists, a group of centrally-based physicians lobbied within their own ranks to discourage the training of non-physicians in STI case management. The evaluation results served to further strengthen support for a role for alternative providers in Nepal's disease prevention efforts.

Expanding Continuing Education STI treatment, condom promotion and chemist–customer communication are difficult topics for community-based chemists. Further improvement of chemists' skills to effectively address these issues will require a commitment by the NCDA to: (1) manage follow-on training for chemists who have participated in the two-day workshops; and, (2) introduce the subject matter into the basic orientation course for new chemists. Nepal's Department of Drug Administration needs to seriously consider the integration of the STI curriculum into the NCDA's 21-day "Orientation Course for Drug Retailers and Wholesalers" as a new minimum requirement.

At the completion of the pilot project, the NCDA recognized they had failed to achieve one of their primary objectives: to integrate key elements of the STI syndromic approach into their basic 21-day orientation course. In terms of effectiveness and impact, the NCDA experience is a reminder of the importance and role of organizational and personal priorities in the design and management of innovative or risky programmes. Setting reachable objectives and maintaining a programmatic focus on meeting them needs full consensual agreement and consistent effort.

Forging Good Community Relations to Gain Higher Profit The STI guidelines offer the consumer a more cost-effective and effective treatment. The results of the simulated client survey show that after training, the average selling price of the recommended STI treatment regimen decreased by 40 per cent. While initially chemists following the guidelines may experience lower profit margins, in time successful treatment and improved customer relations provide a new quality of care to the community. Over time, good dispensing practices enhances one's reputation and role as a preferred referral site, which ultimately improves business profits. It pays to be a trusted and reliable community chemist in Nepal.

Filling a Service-Delivery Gap In Nepal and other resource-constrained settings, it makes sense to identify all potential channels for strengthening education, communication and effective service delivery for STIs and HIV/AIDS. Training community chemists to provide improved, simple, curative care services benefits the community. Improved services lead to increased demand and therefore an improved supply of essential drugs to a community. The provision of quality drug dispensing and health education services by chemists known and trusted in a local community is a *sustainable* best practice and an effective alternative to Nepal's rural public health care dilemma.

WHAT IS NEXT FOR NEPAL?

The NCDA project has demonstrated that community chemists can play an effective role in treating and preventing STIs in resource-constrained settings. The NCDA pilot exemplifies a potential intervention for non-formal community health care workers who can become active caregivers or agents of change in preventing the spread of disease and managing care. Much more can and will be done in the future to strengthen the skills of Nepal's private-sector community chemists.

Likewise, other groups or sectors who can play critically important community health roles need encouragement through similar interventions. Nepal's non-formal community health care workers outside of the chemist community include informal health practitioners, ayurvedic doctors, female midwife/practitioners and "jhakaris," or traditional medicine men. These community health care providers come with a variety of formal and very informal education and experiences, but serve essential roles among specific ethnic groups. In some communities, the female midwife/practitioners are the first reference point for local health care prior to the chemist. In other communities, the informal health practitioner is considered the local medical expert and may be the preferred service point for disenfranchised individuals.

Another related group that could be trained in STI/HIV prevention and care is the medical manufacturers'

"detail men." In Nepal and neighbouring nations, these medical representatives or salesmen represent the hundreds of drug and medical supply houses operating in the countries. They also can be encouraged to deliver basic health and STI-prevention messages to chemists and retail shops as part of their regular sales visits, which could, in turn, enhance their sales and value to their customers.

Other caregiving groups who could be trained include paramedics, community medical assistants and nurses. In Nepal and other countries, many of these professional groups support a national association. Training could be arranged at the local level (taking the training to the trainee) or as part of annual professional meetings or conferences.

Finally, it is important to consider the next steps for chemists. With a solid understanding of the syndromic approach to STI treatment, chemists offer real potential for a complementary intervention: STI prepackaged therapy. In Nepal there are plans to begin an STI prepackaged therapy pilot programme in the near future. This new approach will build upon the innovative initiative by the NCDA among Nepal's community of chemists, which resulted in a qualitative benefit to the whole nation.

AUTHORS

Joy S. Pollock, AIDSCAP/Nepal, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Kathmandu, Nepal
Mahesh P. Pradhan, Nepal Chemists and Druggists Association, Kathmandu, Nepal

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Involving the private sector in a broad HIV/AIDS/STI-prevention agenda is critically important to protecting a country's work force.



PAUL SMITH/PANOS PICTURES

THIS STREET SCENE IN DOWNTOWN SÃO PAULO DISPLAYS THE WEALTH OF BRAZILIAN COMMERCE AND THUS THE PRIVATE SECTOR'S ENORMOUS POTENTIAL TO SUPPORT HIV PREVENTION INITIATIVES.

INVOLVING THE PRIVATE SECTOR IN HIV/AIDS PREVENTION IN BRAZIL

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INVOLVING THE PRIVATE SECTOR IN HIV/AIDS PREVENTION IN BRAZIL

INTRODUCTION

Brazil has undergone major political and social changes in the recent past. Democracy has been restored, the economy has become more dynamic and significant political power has been decentralized to states and municipalities. As the economy has gradually opened up, Brazil's private sector has made progress in efficiency and productivity.^{1,2}

Brazil has the world's ninth largest economy, with a vast commercial sector and gross national product per head of US\$4360. Altogether, more than three million businesses operate throughout the country.³ However, the World Bank classifies Brazil as one of the world's champions of social inequality. Economic stagnation in the 1980s left about 24 million Brazilians—17.4 per cent of the population—living below the poverty line in 1990.¹ According to the World Health Organization (WHO), Brazil has the world's second highest number of reported AIDS cases.

The state of São Paulo is the epicentre of the country's HIV/AIDS epidemic. It is also Brazil's corporate centre,⁴ where more than 65,000 large- and medium-sized companies operate, most of them headquartered in the state. In addition there are an estimated 1.5 million small and "micro" enterprises located in São Paulo.

Although AIDS is the leading cause of death among women and the second leading cause of death among men in the state of São Paulo,^{5,6} most private sector companies do not consider HIV/AIDS to be a priority public health concern. While there are notable exceptions, most do not understand the serious impact the epidemic could have on daily operations and annual profits, and therefore do not promote HIV/AIDS-prevention activities at the work site (other than the required education offered during National Health Week).

While HIV/AIDS is not a major concern for most Brazilian companies, other health issues do receive attention. These include work-related accidents, cardiovascular ailments, cancer, alcohol abuse, and repetitive motion syndrome. A few companies have also started preventive health programmes that include exercise, smoking cessation and weight control.³

In 1998 the Ministry of Labour in conjunction with the Ministry of Health signed a decree requiring all companies to implement HIV/AIDS-prevention programmes in the workplace.⁷ While Brazil's 20 largest companies all reported having implemented such programmes in a 1995 survey conducted by the AIDS Control and Prevention (AIDSCAP) Project of Family Health International (FHI),

funded by the United States Agency for International Development (USAID), and Associação Saúde da Família (ASF) (See Table 1),⁸ the vast majority of Brazilian companies do not comply with the federal decree.⁹ Many factors contribute to this situation, including an unemployment rate of up to 18 per cent, with a sharp decline in industrial employment as a result of downsizing policies. Moreover, businesses are focused on short-term profits and sceptical about the efficacy of HIV/AIDS-prevention programmes, especially with regard to behaviour change.

In a cure-and-care culture like Brazil's, private sector businesses prefer to pay the costs of care when necessary, including triple therapy for HIV infection, rather than spending on prevention. Because their employees pay monthly social welfare and health taxes, private sector businesses deem the government responsible for funding HIV/AIDS-prevention services and, in theory, care and treatment services as well. However, since they judge the public health sector incapable of providing quality care and treatment services, private sector companies also offer their employees private health plans. Thus, business owners consider that they end up paying double for HIV/AIDS-prevention, care and treatment services.

In-depth interviews with key private sector leaders have revealed their general conviction that HIV/AIDS prevention should be a governmental obligation. They commonly view AIDS as a problem of the impoverished and marginalized sectors of society, those not recruited to work for large companies in the HIV/AIDS epicentres, such as São Paulo and Rio de Janeiro. And while the Brazilian trade unions might have encouraged

private sector response to the epidemic, they have not pressured companies to implement HIV/AIDS-prevention programmes because their primary concern has been to protect jobs in the face of downsizing.

Since the onset of the HIV/AIDS epidemic in Brazil, only a small number of companies have implemented comprehensive HIV/AIDS-prevention programmes and are providing treatment for sexually transmitted infections (STIs), and very few provide access to condoms.^{3,10,11} Most nongovernmental (NGO) initiatives to sell services to the private sector have failed, mainly because most companies consider that as non-profit organizations, NGOs should not charge for their services.¹²

Overall, the private sector in Brazil does not consider the HIV/AIDS epidemic to be a threat to their business of making profits. However, the impact of the epidemic on the Brazilian economy is significant and growing.^{10,12,13} This paper will focus on ASF/AIDSCAP's experience with the private sector during the AIDSCAP Project implementation period from 1993 to 1997 and through the following year.

THE HIV/AIDS EPIDEMIC IN BRAZIL

Brazil is the fifth largest country in the world in terms of size and population, and has the second highest number of reported AIDS cases.⁴ First documented in homosexual and bisexual men, there has been an increase in AIDS cases due to heterosexual transmission of HIV. Initially, nearly all cases were male; now about 30 per cent of new cases are female,¹⁶ and the male-to-female HIV-infection ratio is 3:1. In the state of São Paulo, a region with a population of approximately 33 million, AIDS has been the leading

TABLE 1

The 20 Largest Companies in Brazil — in Sales — 1995

Company	Country	HIV/AIDS Program
1. AutoLatina (Volkswagen/Ford)	Germany/USA	Yes
2. Fiat	Italy	Yes
3. General Motors	USA	Yes
4. Shell Oil	England/Netherlands	Yes
5. Souza Cruz	England	Yes
6. Carrefour	France	Yes
7. Gesay Lever	Holland	Yes
8. Mercedes Benz	Germany	Yes
9. Varig	Brazil	Yes
10. ESSO	USA	Yes
11. Texaco	USA	Yes
12. Atlantic	Brazil	Yes
13. Pao de Açucar	Brazil	Yes
14. CSN (National Steel Company)	Brazil	Yes
15. Nestlé	Switzerland	Yes
16. Copesucar	Brazil	Yes
17. IBM	USA	Yes
18. Lojas Americanas	Brazil	Yes
19. COPENE	Brazil	Yes
20. USIMinas	Brazil	Yes

Source: Exame Magazine, August 2, 1995(8)

cause of death among women aged 20 to 34 since 1992.⁵ This reflects a shift in the epidemic from homosexual to heterosexual transmission, with increasingly apparent consequences in the adolescent and female populations.^{14,15,16}

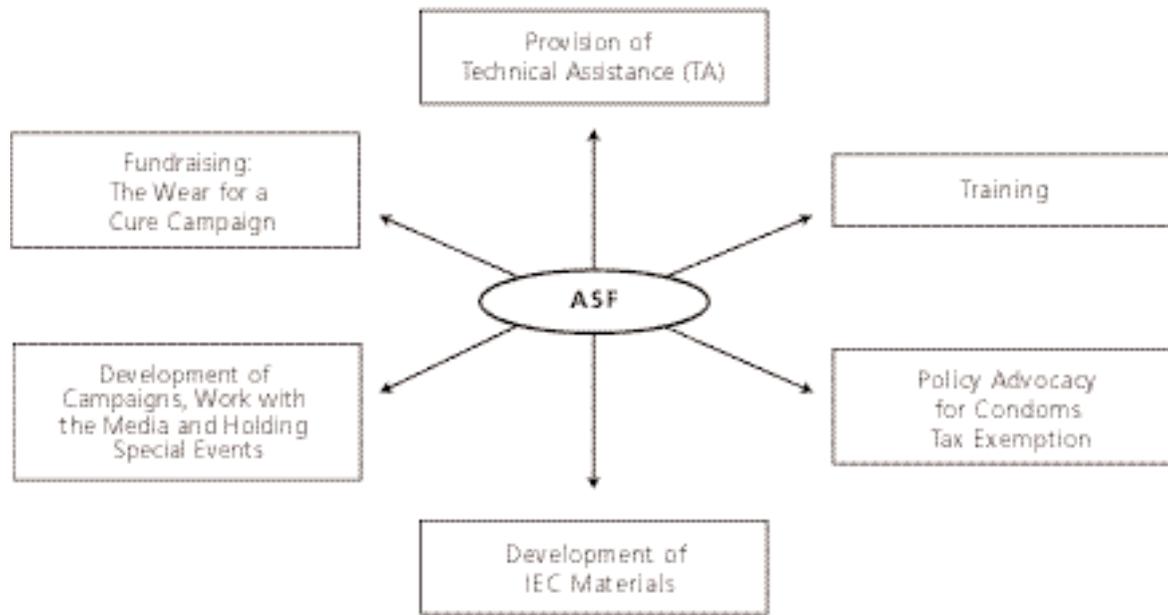
While over two-thirds of all HIV/AIDS cases are still located in the south-east region, the epidemic has spread to other parts of Brazil. Every state in the country has been affected, and of 5,000 municipalities, nearly half have reported at least one case of AIDS. The age

profile of patients has also declined slightly over time. While data are not available on patients' income levels, there is evidence that the education level of new cases has declined since the start of the epidemic, suggesting that increasing numbers of lower-income people are being infected.^{14,16}

A mosaic of transmission routes accounts for the 580,000 estimated HIV infections in Brazil as of 1999. Consistent with a predominantly heterosexual HIV transmission pattern,

FIGURE 1

From Planning to Action: Coordinating Private Sector Outreach



many women have become infected, which in turn has substantially increased child mortality rates: the vast majority of paediatric AIDS cases reported to the Ministry of Health over the past 10 years is due to mother-to-child transmission of HIV. These changes lead to the conclusion that the HIV/AIDS epidemic in Brazil increasingly affects the most impoverished, marginalized and vulnerable populations. Researchers in Brazil have described the “pauperization” of the HIV/AIDS epidemic, as it increasingly affects a population that traditionally has suffered from other infectious diseases, malnutrition, precarious sanitary conditions and generally poor-quality basic health care and educational services.^{14,15,16}

WHY WE SHOULD WORK WITH THE PRIVATE SECTOR ON HIV/AIDS PREVENTION

In Brazil the 15- to 45-year-old age group contains the highest number of AIDS cases. Since this age group constitutes the most economically productive segment of the population, a significant economic burden is created. Productivity falls and business costs rise—even in low-wage, labour-intensive industries—as a result of absenteeism, the loss of employees to illness and death and the need to train new employees. The diminished labour pool affects economic prosperity, foreign investment and sustainable development. According to the Brazilian economist André Médiçi, if 0.6 per cent of the economically

active population is affected by HIV/AIDS, Brazil will lose an expected US\$2.7 billion annually due to AIDS. Therefore, establishing a multifaceted and multisectoral approach to involving the private sector in HIV/AIDS prevention is crucial for the country.^{10,13,17}

The role of Associação Saúde da Família (ASF)

ASF is a Brazilian non-profit nongovernmental organization (NGO) located in the city of São Paulo. Composed of a group of professional women, ASF has a mission to improve the quality of human life through the promotion of scientific, charitable and educational activities for HIV/AIDS/STI prevention and care. ASF was created in 1992 by FHI, and from 1992 to 1997 ASF was responsible for implementing FHI's AIDSCAP Project, funded by USAID, in Brazil.

As an umbrella organization, ASF collaborates with partner institutions in providing technical assistance (TA) for the development of an integrated, comprehensive approach to HIV/AIDS/STI prevention, in order to achieve programmatic and financial self-reliance.¹⁸ Following the end of the AIDSCAP Project in Brazil in October 1997, ASF has received private sector support to continue HIV/AIDS-prevention efforts. While ASF has worked with more than 100 public and private organizations over its seven years on HIV/AIDS project design, management, monitoring and evaluation, capacity building, policy reform, advocacy, human rights, STI diagnosis and treatment and AIDS care and support, this case study aims to demonstrate the strategies used and the progress made specifically in working with the private sector on HIV/AIDS prevention in Brazil, during the ASF/AIDSCAP period and by ASF afterward.¹⁸

Technical Assistance (TA) Provision

In the early stages of AIDSCAP Project implementation (1992 to 1993), ASF/AIDSCAP concentrated on providing technical assistance to the Brazilian Ministry of Health for the development of a private sector plan to be implemented under a World Bank loan to the Ministry's National AIDS Control Programme (NACP). For this task AIDSCAP provided TA through two consultants who worked in close collaboration with NACP staff for two weeks.¹⁹ In addition, the AIDSCAP Brazilian resident advisor participated in a two-day meeting organized by NACP in Brasilia to define the contents of a technical manual for carrying out an HIV/AIDS-prevention programme in the workplace.²⁰

Additional TA was provided to the Federation of Industries in the state of São Paulo (FIESP) for the development of an HIV/AIDS/STI prevention plan. This plan was discussed with the Group of Social Action (GAS), affiliated with FIESP and responsible for the workplace HIV/AIDS-prevention activities to be developed by FIESP. GAS presented their plan and AIDSCAP consultants made a series of suggestions and recommendations.^{21,22} As part of this initial phase, ASF/AIDSCAP also provided TA to Shell Oil in the design of two workplace projects.²³

From 1993 to 1997, the ASF/AIDSCAP Brazil country programme worked with the private sector on the production of information, education and communication (IEC) materials to be used during interventions with specific target groups. For example, in 1993 a booklet called *Everything You Would Like to Know About AIDS, Sex, Drugs, Gynecology and STIs and Never Had the Courage to Ask* was produced by a group

of specialists led by Dr. Veronica Hughes, with the support of a well-known public relations firm, W/Brasil and Gráficos Burti.

The booklet cost an estimated US\$50,000 to produce, and 5,000 copies were donated to the programme to be used in educational interventions with commercial sex workers. An additional 5,000 copies were produced with funding from the U.S.-based Levi Strauss Foundation.¹⁸ *Everything You Would Like to Know About AIDS, Sex, Drugs, Gynecology and STIs and Never Had the Courage to Ask* won an award in 1994 for “best didactic book” and was distributed through three major AIDSCAP educational interventions to 9,500 commercial sex workers in the cities of Fortaleza (1,500), Rio de Janeiro (4,500) and Santos (3,500).

ASF/AIDSCAP also convinced the private sector to produce male and female demonstration models to help teach reproductive health using a participatory approach. The Levi Strauss Foundation funded production of the models in 1996 and 1998 and training of NGOs in their use.²⁴ Following the training, 13,000 of these teaching models (6,500 female and 6,500 male) were produced and distributed in five Brazilian states.

In 1997 ASF/AIDSCAP and the Brazilian Postal Service issued 3 million postage stamps embellished with a freehand drawing of a condom encircled by a red ribbon, the international AIDS symbol. Promoting condom use, the stamp’s banner reads, “Dress this cause,” meaning “Wear condoms,” and its background colours recall the Brazilian flag (blue, yellow and green), reinforcing the idea that HIV/AIDS is also a Brazilian problem. The stamp, worth US\$0.23 was available at Post Offices and

its sales eventually totalled US\$6.9 million. ASF/AIDSCAP’s role in the stamp campaign was to provide the Brazilian Post Office directorate with the rationale as to why they should become involved in HIV/AIDS prevention. The stamp idea had been selected through a competitive process by a Post Office advisory committee. The Ministry of Health launched the stamp at the Pan American Health Organization office in Brasilia to coincide with World Health Day on April, 7, 1997.²⁵

Training Training was a key component of ASF/AIDSCAP’s strategy to work with the Brazilian private sector, and a number of collaborative training efforts took place: in 1992 ASF/AIDSCAP and Partners of the Americas conducted an international seminar for HIV/AIDS prevention in the workplace in São Paulo; in 1993 and 1994 ASF/AIDSCAP and the Institute for Free Labour Force conducted two seminars for 100 leaders from the Worker’s Center (CUT) and the General Confederation of Workers (CGT).^{26,27} In addition, in cooperation with the São Paulo Institute of Health, ASF/AIDSCAP and CUT developed a training programme that educated 15,000 construction workers from seven cities in the state of São Paulo: São Bernardo do Campo, Moji das Cruzes, Campinas, Bauru, São Caetano do Sul, Salto and Guarulhos.

Following the end of the AIDSCAP Project at the end of 1997, in January 1998 ASF and the steelworkers division of CUT, with the support of DKT do Brasil, organized a seminar to mobilize and train a total of 47 CUT leaders from large companies such as Ford, Volkswagen and the petroleum

industry to act as workplace activists for the development of HIV/AIDS/STI-prevention programmes.²⁸ This training included instruction in methods using participatory approaches. As a result, a series of HIV/AIDS/STI prevention activities was developed on the factory grounds. CUT has also become deeply involved in the coalition for condom tax exemption, and in the campaign to include condoms in subsidized food baskets for the low-income labour force.

In 1998 ASF also provided TA and financial support to CUT for the production of 5,000 booklets on heterosexual HIV-transmission prevention for workers. CUT also produced a poster for the food-basket condom campaign. This features a colourful bunch of condoms photographed against a background of rice, beans and spaghetti, under the title “Condoms are Basic to the Food Basket and Basic to Life.” In addition, ASF persuaded CUT to produce a video promoting condom use as part of instructional video kit on employees’ human rights and citizenship issues. Funded by the Ministry of Labour,²⁹ a total of 1,000 videos were distributed throughout Brazil for use in worker training programmes.

Media collaboration Analysis of free media space conducted by an independent private sector firm, Manager Clipping, revealed that from 1993 to 1997 a total of 226 articles produced with TA from ASF/AIDSCAP were published in national, regional and local newspapers and magazines, occupying media space valued at about US\$6.8 million (if it were used for paid advertisements). The articles focused on HIV/AIDS/STI-prevention,

condoms and behaviour change in particular. Many articles on the female condom were published, including 78 just on the “Wear for a Cure” campaign.

The “Wear for a Cure” campaign was launched in collaboration with several private sector partners, including media such as television, magazines, newspapers and radio, which aired and published announcements promoting the campaign T-shirt. These announcements encouraged people to buy the specially designed T-shirt and collaborate on HIV/AIDS prevention. Each T-shirt was sold with a short brochure providing information on HIV/AIDS and on the campaign itself. Analysis results show that the newspapers and magazines potentially reached 65,504,000 readers.¹⁸

One excellent example of effective ASF/AIDSCAP media collaboration was the work done with Brazil’s largest-circulation women’s magazine, *Claudia*, published by Editora Abril.¹⁸ ASF/AIDSCAP persuaded *Claudia*’s editor to publish two features and a number of shorter articles on HIV/AIDS, tagged with a red ribbon graphic and with ASF/AIDSCAP serving as a principal content advising organization.

A two-year *Claudia* campaign was developed, during which articles on the the World Conference on Women in Beijing, China, in 1995 and the 11th International AIDS Conference in Vancouver, Canada, in 1996 were published. One cover showed the Brazilian flag and the red ribbon, and photographs of Brazil’s First Lady Dr. Ruth Cardoso, the soccer star Pelé, artists, scientists and opinion leaders, all wearing the red ribbon to show their commitment to AIDS prevention were also published. For articles

on female and adolescent AIDS prevention, the equivalent of US\$1,974,282 (if space was used for paid advertisements) was donated in free magazine space.

The editor responsible for publishing the *Claudia* articles said the magazine did it “Not because we have good hearts,” but “...as part of a strategic vision of modernizing the image of the oldest women’s magazine in Brazil. More and more modern women won’t read the magazine without this type of article,” she explained. “Furthermore, we sell more magazines, and it is good for our image.”

Another important collaborative effort between ASF and Editora Abril led to the design of a colourful aerogram addressed to President Cardoso and bearing a request for condom tax exemption, which was distributed through an issue of a popular teen magazine (circulation 1 million). The magazine urged readers to send the aerogram in support of the tax-free condom campaign: “Now is your time. Show that you are concerned about the future of this country and send this to the president. Talk with your friends, teachers, and family members... The number of people that write to the president will make a difference.”⁴

The aerogram message says, “Mr. President, one million adolescents become pregnant in Brazil each year. AIDS is increasing among adolescents. The condom can prevent both. This letter asks you to exempt condoms from taxation because we want to live for many years to come,” with space for a signature, name and age.

Special event participation Over the years ASF/AIDSCAP has also participated in special events, such as international book, music,

art and fashion fairs, where a project booth has been used to demonstrate correct use of female and male condoms and to collect signatures on condom-tax exemption petitions. These booths have been provided to ASF free of charge by all the major fair organizers; usually the cost of the space at a large fair is approximately US\$5,000. Considering that ASF was able to negotiate a total of 12 free booths, this translates into a donation by fair organizers of approximately US\$60,000 for the promotion of proper condom use and HIV/AIDS-prevention advocacy.

Several individuals also donated their time to ASF, volunteering as staff for events surrounding World AIDS Day, conferences, the “love parade,” meetings and fairs.

“Wear for a Cure” campaign The best example of successful ASF/AIDSCAP’s collaboration with the Brazilian private sector was the campaign “Wear for a Cure” (“Vista esta Causa”), carried out from 1996 to 1999, during and after AIDSCAP Project implementation in Brazil. Inspired by a similar campaign for breast cancer prevention in the United States and Brazil, “Wear for a Cure” was the result of an agreement between ASF/AIDSCAP and the fashion industry, represented by the Vicunha Group, John Casablancas/Elite Models Agency, and Determined Involved Supermodels Helping to End Suffering (DISHES), a U.S. organization. “Wear for a Cure” was launched in July 1996 by Brazilian First Lady Dr. Ruth Cardoso at the Ministry of Foreign Affairs in Brasilia.¹⁸

The campaign sold T-shirts emblazoned with the red AIDS ribbon, the international symbol for HIV/AIDS prevention.

Internationally recognized “supermodels” and nationally known models advertised the campaign free of charge. A campaign launch video was shown at the July 1996 Fashion Industry Fair and on several TV channels. From October to December 1996, approximately 60,000 “Wear for a Cure” T-shirts were sold in more than 1,000 outlets throughout the country. This generated approximately 414,017 Reais (US\$400,000).

As part of the campaign, a series of promotional shows and events took place around the country, and during one very popular talk show 17,000 “Wear for a Cure” T-shirts were sold in five minutes. The Brazilian marketing industry considered this to be a major achievement. The campaign also received free advertising in several magazines and newspapers and on television. In addition to the fashion models, many Brazilian and non-Brazilian celebrities (TV stars, singers, journalists and sports figures) participated in the campaign, as did retail shops, radios and newspapers.

Audited by Ernst & Young, the funds raised through this campaign were used to implement 49 HIV/AIDS prevention and care activities. These were chosen through a competitive process by a technical advisory group composed of representatives from the Brazilian Ministry of Health, USAID, the Ford Foundation and the European Union. Each selected organization received between 4,000 to 35,000 Reais to implement activities as follows:

- Seventeen organizations were selected to develop HIV/AIDS prevention activities targeting women and adolescents through radio, video, booklets and face-to-face educational interventions in poor

communities, the workplace, schools and community-based organizations. These activities encourage the use of male and female condoms, STI prevention and care, the implementation of educational interventions, and building capacity for negotiation skills.

- Twenty-three organizations were selected to receive funding for institutional support such as for purchasing equipment (including washing machines, computers, freezers, microwaves and school materials), food, salaries for nurses and other personnel, rent, condoms and other support for HIV/AIDS organizations supporting people living with AIDS (PLHA), especially children with AIDS who have lost their parents due to the disease.
- Five organizations were selected to conduct training courses for people who care for children with AIDS, or for outreach workers and peer educators, in order to develop prevention activities.
- Two organizations were selected to develop research or data analysis on HIV/AIDS/STI-related subjects.
- One organization was selected to develop activities related to its sustainability, such as fundraising.
- One organization was selected to provide special services such as dental treatment to people living with HIV/AIDS.³¹

In addition to participating in the fundraising campaign, ASF’s role was to manage and monitor the projects, assuring that results could be achieved. For example, one project developed in collaboration with the News Agency for the Defense of Children and Adolescents generated

SIDEBAR 1

Policy and Advocacy Private Sector "Gatekeepers"

Who Are They?	What Can They Do?
<ul style="list-style-type: none"> • NGO representatives • Trade union leaders • Business representatives • Members of the House of Representatives/Senators • Governors/mayors • Public health authorities • Donors • The media 	<ul style="list-style-type: none"> • Create public awareness of the need for the condom tax exemption and demonstrate the benefits of increased access to HIV/AIDS/STI prevention. • Demonstrate collective concern about proper access to HIV/AIDS/STI prevention methods in Brazil. • Influence their peers, the community, specialists, technical experts, policy advisors and the general public, providing critical information and making recommendations for action. • Mobilize large groups of people. • Represent the interests of many segments of Brazilian society. • Produce a complex publicity campaign.
<ul style="list-style-type: none"> • Famous artists and opinion leaders • Municipal health councils 	<ul style="list-style-type: none"> • Influence readers and inform people, including decision makers. • Collect signatures on petitions during large events. • Increase the power and influence of lobbying for tax-free condoms. • Deliver the petition to key policy-makers with broad media coverage. • Increase access to effective HIV/AIDS/STI-prevention devices.

80 media articles promoting condom use, 10 general articles on HIV/AIDS prevention for adolescents and several press releases as part of the *Condom Always* campaign. Press releases were sent to more than 100 key journalists in the country. This campaign was also supported by UNICEF, Ayrton Senna Institute and the Abrinq Foundation, which highlights ASF's collaboration with other private sector initiatives in Brazil.³²

POLICY ADVOCACY PARTNERSHIPS WITH THE PRIVATE SECTOR

Policy advocacy has been a key component of the ASF/AIDSCAP strategy to increase sustainable access to HIV/AIDS prevention, and alliance with the private sector has been fundamental to achieving results. In 1992, when the AIDSCAP Project in Brazil was designed, commercial condoms were expensive, ranging from US\$0.70 to

US\$1.00 each. The price was elevated due to high import tariffs on latex (the raw material used for condoms), the myriad taxes at every retail level, and, of course, the need for profits. As a result, in 1992

condom prices in Brazil were among the highest in the world and, not surprisingly, overall condom sales were low (about 50 million items), reflecting an extremely low per-capita use.

SIDEBAR 2

Example of Advocacy Letter of Support

"The Federation of Industries in the State of São Paulo, through this letter, wishes to demonstrate its full support to the condom campaign developed by Associação Saúde da Família (ASF), requesting the extension for the exemption of ICMS approved until September 30, 1998 (Agreement ICMS 60/98 of July 19, 1998).

Furthermore, considering the public interest involved, we would like to request the extension of the tax exemption for the female condom because AIDS is the main cause of death among young women in the State of São Paulo. We consider that the lack of access to condoms and consequent non-use is one of the major obstacles in the implementation of effective HIV/AIDS/STI prevention programs, as well as the prevention of unwanted pregnancy."

Max Heinz Gunther Schrappe
President of FIESP
August 31, 1998

The president of FIESP also supports the ASF campaign.²¹

SIDEBAR 3

Advocacy Action Steps

Why?	How?	Major Result Expected
<ul style="list-style-type: none"> • Why should you persuade decision makers, institutions (public, private, NGO) to exempt condoms from taxes? 	<ul style="list-style-type: none"> • Organize a brief, clear statement of the problem and provide recommendations for its solution. Show research data. 	<ul style="list-style-type: none"> • Creation of a coalition to achieve a common goal. • Technically sound action.
<ul style="list-style-type: none"> • Why should we include condoms as part of the food basket for low-income employees? 	<ul style="list-style-type: none"> • Identify your potential partner as someone who can support your action: members of the House of Representatives, Senate, ministries, mayors, trade unions leaders, NGO representatives, journalists, private sector leaders, artists, etc. 	<ul style="list-style-type: none"> • Delivery of a petition to decision-makers, signed by thousands of people. • Lower consumer price of condoms.
<ul style="list-style-type: none"> • Why do we need to mobilize, sensitize and persuade institutions (public, private and NGO), individuals and decision-makers to support this policy? 	<ul style="list-style-type: none"> • Set appointments, organize formal and informal meetings, make presentations to your potential partners. 	<ul style="list-style-type: none"> • Increased access to condoms. • Expansion of condom market and sales.
<ul style="list-style-type: none"> • Why do we need data showing the real benefits of our actions? 	<ul style="list-style-type: none"> • Get media support. • Produce IEC materials. • Organize a petition with your partners to collect signatures. • Collect one million signatures through the petition. • Take signatures to politicians and decision makers. • Collect, analyze and present study results to decision makers. 	<ul style="list-style-type: none"> • Increased and sustained access to HIV/AIDS/STI-prevention methods. • Increased and sustainable access to female condoms. • Increased access to HIV/AIDS prevention methods for adolescents. • Increased access to prevention methods and support for PLHA.

In response, the Population Crisis Committee conducted intensive studies on pricing for contraceptives, including condoms, and determined that in order to be affordable to the general public, the cost of a full-year's supply of condoms should not exceed 1 per cent of average annual income. For Brazil, this means the ideal cost of a condom should fall between US\$0.15 and US\$0.43. Other

studies, notably those conducted by Population Services International (PSI), support this theory.^{33,34,35}

Recognizing that wide availability of responsibly-priced condoms is important for the prevention of HIV/AIDS/STI,² ASF/AIDSCAP collaborated with DKT International (PSI's affiliate in Brazil) on condom social marketing, and with local

manufacturers, importers, the private sector, trade unions, the media and the public sector on a campaign to eliminate taxes on condoms and make them more affordable. In order to achieve this goal, an advocacy plan was designed and a coalition to defend tax-free condoms was created.³⁶

Furthermore ASF, Associação Brasileira de AIDS (ABIA), trade unions and the private sector are lobbying to include condoms as part of the low-income food basket. In São Paulo alone, the two largest private companies buy 2.1 million food baskets a month from the food industry. By the end of each month, these are given to low-income employees as a benefit. Because they would reach so many potentially at-risk people, the Brazilian sociologist Herbert de Souza, former ABIA president (who died from AIDS), came up with the idea of including condoms in the food basket as a strategy to increase condom access. Since December 1997 ASF has been working with partners from the private, public and NGO sectors to realize this idea. So far, companies that sell food baskets to the industrial sector have included condoms as an optional item.

ASF has developed a set of advocacy action steps for tax-free male and female condoms and the inclusion of condoms in the food basket for low-income employees in Brazil.³⁶ While these steps illustrate advocacy related specifically to condom access, they can be used or adapted for other HIV/AIDS-advocacy purposes.

As a result of orchestrated action, substantial results have been achieved by ASF's efforts with the private, public and NGO sectors. The

government has totally eliminated the import levy and the secondary tax on condoms, thus lowering the cost of imported brands by 35 per cent. In addition, the ICMS tax (18 per cent) was eliminated between October 1997 and December 1999.^{18,38,39,41,42,43}

This strategy of introducing a socially marketed condom brand and working on condom tax reduction helped to expand the Brazilian condom market from 53 million items in 1995 to 250 million by the end of 1997. Recent data from Nielsen show that 300 million condoms were sold during 1998 (see Figure 2).⁴⁴

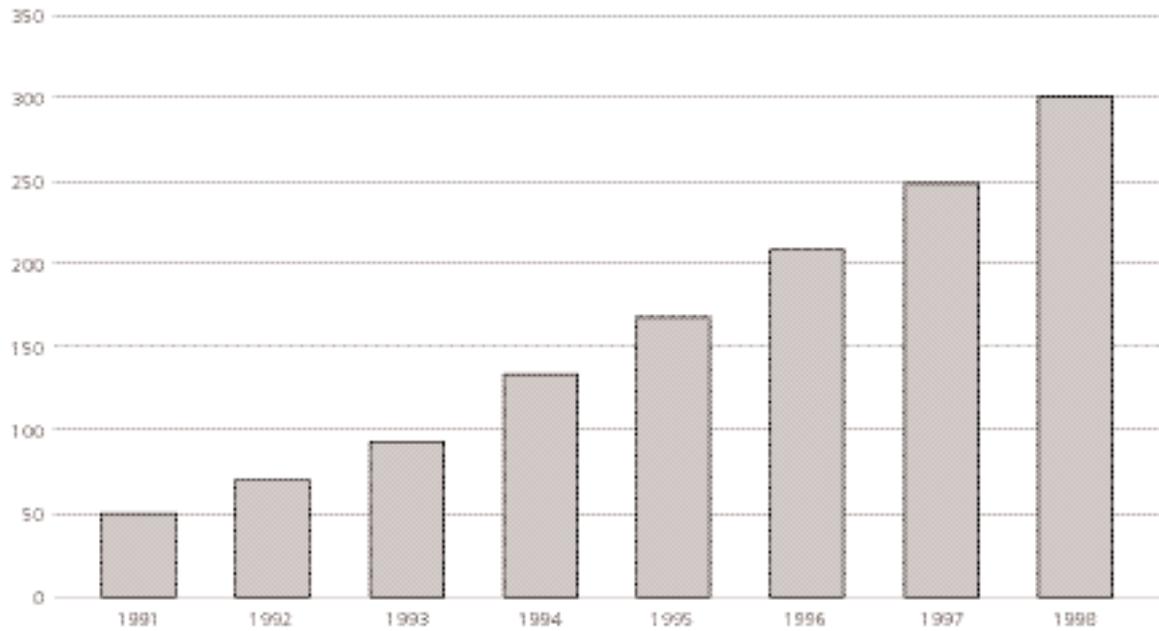
While these developments are encouraging, the Brazilian condom market still has far to go: data from a recent World Bank analysis show that Brazilian men of reproductive age use an average of only six condoms per year.

In conclusion, quantitative and qualitative studies conducted in Brazil have shown that private sector HIV/AIDS/STI prevention initiatives are extremely limited due to several factors, including the lack of perception of need, lack of tradition of social responsibility, especially public health problems, and the conviction that prevention is a governmental responsibility. However, the ASF experience during and after AIDSCAP, described here, creates a new perspective for those willing to work with the private sector.

Seeking new opportunities and studying successful strategies for fundraising, advocacy, media involvement and IEC materials production and dissemination are just some of the possibilities to be considered by those working in HIV/AIDS/STI prevention. In light of limited resources, alliances must be built at international,

FIGURE 2

Total Brazil Condom Market



Projected Sales in Volume¹

Source: Nielsen

national and local levels to increase the impact of prevention activities, and involving the private sector in a more active role is critical to future sustainability of prevention programmes. Slowly but steadily, the Brazilian private sector is becoming involved in social issues: what is good for their image is good for their business.

RECOMMENDATIONS FOR MOBILIZING PRIVATE SECTOR COLLABORATION

- Explore and act upon opportunities. The private sector can be persuaded to get involved in HIV/AIDS prevention efforts through effective advocacy.
- If possible, get a positive, private sector recommendation before a meeting,

and then ask for support. Doors open faster through good connections, but be wary of politics and competition, which increase given the potential level of resources available.

- Use senior managers from businesses already implementing integrated and comprehensive HIV/AIDS-prevention programmes to persuade their colleagues. They will know better than you how to do this.
- The approach taken with the private sector needs to be professional and technically sound. Research data from a respected source can be used to defend your arguments.

- During meetings with private sector representatives, be brief and objective. Time is money. Do not make long academic presentations, but do work with the cost-benefit rationale they understand. Be open to suggestions in your presentations to private sector business leaders and mutual respect will be achieved.
- Demonstrate that involvement is good for their image, their business, and their company profits.
- Demonstrate that private sector involvement in HIV/AIDS prevention can be a useful marketing strategy for the private sector's own interests.
- Explore ways to work with the media: television, radio, newspapers and magazines are able to reach large audiences. Donors can provide resources to increase the collaboration between HIV/AIDS experts and the media. Media and advertising partners can develop campaigns, include promoting condom use in soap operas, talk shows, radio shows, etc. A good campaign will be the result of professional assistance.
- Form relationships with respected and well-known businessmen and women. They can open doors.
- Encourage businesses in the industrialized world to implement HIV/AIDS prevention in the workplace and extend the benefit to their subsidiaries located in developing countries. Many multinational companies are doing just that. Use good examples to persuade those who have not yet started prevention programmes.
- Many philanthropic organizations offer tax deductions to donors—private and corporate—who help

fund social projects. This is a good advocacy area. If your country does not offer corporate or individual tax deductions for such donations, it is time to start lobbying for this opportunity.

- UNICEF has extensive experience in mobilizing funds and working with the private sector. Learn from UNICEF's experience and that of other organizations with successful private sector advocacy track-records.

BEST PRACTICE CRITERIA

This case study illustrates concrete steps organizations can take to mobilize and work with the private sector beyond developing HIV/AIDS/STI-prevention workplace programmes.

Relevance As in other countries, the HIV/AIDS epidemic in Brazil has had a significant impact on both large and small businesses. Involving the private sector in a broad HIV/AIDS/STI-prevention agenda is critically important to protecting a country's work force.

Efficiency The private sector is used to operating according to the cost-benefit rationale. When convinced to implement HIV/AIDS-prevention activities, private sector businesses can play a major role, not only in allocating resources for their workers but also in supporting programmes and projects beyond the factory grounds (e.g., Levi Strauss Foundation, the fashion industry, public relations firms).

Effectiveness Private-sector business leaders know their peers and can help persuade their colleagues to develop HIV/AIDS/STI interventions in the workplace and convince them to engage in other activities such as fundraising, production of IEC materials and allocating resources to assist PLHA. In addition, businesses can support and lobby effectively for policy actions such as a condom tax exemption.

Ethical soundness Wide access to reasonably priced condoms is very important for the prevention of HIV/AIDS in any country. Thus, the advocacy component of this case study may inspire scientific and social actors involved in HIV/AIDS/STI prevention to implement similar activities. The support of the private sector for the tax-free condom campaign in Brazil was crucial; as a result, the Brazilian population now has increased access to condoms, meaning lives will be saved.

Replicability The examples and recommendations described here, as well as the implementation steps, can be applied in most countries. In order to achieve results with the private sector, it is important to show businesses that what is good for their image is also good for their business.

Sustainability To increase private sector participation, it is essential to show transparency in post-fundraising budget allocation. Furthermore, public health activities need to demonstrate results to the private sector. Two good examples

of sustained action involving the private sector are presented in this report: advocacy for a condom tax exemption, which contributed substantially to the increase of condom sales in Brazil, and the “Wear for a Cure” campaign, which was very successful and audited by Ernst & Young.

AUTHOR

Maria Eugênia Lemos Fernandes, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, and Associação Saúde da Família, São Paulo, Brazil.

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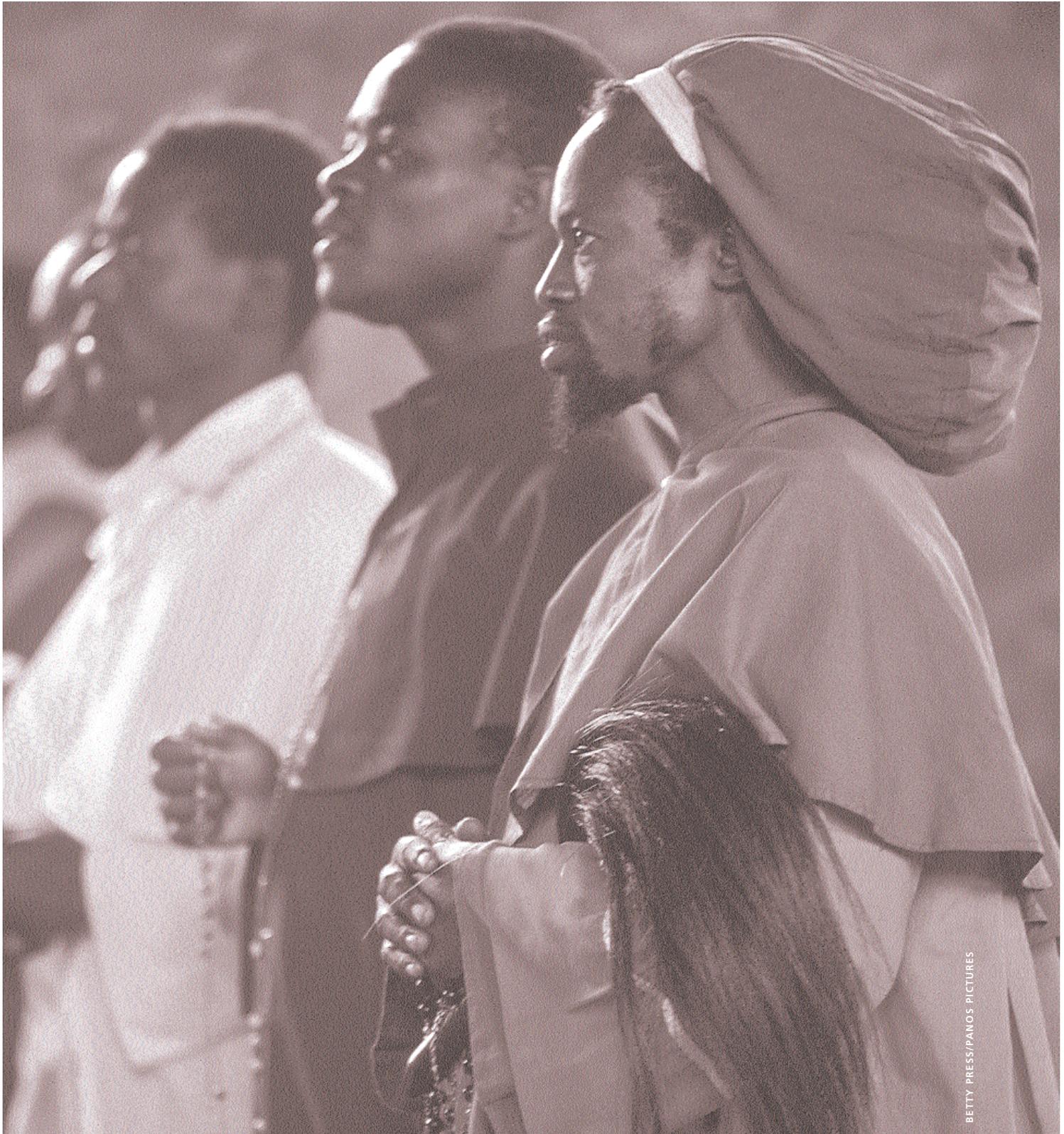
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Giving church leaders the support and guidance they need to become involved in HIV/AIDS prevention is a highly sustainable approach, because many prevention and care activities can be undertaken as part of the services they offer to their congregations.



BETTY PRESS/PANOS PICTURES

THE POWERFUL INFLUENCE OF RELIGIOUS LEADERS, SUCH AS DEACON JAMES IN NAIROBI, KENYA, FOMENTS SAFER SEXUAL BEHAVIORS IN THEIR CONGREGATIONS THROUGH RELIGIOUS-BASED MESSAGES.

WORKING WITH THE CHURCH IN KENYA TO PREVENT THE SPREAD OF HIV/AIDS

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WORKING WITH THE CHURCH IN KENYA TO PREVENT THE SPREAD OF HIV/AIDS

INTRODUCTION

Churches are part of virtually every community in Kenya. Most Kenyans are churchgoers and four out of five declare themselves to be Christians. Yet until recently, Christian churches in the country had done little to address one of the most pressing challenges facing their congregations: HIV, a deadly virus that had infected more than 1 million Kenyans by mid-1994.

During the early 1990s, Catholic, Protestant and independent Christian churches were at best only marginally involved in HIV/AIDS prevention or care. For the most part, they did not have policies, plans or activities designed to control the epidemic on their doorstep. Indeed, many religious leaders believed that the epidemic was occurring outside their communities and was therefore not their responsibility. Few clergy had much knowledge of HIV/AIDS or any training in HIV/AIDS prevention, care or counselling.

The capacity and influence of Christian churches in Kenya make them a natural and critical first line of defence against HIV and a key to policy-making and intervention at all levels of society. Family Health International's (FHI) AIDS Control and Prevention (AIDSCAP) Project, funded by the United States Agency for International Development (USAID),

recognized this untapped potential of churches to help slow the course of the epidemic and alleviate its impact on families and communities in Kenya. It contracted with the Medical Assistance Programme (MAP) International, a nondenominational Christian health and community development organization with an office in Kenya, to implement HIV/AIDS policy, communication and training activities for Kenyan religious leaders and members of their churches.

THE PLAN

The AIDSCAP/MAP project was designed to increase the capacity of Kenyan churches to design, implement, manage and evaluate effective, culturally appropriate and locally sustainable HIV/AIDS programmes for their communities. This would be achieved through interventions with audiences at two levels: (1) church leaders, policy-makers and educators; and, (2) local church leaders.

It was anticipated that the involvement and approval of church policy-makers and educators would have a tangible effect at the community level, motivating local church leaders and congregations to participate in efforts to encourage individual behaviour change and support those affected by HIV/AIDS. A mass media campaign

and other communication activities would also promote behaviour change among Kenyans, particularly churchgoing young people.

Under the original agreement between FHI and MAP International, the project was to run from 15 June 1994 to 26 August 1996, with some matching funds from MAP. Subsequently, the project was extended by three months to 30 November 1996, and more funding was added to support additional activities and materials and to make up for shortfalls caused by fluctuations in the Kenya shilling to U.S. dollar exchange rate.

The following activities were planned:

- Conduct baseline research among church leaders and churchgoing youth.
- Establish and implement national church guidelines on HIV/AIDS issues.
- Design and implement a mass media campaign targeting the churchgoing public.
- Develop and distribute curricula on HIV/AIDS for pastoral and theological training schools.
- Train a team of clergy and lay leaders in HIV/AIDS prevention and counselling.
- Develop and distribute materials on interpersonal relationships, HIV/AIDS and other sexually transmitted infections (STIs) to church-related primary, secondary and Sunday schools.
- Develop and disseminate HIV/AIDS information packets to pastors and lay leaders.
- Create national and regional multi-denominational church networks to provide support and guidance to churches involved in HIV/AIDS interventions.
- Conduct follow-up surveys and focus group discussions to assess progress.

A number of organizations were to be involved in the project. These partners and their roles were as follows:

- The Association of Evangelicals of Africa, to contribute to church guidelines, networking, focus groups and policy advocacy.
- The National Council of Churches of Kenya, for advocacy and policy development.
- The Oasis Counselling Center, for pastoral counselling workshops, focus group discussions, policy development and consultations with church leaders.
- Daystar University, to manage behavioural research, help run focus group discussions and provide advice regarding video and materials production.
- The Evangelical Association of Kenya and the Africa Inland Church, to collaborate on consultations with national church leaders and policy development.
- The Scripture Union of Zimbabwe, to provide advice on youth curricula development.
- The Kenya AIDS NGO's Consortium, to assist in networking with non-governmental organizations and advise on government linkages.
- The National AIDS and STD Control Project (NAS COP) of Kenya, to identify possible areas of collaboration.

Research: The Foundation Of seminal importance to the success of this project was the baseline research conducted in late 1994 on the HIV/AIDS knowledge, attitudes, beliefs and practices (KABP) of church leaders and churchgoing youth in Kenya.¹ The research was nationwide in scope and interdenominational in breadth. It consisted of quantitative surveys

and focus group discussions among church leaders and young people aged 12 to 19.

The survey results revealed that most church leaders (97 per cent) recognized AIDS as a problem in their communities, but the majority (61 per cent) did not know how to address the problem. While almost three-quarters of these leaders knew community members living with HIV/AIDS, only 17 per cent were involved in caring for people living with HIV/AIDS (PLHA) and their families. Nearly all the church leaders knew that HIV can be sexually transmitted, yet one in three claimed to know other church leaders who were unfaithful in their marriages. Finally, church leaders admitted that they were poorly equipped with any type of HIV/AIDS training: six out of every ten had no training whatsoever in HIV/AIDS interventions.

Church leaders identified the following areas of need and opportunity:

- training in how to start programmes
- developing counselling skills
- the need for support from senior church leaders.

The research also showed that most of the churchgoing youth recognized HIV/AIDS as a problem in Kenya and knew the primary means of avoiding infection (abstinence and condom use). Yet 43 per cent believed they had a “good to moderate” chance of becoming infected with HIV because they were sexually active, and many were engaging in high-risk sexual activity. Only half said that HIV/AIDS was discussed in their churches. They received information about sexuality and HIV/AIDS primarily from peers and the media, but said that they valued information from parents and church leaders above that from all other sources. The gap

between HIV/AIDS awareness and practicing HIV prevention was wide.

From this study, it became clear that barriers to HIV/AIDS prevention among youth in Kenya included:

- lack of sex education for pre-teenagers from valued sources
- lack of role models, both peer and elder
- lack of church programmes that met young people’s needs.

The study results guided the design of tools used in the project, including pastoral training curricula and youth educational materials. They also formed the basis and rationale for onsite assistance in developing church programmes.

Perhaps most important, however, the research had a powerful impact on Kenya’s church leadership across all denominational lines, awakening them to the need for policy development and practical interventions at all levels. The results underscored the fact that HIV/AIDS is a problem for religious people throughout Kenya, forcing the churches to take some ownership of responses to the emerging crisis.

Policy Development The policy component of the project worked at two levels, involving local clergy and church members as well as national and regional leaders of various denominations. At the grassroots level, religious leaders sought to influence their archbishops, bishops and general assemblies by writing to them about how HIV/AIDS was affecting their congregations and making sure that these concerns were presented at denominational meetings. Clergy and lay people who attended MAP training workshops provided recommendations that MAP presented to their leaders.

At the national and regional levels, MAP's staff and members of its advisory committee visited, called and wrote to key denominational leaders. They also organized three national workshops to encourage consensus among religious leaders on a more active church role in HIV/AIDS prevention, care and support.

At the conclusion of the first of these workshops, the participants issued a general statement through the national press, committing their churches to an active and passionate response to the HIV/AIDS crisis. This was the first statement of its kind in Kenya.

At the second workshop, held in February 1996, all of Kenya's umbrella church agencies, together with three Africa-wide church agencies, adopted, signed and issued a joint declaration outlining their commitment to developing policy in 14 critical areas. These included providing education about family life and sexuality, developing support groups for PLHA offering premarital counselling and HIV testing, caring for orphans and PLHA, and supporting the rights and needs of women. The leaders said churches should develop policies on "appropriate and acceptable methods of protection," and called for a revitalization of moral values in church leadership.

Since that declaration was published in a large advertisement in the 19 March 1996 edition of the national newspaper, the *Sunday Nation*, at least three major church denominations have incorporated HIV/AIDS issues into their church policy guidelines, and more than a dozen other churches and denominations have taken steps to address these issues. Some, for example, have put HIV/AIDS on the agendas for their annual general meetings.

The third workshop resulted from a request by the Organization of African Instituted Churches, an umbrella group of more than 10,000 independent churches whose teachings combine Christian and traditional beliefs and rituals. At the end of the workshop, bishops and pastors from a dozen independent churches in the Nyanza province of western Kenya, representing hundreds of thousands of people in an area with the country's highest HIV-prevalence rates, signed a statement acknowledging the threat of HIV/AIDS. Their statement also confronted centuries-old cultural practices that increase HIV transmission, specifically mentioning wife inheritance (a widow marrying her brother-in-law) and sexual cleansing (having sex with a designated person in the village as a "cleansing" ritual). Coming as it did from the region of Kenya that is most accepting of polygamy and other risky traditional practices and from clergy who had been among the staunchest defenders of such practices, this statement is particularly significant.

The foundation for all of these efforts to develop guidance for Kenyan churches and their congregations was the 1994 All Africa AIDS and the Church Consultation in Kampala, Uganda, involving 150 church leaders from 28 different countries in the region. MAP printed and distributed 7,000 copies of a synthesis of the proceedings and recommendations and guidelines from the consultation. These guidelines have also been translated and published in Kiswahili, Portuguese and French and are being disseminated across the continent.

The AIDSCAP/MAP project's advisory committee, established early in the project, included one of Kenya's most respected and

influential church leaders, Bishop Nthamburi of the Methodist Church of Kenya. The advisory committee's clear and able guidance was particularly crucial during the formation and early development of the interdenominational Kenya Christian AIDS Network (K-CAN).

Raising Awareness The project's mass media campaign centred on a video, "Springs of Life," produced by MAP to present positive models of church involvement in HIV/AIDS care, support and prevention. The film ends with a powerful scene in which a pastor gives a drink to a man with AIDS, then drinks from the same cup. Through the efforts of the project's regional coordinators, "Springs of Life" was shown at churches country-wide and to 800 church leaders attending the Pan African Christian Leaders' Assembly in 1995.

Although its main target audience was churchgoing youth, "Springs of Life" reached a much broader audience. It was aired three times on national television during prime viewing hours. The video also was shown 683 times over two years in public areas throughout the country through three touring cinema vans, reaching about 2.8 million people.

Other mass media activities included placing six different advertisements in Kenya's daily newspapers at strategic intervals during the project and developing and broadcasting ten radio spots. The spots addressed key policy issues and World AIDS Day themes.

Training Church Leaders Perhaps the most important output of the project was a series of training workshops for clergy and lay leaders from every region in Kenya. A total of 160 people—60 per cent male and 40 per cent

female—representing 30 religious denominations and organizations, were trained in HIV/AIDS awareness, prevention and intervention, with an emphasis on counselling. Each participant attended two workshops, introductory and advanced, separated by two to three months. They were expected to use their training to initiate activities in their churches and communities.

The subsequent commitment demonstrated by these trainees, evidenced through sustained voluntary activities, far exceeded expectations. In the short time between the first and second workshops, 105 of the participants conducted a total of at least 576 activities, meetings and sessions, including some multiple-day seminars and workshops. More than 56,400 people were reached during these activities, which can be divided into 12 categories: awareness raising in primary and secondary schools; training and awareness raising among teachers; training in theological institutions; church functions; youth meetings and rallies; public meetings; sessions with church leaders; sessions with community and government leaders; training of health workers; counselling of PLHA; marriage counselling; and, other kinds of counselling.

After the first eight workshops, a fifth and final series of two workshops was requested and organized for Nairobi-based clergy, lay leaders and church leaders. The largest of the workshops, this series included key participants from each region in Kenya and regional representatives from Zaire, Rwanda, Mozambique, Tanzania and Angola.

Three manuals that had been developed earlier by MAP International were used and distributed at the workshops. Two thousand copies of each manual had been printed. The

project provided funding for translating the manuals into Kiswahili and printing 1,000 copies of each.

Information packets on HIV/AIDS and the church also proved very popular. Containing posters, leaflets, and outlines for sermons and Bible study sessions with HIV/AIDS themes, these packets were initially distributed to 1,000 pastors and lay leaders. The demand for them was so great, however, that an additional 2,000 were printed. By 1997, most had been distributed and were being used at the grassroots level.

Pastoral Training Materials Discussions with participants in the pastoral counselling workshops were one of the most important sources of information and guidance for the development of curriculum modules and materials on sexuality, marriage, relationships, STIs and HIV/AIDS for pastoral training. Issues and themes raised in these discussions, as well as in the baseline research and policy workshops, were incorporated into the modules MAP designed for pastoral and theological training institutions and schools. MAP also consulted with these institutions and with church denominations and Kenya's Commission for Higher Education.

This participatory approach delayed production of the materials, but resulted in comprehensive curriculum modules and materials that directly address the principal concerns of Kenyan churches in confronting HIV/AIDS. Entitled "Choosing Hope: The Christian Response to the HIV/AIDS Epidemic", the modules include all the materials and tools developed during the project, providing instructors and students with ready reference materials for each subject area.

Topics covered include:

- understanding the facts about HIV/AIDS
- addressing biblical and theological responses to HIV/AIDS
- means of mobilizing the churches to respond to HIV/AIDS
- giving pastoral care to persons, families and communities affected by HIV/AIDS
- offering pastoral counselling to persons, families and communities affected by HIV/AIDS
- guiding parents and youth on issues of adolescence, sexuality, gender and HIV/AIDS
- teaching about home care in the context of HIV/AIDS.

Curriculum modules and materials for 300 institutions were produced late in the project, so they were distributed during a follow-on project, also funded by USAID through a cooperative agreement with FHI. Soon after, the modules were endorsed by Kenya's largest Protestant denomination, which distributed them to all its 23 theological schools and pastoral training institutions nationwide.

Reaching Youth MAP had planned to produce a guidebook on sexuality and HIV/AIDS for churchgoing youth. However, the findings from two workshops with parents, teachers and youth workers and the baseline research among churchgoing youth indicated overwhelmingly that the audience should be parents and pastors. Young people had identified parents, then church leaders, as their preferred and most trusted sources of information, yet very little guidance was coming from those sources.

Growing Together, an integrated guide to youth, sexuality and parenting, was developed, field tested, published and distributed to parents, clergy and lay leaders in 16 workshops nationwide. The initial supply of 5,000 copies was exhausted within three months of publication, and an additional 6,000 were printed. The reception has been enthusiastic among youth and parents throughout Kenya.

Building Church Capacity One of the ways the project achieved its central objective—to expand the capacity of Kenyan churches to design, implement, manage and evaluate AIDS programmes—was by developing a national interdenominational network of churches involved in HIV-prevention activities. The Kenya Christian AIDS Network (K-CAN) was launched nationwide through the policy development workshops, but its growth was fueled by the pastoral counselling workshops. During 1996 the network grew from three to more than 30 regional and local branches throughout the country.

Through K-CAN, church leaders and Christians concerned about HIV/AIDS have met on average every two months, at their own expense, to share ideas, lessons and resources. A national advisory committee was established in 1994, during the first policy workshop. Its members have been fully involved, also at their own expense and on their own time, in the ongoing development of the network.

The *K-CAN Newsletter* provided members of the network with practical information on how to carry out HIV/AIDS-prevention and care activities. Six editions of the newsletter were written, printed and distributed to and through

the local and regional branches, with print runs increasing incrementally from 1,000 to 2,000 copies.

The MAP International/AIDSCAP Project disseminated information about HIV/AIDS prevention, care and policy through other publications as well. Eighteen articles were published in magazines, national and international journals, reference works, and denominational newsletters and publications.

MAP also established a video library at its regional office and made documentaries and materials on HIV/AIDS available to churches. Videos produced in Kenya and internationally were purchased, screened and catalogued. These videos have wide distribution, primarily through the project's regional coordinators, who have used them for training and awareness raising.

As a result of these capacity-building efforts, more than 200 local churches in Kenya initiated active and ongoing HIV/AIDS-prevention programmes. Many of these programmes center on the K-CAN network, but others are carried out through the energies of individual pastors and/or lay leaders. Church denominations, including the Methodist Church in Kenya, Presbyterian Church in Kenya, Church of the Province of Kenya, Organisation of African Instituted Churches and the Africa Inland Church, are developing policies and using the theological training curricula. Other responses and activities of the churches include youth programmes, counselling activities and visits and home-based care programmes for PLHA, as well as general awareness activities through youth seminars, women's group meetings and Sunday activities.

FINDINGS AND RESULTS

MAP and AIDSCAP used a combination of quantitative and qualitative methods to assess whether the project had met its goal of increasing the number and capacity of Kenyan churches initiating and managing effective, culturally appropriate and locally sustainable HIV/AIDS-control programmes within their communities. Near the conclusion of the project, a KABP survey and focus group discussions were conducted with church leaders and church-going youth. Process indicators such as number of people trained and materials distributed, which had been compiled regularly for project monitoring, and the observations of project staff also contributed to evaluators' understanding of the project.

Policy efforts were measured against a target set by project planners of having at least three policy issues placed for resolution before decision-making authorities in at least two national Church umbrella groups and five major denominations. This target was achieved and surpassed. During the second policy workshop, participants identified and committed to addressing 14 major policy issues with their constituencies. Signatories to this document represented four national and two international church umbrella groups, as well as 19 denominations. Specific policy development has been undertaken in these 14 areas by the National Council of Churches of Kenya, the Organisation of African Instituted Churches, the Methodist Church in Kenya, the Presbyterian Church of East Africa, the Africa Inland Church, the Church of the Province of Kenya and 12 independent denominations from Western Kenya.

MAP also attempted to measure how many people were using the various materials produced by the project, but this proved difficult. Each

of the almost 3,000 church and HIV/AIDS-information packets distributed included an evaluation questionnaire, but fewer than 50 responses were received. The volume of requests for the packets and other materials, however, suggests that people are using them. For example, the demand for the packets was such that MAP found it necessary to increase the number printed by 200 per cent. And in discussions with regional coordinators and travels throughout Kenya, it became clear to project staff that the materials were being displayed, used and distributed within churches.

The focus group discussions and KABP surveys² were designed to assess changes in church involvement in HIV/AIDS activities and church leaders' attitudes toward PLHA, as well as the HIV knowledge, attitudes and behaviours of young people targeted by the project. The format and audience for this follow-up research closely matched those of the baseline research. A total of 299 church leaders and 299 Christian youth aged 12 to 19 were surveyed. A third of the respondents were selected from areas where church leaders had not participated in pastoral counselling workshops, to serve as comparison groups.

The survey found that 60 per cent of church leaders were offering various services for PLHA, up from 38 per cent in 1994. The proportion of clergy offering such services was 22 per cent higher among those who had participated in workshops or other project-related activities than it was among those in the comparison group. Likewise, counselling of PLHA increased by 6 per cent overall, but was 17 per cent higher among clergy who had been affected by the project. Affected clergy were twice as likely to counsel people on the use of condoms as clergy who had not been influenced by the project.

Church leaders and people in the areas affected by the project were participating in a wide variety of HIV/AIDS activities, including marriage enrichment, AIDS care and support, behaviour change seminars, counselling, training of trainers, education on sexuality and marriage, and community outreach. All the church leaders who had attended two pastoral counselling workshops were involved in HIV/AIDS activities, and many of them were active in the development of K-CAN branches.

The commitment of these workshop participants to sustained, uncompensated initiatives is perhaps the most promising indicator of the project's success. They have reached deep into their communities through churches, schools, hospitals, clinics, civil administrations and other institutions to carry out a wide variety of activities. They have, on their own time and at their own expense, helped develop and expand K-CAN to more than 30 branches nationwide. And they are seeking means of broadening their impact in their communities using resources locally available to them, while at the same time seeking outside donor support for some specific activities.

Other findings revealed in a comparison between the baseline and end-of-project research results are as follows:

- More than 80 per cent of both church leaders and young people were able to identify at least two correct strategies for HIV/AIDS prevention. The proportion of respondents identifying these strategies increased by as much as 15 per cent.
- Among the youth in the target audience, there was a 50 to 75 per cent decrease in the number of individuals' sexual partners. More than 40 per cent of the young people

surveyed in 1996 had decided to have sex with only one partner, compared with 25 per cent in 1994.

- A significant increase in the number and frequency of church HIV/AIDS activities was noted from 1994 to 1996. In the 1996 survey, 55 per cent of pastors said that the churches were responding "well" to the HIV/AIDS crisis, as opposed to less than 2 per cent in 1994. The frequency of discussion about sexual matters, HIV/AIDS, male-female relationships and parent-youth issues increased by 15 to 20 per cent.
- Church involvement in HIV/AIDS-prevention programmes has begun to change pastors' attitudes toward PLHA. A significantly smaller percentage of affected church leaders believed that HIV/AIDS is a curse from God, compared with those in the comparison group. Their responses also seemed to provide evidence of greater sensitivity, alertness and acknowledgment of the impact of HIV/AIDS, as opposed to the indifference, silence and ignorance that had frequently existed before.

LESSONS LEARNED

Policy Development Issues One of the most fascinating lessons learned from the project was about the dynamics of policy development. When the project began, religious leaders saw very little need for church involvement. Not only was HIV/AIDS widely perceived to be a disease of "sinners," but it was also assumed that the epidemic did not significantly affect the church. PLHA were largely viewed with judgment and condemnation.

Local pastors, lay leaders and churchgoing young people, however, knew that HIV/AIDS was a severe problem for the church. The baseline research revealed that HIV/AIDS had already affected at least 70 per cent of local congregations, that promiscuity was common even among church leadership and that churchgoing young people were as sexually active and as engaged in risky sexual behaviour as non-churchgoing youth.

Yet because of the attitudes and beliefs of the church leadership, local congregations did not have the approval, mandate or training needed to deal with the emerging crisis. In some cases, local clergy were censured or disciplined for broaching the subject of AIDS in their churches. What was needed was for the church leadership to understand the magnitude of the HIV/AIDS crisis and its impact in the churches and for the local pastors and church leaders to be empowered to meet the needs of their communities.

The project used the baseline research results in various forums, including the policy workshops, to inform, sensitize and educate church leadership. When confronted with the reality and severity of the situation, they began to express their concern and to address policy issues with urgency, unanimity and commitment. This response was immediately and correctly perceived by local church leadership as providing empowerment and authorization. MAP was able to play key roles in facilitation, coordination and communication, which considerably accelerated the process.

The Role of Mediator/Facilitator It became clear very early in the project that MAP International's position as an "outsider" with "insider" credibility was key to the project's

success. The church in Kenya is fractured along denominational, theological and, in some instances, ethnic lines. As a Christian organization with credibility in health and development issues that was not identified with any particular church or denomination, MAP came to be viewed as a trusted facilitator. It was essential to the success of the project that facilitation not be associated with any particular perspective or viewpoint.

Information Development Dynamics One of the most valuable resources the project was able to provide to churches was information. Churches, for the most part, were not overly interested in advice, counsel or specific policy recommendations. They were very interested in knowing what the issues were. MAP was able to present balanced, well-researched, well-documented information from which churches could develop policies tailored to their own needs and philosophies. The policy statements for which there was such widespread consensus identified the issues, but left the specifics to the churches to address.

Capacity Building The project's experience reaffirmed the depth of the human resources available to churches in Kenya. What clergy and other church leaders lacked, for the most part, was knowledge, affirmation and encouragement. Initial encounters with most local church leaders revealed that they were well aware of the magnitude of the epidemic and the vulnerability of their communities, but felt powerless to act effectively. Training, provision of awareness raising and educational materials and interaction enabled them to engage more effectively in HIV/AIDS intervention.

Importance of Research The project's experience also affirmed the importance of baseline research. The research results provided the credibility and rationale for intervention. They also helped project planners identify the direction, content and target audiences for a number of the interventions.

A case in point was the development of materials for young people. Originally, it was proposed that these materials be targeted toward teachers for use with primary and secondary school students. But the baseline research indicated that parents and church youth leaders, rather than schoolteachers, were the preferred source of information about adolescence and sexuality. Therefore, the target audience and content of the youth materials were shifted. The result was that adults and young people received the parent-youth guide with overwhelming enthusiasm. *Growing Together* may prove to be the most widely used and successful teaching tool developed by the project.

Knowledge, Attitudes and Behaviour The project confirmed that although knowledge and attitudinal change are necessary precursors to behaviour change for HIV-risk reduction, behaviour change is usually a more long-term and complex process that is influenced by many other factors. Knowledge of HIV and prevention of the virus was raised to high levels and some corresponding attitudinal changes were documented, but only small changes in sexual behaviour were detected.

The project period of less than two-and-a-half years probably was not long enough to achieve dramatic changes in sexual behaviour.

Nevertheless, there are significant issues, often centering on core cultural values, where knowledge does not necessarily result in either attitudinal or behavioural change. Counterproductive and even dangerous behaviour seems to continue long after its negative effects have been proven.

Cultural Issues It is often said that Christianity in Africa is a mile wide and an inch deep. What this emphasizes is that underlying traditional cultural and religious values continue to be the foundation upon which behaviour is built. Changes in these core values are very difficult to achieve.

To effectively reduce the threat of HIV/AIDS, people must modify or dramatically change behaviour based on their core values. To do this, they have to be absolutely convinced that no alternatives are possible and that modification of their behaviour will not lead to greater ill.

For example, many Kenyan communities, both "traditional" and Christian, believe that HIV/AIDS has entered their communities precisely because they have abandoned traditional cultural practices, displeasing the supernatural forces that are entrusted with protecting them. They believe that the only way to restore health (in a broad and holistic way) is to return to strict adherence to those practices. Included among these practices are behaviours that significantly increase the risk of HIV transmission, such as polygamy, wife inheritance and sexual "cleansing."

Current HIV/AIDS interventions probably do not touch very deeply on these cultural issues and, as a result, achievements are considerably

weakened. It is also possible that as the epidemic intensifies, the practice of traditional cultural behaviours will increase.

Process vs. Productivity The project was well conceived, but significantly overambitious. Achieving consensus and collaboration among churches and religious denominations with fundamentally different theological, interpretative and cultural perspectives proved to be a tremendous challenge that required significant time and patience.

The resulting emphasis on building relationships during the first 12 to 15 months of the project often came at the expense of productivity. Logistical constraints, such as technical difficulties with computers, turnover of managerial personnel and questions about the budgetary ramifications of the devaluation of the U.S. dollar against the Kenyan shilling also made it difficult to meet some project deadlines. By early 1996, the project was behind schedule in the production of materials. As a result, MAP was forced to favour productivity over process during the last year of the project.

Finding a balance between capacity building as a process and the exigencies of productivity is likely to be a struggle in any project. Longer project cycles and a better understanding of the time involved in effective capacity building would help project planners build in sufficient time for the process to unfold.

BEST PRACTICE CRITERIA

Relevance Eighty per cent of the Kenyan population is Christian, and Christian churches have a highly visible role in national affairs, yet the churches were only marginally involved

in HIV/AIDS activities. The AIDSCAP/MAP project was able to foster a synergy between policy-makers and the grassroots in the churches, encouraging them to take a more active part in addressing the effects of the AIDS epidemic. This approach is relevant to other countries in the region where churches are equally influential.

Efficiency Despite a number of logistical difficulties and an ambitious scope of work, this project met the challenge of managing and monitoring its combination of process (capacity building and bringing together church leaders from different denominations) and products. In addition to submitting monthly financial and process reports, project managers used regular team meetings for regional coordinators to provide support, monitor activities and gain feedback.

Effectiveness/Impact The project well exceeded its quantitative objectives (persons trained, network branches created, materials printed and distributed). The KABP survey results showed that pastoral participation in HIV/AIDS-prevention activities increased from 1994 to 1996 by 6 per cent overall and was 17 per cent higher among clergy who had been reached by the project. More than half of pastors felt that the churches were responding “well” to the HIV/AIDS crisis in 1996, compared to less than 2 per cent in 1994.

Ethical Soundness The anonymity of all participants in the KABP survey and focus groups was assured. Participation was voluntary, and this was made very clear, particularly to young people. In recognition of some

churches' strong stands against condoms, participants in the pastoral training sessions were given a choice of whether or not to join the session in which condom use would be discussed. For those who did participate, the decision about whether to promote condom use was left to individual participants or denominations. Discussions on condom use included a factual presentation of scientific data on the efficacy of condoms as a prevention tool.

Sustainability Giving church leaders the support and guidance they need to become involved in HIV/AIDS prevention is a highly sustainable approach, because many prevention and care activities can be undertaken as part of the services they offer to their congregations. Three elements of the programme, in particular, fostered sustainability. These were the establishment of the Kenya Christian AIDS Network, which continues to link different church denominations at national and local levels; the development of a curriculum for pastoral training centres, which has already been adopted by some churches; and, plans to set up a revolving fund for reprinting materials.

Replicability This project is considered a replicable model for several reasons. Most important, churches in most sub-Saharan African countries and communities are seen as influential agents of change, and they have the same distinctive, two-tiered structure found in Kenya, with both the policy making and grassroots levels playing an instrumental role in mobilizing churches to action.

AUTHORS

Paul Robinson, Medical Assistance Programme (MAP) International, Nairobi, Kenya

Debbie Dortzbach, MAP International, Nairobi, Kenya

Ndunge Kiiti, MAP International, Nairobi, Kenya

Wilfred Amalemba, MAP International, Nairobi, Kenya

Brenda Rakama, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Nairobi, Kenya

Janet Hayman, AIDSCAP Project, Family Health International, Nairobi, Kenya

Michael Wamae, MAP International, Nairobi, Kenya

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