PN-ABY-800

91012

Proceedings from The Third USAID HIV/AIDS Prevention Conference

August 7–9, 1995
Washington, D.C.

Prepared for
The United States Agency for International Development

J. Brian Atwood, Administrator
Jacob Gayle, Chief, HIV/AIDS Division
Victor Barnes, Deputy Chief, HIV/AIDS Division
and

The United States Department of Health and Human Services

Edited and Produced by
AIDSCAP/Family Health Internatonal
Peter Lamptey, Director
Mary O'Grady, Associate Director, Information Programs
Addison Greenwood, Primary Consulting Writer/Editor
Helen Schietinger, Contributing Writer

The AIDS Control and Prevention (AIDSCAP)
Project/Family Health International

Project 936-5972.31-4692046; Contract HRN-5972-C-00-4001-00

July 1, 1996

Dear Participant:

It is my pleasure to share with you the Proceedings from the USAID Third HIV/AIDS Prevention Conference. Like its predecessors, the August, 1995, meeting was historic in its significant impact upon the direction of USAID's response to the HIV pandemic. By virtue of bringing together those from around the world who work toward the prevention and mitigation of HIV/AIDS, these meetings have provided a unique chance to record the collective knowledge and wisdom borne of the efforts of many. We call these opportunities "lessons learned," and nowhere is it more important to distill and disseminate such knowledge than when the lives of so many may depend upon it.

Over the years, USAID has maintained its global leadership role in HIV/AIDS prevention through its devotion of more than $700M to the support of multilateral, regional and bilateral programs in more than 50 developing countries. In pursuit of the Global Bureau mission, USAID continues to encourage the sharing of "lessons learned" among those directly engaged in HIV-related interventions worldwide, and the HIV/AIDS Prevention Conference successfully demonstrated that commitment. For through this landmark interaction, participants shared insights on how to improve efforts in providing technical leadership in assembling diverse thematic and geographic perspectives on problems of recognized significance for HIV prevention in the developing world; how to advance the state of the art by systematizing and disseminating new joint analyses of these problems; and how to highlight the relevance of insights from global HIV/STD efforts for improved policy and programs in the U.S. and elsewhere.

We are gratified by the results. We invited people to a working conference, and the 750 who came worked long and hard to fashion conference products that would be of maximum value. They brought their experiences from the field into a forum where they could compare and analyze projects, in the process expanding the catalog of lessons learned, and establishing a basis for consensus about where to go from here. Resources are always limited, and thus the Agency needs to direct them toward the most efficient and effective interventions. Only through such a dialogue as the conference engendered can we begin to arrive at such a consensus that truly reflects the many diverse perspectives, communities, and constituencies involved.

We want to commend those who participated and devoted themselves to these discussions with passion and compassion and commitment. The Proceedings report contains its share of conclusions and recommendations based on the Third Conference, which was designed to establish the context for a sharing of insights. USAID has already begun to reflect its responses to these summaries in its programs and policies. But the report is far richer than a string of recommendations, for it conveys the sense of commitment and consequence shared by those who work in HIV prevention. When we gather to talk about HIV/AIDS prevention, we must also listen. In this report, our conversations are recorded, and we hope the reader will develop a deeper appreciation for the important mission we share on behalf of a humanitarian world.

Yours in partnership,
Jacob A. Gayle, Ph.D.
Chief, HIV-AIDS Division

Table of Contents

iii Letter from the Chief, HIV-AIDS Division, U.S. Agency for International Development
vii Acknowledgements
1 Introduction
3 Executive Summary

9 PLENARY SPEAKER SUMMARIES

49 ROUNDTABLE SUMMARIES

Issues Cutting Across the Prevention and Care Continuum
53 Prevention and Care: Implications for Program Improvement and Sustainability
60 Protecting, Respecting and Strengthening Human Rights: Ethical Dilemmas in Clinical Practice
64 Pros and Cons of Merging HIV and/or STD Services into Other Health and Family Planning Services
69 Benchmarks, Performance Indicators, and Evaluation of HIV/AIDS Interventions: How Do We Measure Intervention Results?

Communities and the Context of Interventions
77 Community Participation and Sustainability: Increasing Participation of and Advocacy for Beneficiary Communities in HIV/AIDS Programming
80 Building Bridges Among Communities to Introduce New HIV/STD Products

Specific Strategies and Components of Behavior Change
87 HIV Counseling for Behavior Change: Available Approaches and their Requirements and Uses
92 Behavior Change Communication: Selecting Strategies to Suit Specific Audiences and Settings

97 ORAL SESSION SUMMARIES

Issues Cutting Across the Prevention and Care Continuum
101 The HIV/AIDS Prevention and Care Continuum
103 Pros and Cons of Integrating HIV/STD Services into Other Health Services
104 The Private Sector Response to HIV/AIDS
105 Policy Dialogue: What It Is, How to Use It?

3'

Communities and the Context of Interventions
107 Community-based Interventions in HIV Prevention and Care
108 Targeted Interventions: Communities Respond to the HIV Epidemic
109 Impact of Culture, Socioeconomic Status and Gender on HIV
111 The Role of Social Environment in HIV Risk Behavior
112 Involving Indigenous and Traditional Groups in HIV Prevention

Specific Strategies and Components of Behavior Change
115 HIV Counseling and Testing
116 HIV Education: Working with the Media
118 HIV and Youth: Meeting the Challenge
119 Condom Social Marketing: Generating and Meeting the Demand for Condoms
120 Intervention Research: New Strategies and Methods
121 Case Management of Sexually Transmitted Diseases

123 CONFERENCE AGENDA

129 ROUNDTABLE PARTICIPANTS

135 ROSTER OF ORAL SESSIONS

153 CONFERENCE PARTICIPANTS

189 ACRONYMS/ABBREVIATIONS

APPENDIX
195 Oral Abstracts

-4-

Acknowledgements

This Proceedings report tries to convey the sense of exploration and dialogue that characterized the conference. With three full days of symposia, speeches, working group meetings and oral sessions among 750 participants—and dozens of discussions before then to prepare for roundtable sessions—the sheer volume of ideas and conversation threatened to overwhelm any attempt to render it. USAID and AIDSCAP/Family Health International believe the important ideas developed by participants deserve the widest possible circulation, and thus selected a narrative format designed to appeal to the reader, built around summaries of essential content rather than attribution to particular individuals. Summaries of the speakers' remarks were *not* reviewed by individual speakers, and we hope they do not misrepresent their intentions or their speeches.

Every idea and most of the words in these Proceedings come from too many individuals to cite or credit, but we would like to acknowledge here the contributions of the many people who helped to generate and refine the insights we have synthesized. In particular, we would like to thank the many staff members of AIDSCAP/Family Health International and the HIV-AIDS Division of USAID who served in so many vital support roles, acting as advisors, facilitators and rapporteurs for the conference.

We also would like to thank Panos Pictures in London for allowing us to continue using Sean Sprague's (cover) photograph of an AIDS counselor clasping the hand of a person living with HIV as the conference emblem; and, The Magazine Group in Washington for designing these Proceedings, providing the opportunity to more widely share and continue this dialogue.

5

Introduction

As the principal bilateral donor of resources to the developing world for the prevention and control of HIV/AIDS, the United States Agency for International Development (USAID) conceives its mission as assisting countries to find the most effective way to respond to the epidemic. And while opinions may differ about how best to accomplish that mission, experience in the global responses to HIV/AIDS for over a decade has shown one resource in particular to be most valuable:

The lessons learned and insights developed by those working on the front lines.

In an effort to collect, distill and disseminate that resource, the 3rd USAID HIV/AIDS Prevention Conference organizing committee, invited to Washington representatives of those most likely to possess this vital intelligence: Program implementers, health care providers, activists, thinkers, researchers, policy makers, educators and people living with HIV/AIDS from around the world. Over 750 professionals from 52 countries convened for three days of intense, provocative and searching dialogue. They came to share, to challenge and to learn; to pose important questions, and to search together for answers.

To provide a supportive context for this exchange, the conference was organized around an intensely interactive process. Eight central themes were selected from a wide range of possible subjects; these would serve as the basis for eight Roundtable tracks. Background papers to establish the context and major issues for each were commissioned. Groups of experts versed in each of the eight topics were convened for pre-conference workshops, Co-chairs were appointed, and staff rapporteurs were assigned to facilitate and record the essence of the discussions.

When the conference proper began, participants were free to choose the subject that most engaged them, and to join the Roundtable panel members and become thereby part of a larger working group of several dozen or more. These de facto committees met formally and informally several times over the three days, and each produced a report that was summarized for the Conference during the Closing Plenary Session. The participants in all of the Roundtables shared a common charge: To collaborate on a report that would reflect a synthesis of their views on the major issues around that topic, and to try to articulate practical recommendations for action. Some were directed explicitly to USAID, others to the field at large. A fuller version of the deliberations behind those reports is summarized in this document.

While conference participants were engaged in this ongoing Roundtable process, they were also able to attend a number of two-hour oral sessions. Organized around fifteen discrete issues, each of the oral presentations flowed from a half dozen discrete topics, chosen to represent the major issues facing HIV/AIDS programs and the projects supported by USAID's prevention program. The abstracts of the 90 original research projects, as well as a summary of each oral session, also appear here.

Finally, the format provided a forum for seventeen individuals to address conference participants on a chosen issue of significance in the HIV/AIDS universe. Speakers came from the U.S. government, from international organizations, from nongovernmental organizations and from private voluntary organizations. Each provided her or his views and these also are summarized herein.

As all of this material is gathered into print for the first time here, a number of emergent themes are apparent. The Executive Summary that follows begins to distill what

- 6

emerged from this three-day gathering of individuals and the nations they represent, as they design and implement global and local prevention strategies, as they fight for and alongside of those living with—and dying from—HIV/AIDS, and as they collaborate on a common goal: A global response to HIV/AIDS. One small but important episode in that collaboration was this conference, and USAID is committed to devising ways to act on the suggestions it produced. We hope this publication reflects the wisdom and honors the spirit of truth-seeking of those whose participation made the conference a memorable and significant event in the global struggle to combat HIV/AIDS.

Executive Summary

The prevention and control of HIV/AIDS has become an issue of global significance—well into the last decade of this millennium, nearly 20 million people have contracted the virus, and epidemiologic forecasts suggest that as many as 40 million people will be infected with HIV by the year 2000, possibly decades before—and *if*—scientists develop and disseminate an efficacious vaccine. Thus must everyone face the universal threat and construct their own response to the challenge, which is faced forthrightly by those who convened for the Third USAID HIV/AIDS Prevention Conference: How to prevent the spread of the virus, and how to construct a response to the pandemic that will assist in the mitigation of the virus' devastating effects on the people, communities, nations and societies of our world.

If the successful search for a vaccine—as well as for a way to reverse the lethal effects the virus has on the human immune system—is an effort of future benefit, there remain very real, pragmatic and crucial steps to be taken today, every day, and these comprise the province of HIV/AIDS prevention and care.

ISSUES CUTTING ACROSS THE PREVENTION-CARE CONTINUUM

The virus has circled the globe relentlessly, penetrating into every community and level of society. Its biological success, to our chagrin, brings home one important lesson: Controlling the spread of HIV/AIDS requires a new and wider range of systemic, social and medical responses; and a first step must be to reexamine the traditional categorical distinctions on which health care and social service systems have relied. Thus, in this new era and under circumstances that are becoming increasingly clear and urgent, prevention efforts and care services must be viewed—and delivered—as a continuum. This recognition in turn requires that several important factors frame the entire enterprise—

- ***Decision-makers, policy planners, donors and the general public all need to better appreciate how prevention interventions depend on effective overarching national HIV/AIDS policies.***

A great challenge faced by a nation responding to the HIV/AIDS epidemic is to shorten the time between recognizing the nature and severity of the threat, and figuring out how to effectively deal with it. How well and how quickly the lessons learned in HIV/AIDS prevention and control can be effectively conveyed to countries will be scored in the numbers of lives saved and prolonged—and those numbers could be in the millions. Thus while conferences like this one are vital to synthesizing these lessons and insights, communicating them is even more crucial; and that communication becomes an intricate process of feedback at many levels and in many directions. It also relies on a more cogent awareness of the gender, class and power differentials that can compromise even acknowledging the true nature of the problems, as well as affect individuals' ability to implement solutions.

The primary lesson learned by nations as a whole has been that HIV/AIDS threatens the very social fabric, well beyond the tragic toll of actual lives lost. The resources diverted from a country's development program to provide care for those affected is only the most literal cost. As HIV/AIDS has moved to general populations, the infection of increasing numbers of women and youth further diminishes the human capital nations rely on to invest in the future. The urgency of the pandemic needs to be translated into every context from boardrooms to village gathering places, and translated into prevention efforts and programs that begin to break the cycle

8

of poverty, powerlessness, unawareness, vulnerability and disease.

The underlying basis to inform this process is evaluation. Figuring out how and to whom to deliver recommended programs is important, but the pre-requisite is knowing—and being able to demonstrate—what works, and why. The key to this is building evaluation into programs from their very inception. Second, ensuring a sense of ownership, across all social levels, for the response to HIV will clarify and fortify linkages among all social strata along the prevention and care intervention continuum, from policy maker to community worker.

- ***HIV/AIDS does not pose its threat in isolation—it* is *a sexually driven pandemic which must embrace those infected and affected in order to prevent new infections.***

Several basic facts underlie this recognition. Those at risk for STDs and those being treated for them are at greater risk for HIV/AIDS; people living with HIV/AIDS have important roles in formulating and implementing responses to the pandemic; and resources to provide care and to mount prevention efforts are—ultimately—limited and linked. Thus, even though everyone who is sexually active is at *some* risk of contracting the virus, dollars spent on prevention strategies are likely to save more lives when targeted toward behaviors that put people at the greatest risk.

And yet there is no universal formula, since effective prevention as well as good health care needs to be tailored to the client or intended audience. Models can be judged however, by their effectiveness and efficacy, and by how feasible and affordable they are over the long-term; altogether these criteria must translate into programs that are fully accepted by the recipients and sustainable beyond the specifics of donor funding. Health care providers need to be trained to provide both appropriate care and prevention services. And one way to ensure that services are appropriate is to fully involve people living with HIV/AIDS in all planning aspects of their own care, as well as in crafting prevention education messages and interventions.

- ***The human rights of those affected by HIV/AIDS are inalienable; therefore, all policies, programs and interventions need to be built around a core of basic ethical principles.***

Those living with the virus confront a society that flagrantly challenges their fundamental rights. Within the social and cultural context of their community, and the legal context of their society, they must make their living, try to gain the health care and other services that they need, and assert their basic human rights. Thus, the question is not whether but *how* to implement this goal in the context of HIV/AIDS prevention and care.

A number of factors need to be addressed. People must be free to speak and associate, despite the stigma and discrimination that often surrounds those with HIV/AIDS. Women and other groups at higher societal risk for contracting the virus must be acknowledged, and given the social and structural supports they need to mitigate this increased risk. And people must be able to address their basic human needs, including access to available care, once they fall ill.

In most health-related situations, the issues should be framed around some fundamental principles: People should be given as much autonomy as feasible; their opportunities should be protected and strengthened; their treatments should certainly do no harm, and ideally should be structured to accomplish some valid aim of value to them. USAID and other donors should work with national governments and the private sector, as well as with counterparts in the community, especially people living with HIV and AIDS, to develop policies and practices that ensure an ethical response to the pandemic which protects human rights.

9.

COMMUNITIES AND THE CONTEXT OF INTERVENTIONS

What determines whether an intervention will actually work? Perhaps the primary lesson learned over the last decade provides a starting point to answer that important question—

- ***Communities must participate at every level of policy and program development.***

To recognize this important factor is not the same as realizing it. There are a number of crucial facts that planners need attend to in order to fully involve the community. To do so is not deference to local authority and custom—rather, it is vital to an intervention's success, for several reasons. First, the community is most "in touch" with what is most needed at the local level. Second, community leaders have local credibility and access to those intended as recipients of services. Third, the goal of most interventions is behavior change, and we have learned that attaining this difficult outcome is more likely in the context of an ongoing relationship—community-based organizations are best equipped and constituted to develop and maintain such relationships. And most importantly, only by "growing" such relationships—between those who need HIV/AIDS prevention and care interventions and the providers and implementers who ensure that they receive them—will the program and the behavior it is directed at likely be sustained through the vicissitudes of donor funding and support.

- ***Common purpose must be established and bridges built among all stakeholders.***

The world of HIV/AIDS prevention and care programs is an incredibly diverse patchwork of governments, nongovernmental organizations (NGOs), community-based organizations (CBOs), delivery systems and the cultures that underlie them, but the crucial recognition is that *people* are the basic element; systems only serve—better or worse—to help the actors to realize their intentions and ambitions. From this basic premise, several principles can be seen at work fueling effective interventions.

First, each actor and constituency must be recognized and their inherent characteristics appreciated (e.g., diverse groups of individuals, health care and service providers, industries which produce products, researchers who develop and evaluate them, implementers in government and nongovernmental and other organizations—local, national and international—who fund and deliver them, and the media who generate and disseminate ideas about them). Second, a common agenda must be constructed, and a consensus must be built around it. Lessons learned about communication and acknowledging the history and context of these interactions must be harnessed to the goal of building trust and resolving conflicts. And third, the process must be participatory. The idea is not to merely acknowledge everyone's stake, but to construct a workable system, for designing, implementing and sustaining interventions and the delivery of products, that works for everyone.

- ***To be effective, prevention and care interventions must be tailored to the sociocultural context of individuals and communities at risk for HIV/AIDS.***

Most interventions, especially those intended to change behavior, will work only when they have been constructed "from the inside out;" that is, with the overt thinking and underlying cultural realities of the clients in mind. Women and youth for example—both groups increasingly at risk in many developing world societies—should be perceived and approached in the world where they live, with the power differentials and the cultural roles they inherit and must cope with. Another "group" at increased risk for HIV/AIDS is the poverty-stricken. Whether from lack of access to health care services, or due to risky behaviors that evolve more easily in the overstressed lives they must

19

lead, to suffer from poverty in many countries is to be more vulnerable to STDs and to HIV/AIDS.

Here again, the community-based perspective proves crucial. People live their lives through patterns, and health care providers will have more success in delivering their services when those patterns are respected. You go where and when the people are; you speak to them in ways, words and images they respond to; and you appreciate the personal context in which they receive your interventions. To communicate effectively and to penetrate to the level of meaning that can lead to behavior change, you must take people as you find them. This incredible diversity requires a dedicated, ingenious, and ongoing effort to devise and implement meaningful interventions.

SPECIFIC STRATEGIES AND COMPONENTS OF BEHAVIOR CHANGE

As with the sustainability of projects mentioned above, so too can behavior change serve as both a goal of intervention and as the context for stitching together various approaches into a coherent response to HIV/AIDS.

- ***To be successful, messages about HIV/AIDS and strategies to influence behavior must be conceived and delivered in the wider and more collaborative context of education.***

Across the diversity of human communities, certain facets of human nature seem to constrain the ways one can prescribe and dictate human behavior, especially as concerns sexuality and sexual behavior. Much has been learned since the early days of the epidemic, when the standard message was fear-driven, and generally empty of content. Now it appears that the most effective messages target behaviors, not groups; they anchor and relate these behaviors in a natural way to the cultural context the target audience recognizes (and at times to other programs already generally accepted); they focus realistically and strategically on reducing risk and on "improving," rather than "fixing" or eliminating risk altogether; they are best conceived and designed by *all* of those affected in the community—especially those living with HIV/AIDS—and they come from recognizable or credible spokespeople.

Notwithstanding the diversity of cultures where HIV/AIDS prevention messages must be created, a demonstrably effective and universally acknowledged strategy is to promote the use and assure the availability of condoms. Condom social marketing is beginning to leave behind the question of whether it is *appropriate,* despite pockets of continuing religious and cultural resistance. Now two other issues have assumed center stage: How to get the product into the hands of those who need it most efficiently and reliably, and how to develop the awareness among those at risk that *they do need it.* In this connection, the private sector has developed a range of creative and specifically-tailored strategies and interventions, for delivering condoms as well as for elevating HIV/AIDS awareness.

- ***Counseling in HIV/AIDS prevention and care is time- and labor-intensive and potentially controversial, especially when linked to mandatory testing for the virus; yet behavior change is most likely to endure when based on the deeper understanding such encounters promote.***

The role of counseling for those at risk or already infected provides an effective method of delivering prevention messages as well as an important way to *know* whether the appropriate messages are getting through to those who can most benefit by them. However, given the astounding diversity of background and world views of its millions of potential clients, and the resources required to do it well, the challenge is daunting. While counseling—especially in conjunction with testing—offers a crucial

"moment for intervention," it also affords the potential to undermine the civil and human rights of individuals, especially with the specter of mandatory testing and the problems of confidentiality and misuse of test results. And here also does the prevention community run up against their greatest challenge, using limited resources to try to attain a difficult goal—changing how people think and behave.

- ***Targeting interventions toward those at higher risk courts the danger of stigmatizing them, while at the same time providing the opportunity to effectively change behavior.***

Nowhere are the challenges more formidable than with reaching the young, though it is widely believed that behavior change is more likely to endure when it is instilled during a person's development, and based on ways of thinking that are themselves likely to be sustained. Here the most innovative strategies must be developed, and delivering prevention and education messages through peers and those who possess inherent credibility has been promising. Similarly, risk behaviors in this group are more often peer-driven than chronic. A key recognition has been that all young people face many difficulties in just growing up, and that effective behavior messages should embrace all of a youth's world comprehensively.

Targeting those being treated for sexually-transmitted diseases (STDs) also provides an opportunity to intervene at a particularly strategic point. Not only are those with STDs at increased risk for HIV/AIDS, but they are likely to be receptive to awareness and behavior change messages. Since they are "in the treatment system" to some extent, that system might better seize on the opportunity by reorienting the case management of STDs to further emphasize HIV/AIDS prevention strategies, which are equally relevant to STD control.

A World Without HIV/AIDS? No time soon...

The sobering truth is that the world is having to learn to co-exist with the virus and the disease course that it follows. As each country faces up to the challenge of caring for its own, civilization's collective history is being written. The story can be broken down in two ways. First, there is the division of labor among those responding to HIV/AIDS. Traditionally, this has included biomedical people in their laboratories, searching for the magic bullets, the vaccine, the cure. Then the health care providers, who help people with the virus deal with their disease. Finally, the "long-term" professionals and advocates, concerned with prevention, which has been the formal province of many initiatives such as those supported by USAID.

What the world must now face, and what those convened at this conference made especially cogent, is that these distinctions have blurred. The social world that has become the home for HIV/AIDS is now global, as the virus has reached the proportions of a pandemic and penetrated into every corner of every society. The political/economic world has long appreciated the crucial interdependence of the "North and the South," and has emphasized the links between the developing and the developed countries. But now as the epidemic enters a mature phase in some areas in sub-Saharan Africa—where a majority of those infected with HIV/AIDS live—the horrible swath of tragedy begins its inexorable shift toward the most populous areas of the world, India and Southeast Asia. The one lesson learned above all else has been that the virus knows no borders; our response to it must be equally dynamic, and this means developing a global, unified response for HIV/AIDS prevention, research, care and management.

But a second way of reading the history of HIV/AIDS is as a sequential narrative, leading us into an unknowable future.

Beginning with the mid-1970s, the "era of silence" saw the virus spread internationally, moving along almost invisibly as few people had progressed to AIDS, and precautions were few. When HIV/AIDS was "discovered" as a social and medical problem in 1981, the era of discovery was launched. Much was learned about the nature of the disease, but its sociological implications remained for the most part hidden. By 1985, the world was beginning to appreciate the true proportions of the threat, and the World Health Organization's demonstration of this truth launched the era of HIV/AIDS as a global issue. Whether we have begun a "fourth era" after 1995 is a matter of semantics; what is clear is that though the virus is now receding in some populations, in others a dramatic increase in infections has made the epidemic a critical element in the social fabric of many countries.

The issue before the world is now becoming starkly clear. Biomedicine may take decades to "conquer" the virus. Meanwhile, 20 million people have contracted a deadly disease, and whether that number will double or even triple depends almost exclusively on how people—individually and collectively—behave. This is the fulcrum for the future: The behavior of people will determine the ultimate course of HIV/AIDS. Supporting, educating and enabling people to *choose* a future free of HIV/AIDS is what prevention is all about. It is a mission that a humanitarian civilization—and a dramatically interconnected one—cannot shrink from.

13

Plenary Speaker Summaries

14

Plenary Speaker Summaries

THE OPENING REMARKS OF
J. Brian Atwood
Administrator
United States Agency for International Development
Washington, D.C.

The pandemic that is HIV/AIDS continues. Keynote speaker J. Brian Atwood, Administrator for USAID, welcomed the conferees to the Third USAID HIV/AIDS Prevention Conference with the paradox and twin sentiments that would echo throughout the three days: "Together we have overcome fear, comforted those who have contracted the virus, and helped to prevent millions of others from suffering its consequences." And yet, he insisted, "we must commit ourselves to be honest about our failures as well as our successes...for the stakes are high. After 15 years, though much has been learned, our knowledge still lags far behind our commitment."

The 1980s was the decade of HIV infections, but as the lengthy inexorable progression of the disease makes its way through the communities and countries of the world—and the bodies of its victims—the pandemic has taken on new proportions. For the 1990s and the dark ominous cloud of the coming years surely represents the time of AIDS mortality. That cloud augurs a "gathering storm, because of the more than 19 million men, women and children (through 1995) who are infected. This year alone, between 300,000 and 600,000 will die from AIDS," and the infection figures are such that we can now predict that during the year 2000 that somber annual death figure will climb past 1.5 to perhaps as many as 3 million. "This toll will reverberate in every nation, and especially in the developing world...and the early demise of those who die of AIDS is a tragedy—their deaths shake the very foundations of our communities, and our nations."

Such language is not hyperbole; if language can begin to capture the urgency and gravity of the situation, then it must be forthright and it must be mobilized to serve the cause of prevention. "Only by being provocative," said Atwood, "can we overcome that dangerous blend of fear and complacency and provoke our fellow citizens—if necessary embarrass them"—into the kind of community action that we have learned *must* be erected as the foundation to effectively inhibit transmission of the virus.

The human toll

"HIV increasingly targets women," noted Atwood. "Already in Africa, more women than men are infected...not because of their behavior but because of the behavior of their partners." And in both the developed and the developing world, the largest group of newly infected are adolescents aged 15 to 25. "And children, both directly and indirectly. By the year 2000, there could be 10 million orphans" spawned by AIDS. That number is terrifying, but commonplace in the era of HIV/AIDS; what is important is to put a human face on these statistics. For Ugandans presently in the throes of a mature epidemic this is not hard to do: Their life expectancy has declined to 37 years, a number that was last common to men millennia ago. Others in the developing world in the next 15 years will watch their nation's life expectancy plummet by more than 25 years.

The uncontainable scourge

But it is our job, said Atwood, to "communicate the simple truth that these statistics are not someone else's problem; that if communities wither and nations fail, all of us will pay." The price we face is not only money for relief and to keep the peace as civil unrest increases; it is also the loss of markets and jobs, and "most importantly, the spiritual price. Not only from the loss of so many souls, but from the loss of people who could have been the scientists, the teachers, the legislators and builders of their nations." The virus "robs nations of caregivers; it destabilizes families, the basic unit of development."

15

Thus emerges a simple basic truth of the epidemic, which cannot be confined to medicine: HIV/AIDS is a development issue, "striking those who should be at the forefront of development in their communities—women, young people and children." As the world shrinks from the sheer technological pressure of global communications, experts need to broadcast the inescapable truth that "the epidemic threatens *all* people, rich and poor alike; it is not just a problem for countries far away, for people of a particular sexual preference, not just for those already infected. It is," urged Atwood, "*our* problem." Our success depends on "our ability to personalize a disease that has been stigmatized. Too many have ignored the threat this disease constitutes to our communities" by framing it in the context of remote peoples, nations, subgroups or lifestyles that are not our own. The time for such rationalizations is at an end. Fifteen years and millions of deaths after its appearance, HIV/AIDS now requires our personal attention: "No one can be excused for ignoring the human and societal consequences of this disease."

The turning point?

Thus does the Third Prevention Conference unfold at a critical point in human history, for while "the deaths predicted for the year 2000 may indeed be unavoidable...the 1990s can become [for historians] the decade of containment, the high water mark of the HIV epidemic, the beginning of the end." For us to write this history, a number of challenges must be met. Governments and leaders who would deny the reality or significance of the threat must be challenged. Nations in both the developing and developed worlds must meet the challenge of committing the vital resources for this war. "And we must," Atwood addressed the conferees directly, "challenge ourselves, as professionals on the front line: This conference is an opportunity to take stock, to debate and disseminate our most valuable lessons; to assess what we have actually accomplished, to identify what worked and why," as well as what failed—and also why that happened.

And the final and ultimate challenge: "Coming to grips with the nearly open-ended challenge of assisting and supporting people with AIDS." Everyone in this struggle knows many people living with HIV/AIDS, and tragically, many who no longer are. Atwood recalled family friend Richard Stone (who had learned to live with hemophilia from birth), "a highly successful professional with a well developed sense of humor and a [passionate] love of life...His death and that of so many other young people bring painfully to mind that old Roman curse: *May you outlive your children*—what could be worse?" And yet his parents and brother and sister and his surviving friends will "forever be inspired," insisted Atwood, by the positive outlook he maintained while suffering and—inevitably—dying from AIDS. Such pain and tragedy, which plagues so many parents in all parts of the world, can be borne and it can be shared, once we sketch the human face onto the social abstraction.

Shortly before the conference, Atwood was visiting The AIDS Support Organization of Uganda (TASO), and talking with colleagues in a courtyard there. His briefing came from Noerine Kaleeba, who, though she had lost her husband to AIDS, is "one of the most impressive and optimistic people I have ever met." She gave him her memoir, *We Miss You All*, only after he promised to read it, which he did. Therein he came upon the secret to her success:

> *I live with the agonizing fears and questions of when, where and how it might come for me. I have, however, opted to live positively with these fears, fight in the open, contribute as much, for as long as I can, to the fight that will eventually lead to HIV's defeat.*

The mission and the challenge

Such people as Richard Stone and Noerine Kaleeba and thousands more contin-

ually provide the human face on the disease for the professionals working in HIV/AIDS prevention and cure. The human nature that provides the context for the epidemic also cannot be ignored, however: "To be frank, AIDS is a battle against homophobia and racial prejudice," charged Atwood, who left no room for doubt: "This Administration will fight both *against* this horrible disease and *for* the rights of those who suffer from it." This is the human flesh on the skeleton of the Agency's work: 400 prevention programs in 42 developing countries, reaching nearly 3 million people in communities (through support of over 200 PVOs and NGOs) with comprehensive HIV/AIDS prevention education and training.

Atwood rang down his keynote with the hope that the conference could provide those gathered for it with a "renewed commitment to [all of] the people who are affected by this disease." He hoped they would carry away an enhanced effectiveness from having shared their knowledge. "Whether scientists, public health officials, politicians or development experts—you must also be an advocate," he charged, "demanding of your fellow citizens" the commitment to galvanize their governments to make the investments, and to develop the policies and the tools [required] to fight this disease.

A PANDEMIC WITHOUT BORDERS: U.S. INTERESTS IN HIV/STD PREVENTION WORLDWIDE

Patricia Fleming
Director
Office of National AIDS Policy
Washington, D.C.

When the Office of National AIDS Policy was established by the Clinton Administration, it signaled a rededication to the U.S. commitment to combatting the HIV/AIDS pandemic, at home and abroad. A number of NGOs and government agencies come together in this vital struggle, and Ms. Fleming saluted USAID, the Department of Health and Human Services (HHS), the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) as part of this American infrastructure. She also acknowledged the people gathered for the international prevention conference, saying it was "like a family reunion...of women and men committed to fighting HIV and AIDS and standing up for the people affected by this insidious disease."

Though the million people living with HIV in the U.S. amount to 1 in 250, Fleming acknowledged that "in some communities in developing countries, that rate is one in two and the ravages of HIV and AIDS are leaving many nations unable to cope and unable to compete in the world economy." She also cited the more personal face of that tragedy in that "AIDS is wreaking havoc on families around the world." And though the numbers pale in comparison to some other cultures, some 80,000 American children will be orphaned by the end of the decade. "These are not just problems to be dealt with today, they are a threat to our very future," she warned. "When we wipe out a generation of leadership, we erase part of our future. That is something that none of us can afford."

Domestically, a number of signs are encouraging. Each of President Clinton's three budgets has increased funding for AIDS research, prevention and care—a total

of over 40 percent, and much of those funds went to USAID and international efforts. Her own office has been established to coordinate all of this activity, and in July 1995 the President's Advisory Council on HIV and AIDS held its first meeting.

The Office of AIDS Research at the NIH has been strengthened, and the CDC HIV/AIDS prevention programs have been reviewed and reorganized. "We have gone to the community for some of the answers through the community planning process," she explained. Instead of a top-down approach to prevention, we are asking community councils, along with state and local health departments, to decide how to use their prevention dollars from CDC. We are beginning to see that this kind of empowerment can work."

Ms. Fleming saluted the early work of Dr. Piot in getting UNAIDS off the ground in spectacular fashion. She reinforced that America has "also worked hard in the international arena to maintain and expand the American contribution to the global fight against AIDS. The U.S.—through USAID—remains the leading contributor of funds for AIDS prevention and research activities throughout the world, including our contribution to the new UNAIDS program."

She reassured the conference that attacks on USAID and international aid in the Republican congress would not compromise the Administration's commitment to supporting the global war on HIV/AIDS. "Let me make one thing clear," she said, "No matter how this debate goes, the United States will not retreat from its commitment to be a full partner in the global response to HIV and AIDS. It is much too important a fight for us to sit on the sidelines."

One of the tactics is to support stronger links between international and national NGOs, which she considers a crucial foundation for effective prevention. "We can design the best interventions in the world, but if they don't work in the real world they aren't worth doing. We need the insight and the input of the community to make sure that programs" are designed to produce the results that the consensus agrees on.

Research is also a vital piece of the picture, she said, citing recent work in the U.S. heralding a way to sharply reduce perinatal transmission; also progress in the development of protease inhibitors as an anti-viral agent; also increased attention at NIH to vaginal microbicide agents. But research is more than just doing the science, she insisted. "We need to work on the transfer of research results. We cannot, in good conscience, just watch as millions of people around the world are unable to get help from the advances of medical science. We have to find better ways to share the fruits of our labor with the people of developing countries. I don't have the answer to this dilemma, but I am determined to pursue it," she promised. A related issue is how people in other countries can be assured benefit from the research American and other foreign scientists conduct in their communities.

Ms. Fleming invoked her own history to stress the priorities she intends to pursue in her post. As an African-American woman with a gay son, she appreciates how much the fight against HIV/AIDS "is also a fight against sexism, racism, and homophobia." She cited figures to show that AIDS "is now the leading cause of death among African-American women between the ages of 25 and 44." Women around the world are caught directly in the line of fire, and she wants to encourage, among other interventions, greater use of the female condom.

"I know first hand the value of gaining a seat at the table," she said, invoking her background as a long-time congressional staffer, when much policy affecting African-Americans was being decided on. It is for this reason that her office devotes so much energy to reaching out and involving affected communities in all aspects of their work and mission.

Her final words to the conference reminded them of a sobering statistic. After

18

fourteen years of the epidemic, "more Americans lost their lives than were killed in the Korean War, the Vietnam War, and the Persian Gulf war combined." And she knows that around the world, the death toll is much higher: An average of 6,000 people are infected with HIV every day. "We must maintain our commitment to ending this epidemic. I pledge to you that as long as this Administration is in office, we shall do just that. If we are to prevail—and I believe we will—we will need an alliance of the hearts and minds and resources of the world. With the passion, compassion, and the will of the people in this room today and our comrades around the world, I know we can prevail. Because we must."

EVOLVING RESPONSES TO THE AIDS EPIDEMIC: A DEVELOPING COUNTRY PERSPECTIVE

Dr. Eustace P. Y. Muhondwa
University of Dar es Salaam
Dar es Salaam, Tanzania

As a self-described "middle-aged man from Tanzania who has been long involved in the fight against HIV/AIDS, and whose extended family has been affected by the epidemic," Dr. Muhondwa was reluctant to generalize his remarks to all of the developing world. But his views provide great insight into what the war on HIV/AIDS looks like from inside East Africa. He unveils a way of thinking among his countrymen and women that strips away some of the political rhetoric often applied to them.

He began his story at the beginning of the epidemic, which in Tanzania—as in much of Africa—preceeded by years the public recognition of, and political response to, HIV/AIDS as a real problem. The reasons for this are several, but one is a legacy of faith in the colonial (now Western) powers to define and solve indigenous problems, at least where medicine and technology are concerned. The changing face of how HIV/AIDS has come to be understood, and ambiguities about transmission and prevention, left many Africans quite incredulous. This reluctance to acknowledge the killer in their midst was exacerbated at the national level, where few nationwide AIDS control programs were established until the WHO assembly in 1987. This body described the epidemic as a global emergency, and even then acknowledgement was half-hearted until the present decade was underway.

He believes that some of the problems faced by his and similar countries National AIDS Control programs "have their roots in this denial...[which] has dented the credibility of both governments and scientists" on AIDS issues, such as education. He finds "a great deal of dogmatism" that fails to adapt quickly enough to the evolving face of the

19

epidemic. "Fear arousal remains the dominant paradigm," contended Muhondwa, though many studies have shown this approach to be often ineffective. Though much behavior change has occurred, practices are still less than 100 percent safe; it is important, he contended, that these changes be recognized, however, and that further education efforts built by using them as a foundation.

Social change due to the epidemic has been profound. Traditional taboos against openly discussing sexuality are being overcome, and condoms and safe sex are urged on everyone, including the young. Some see it as a choice between upholding age-old behavioral customs and traditions or facing extinction. Muhondwa nonetheless believes that HIV/AIDS control is synonomous with social change, and that this must be planned, designed, controlled and implemented by people conscious of their role as agents of change.

He also laments the imposition of a narrow range of judgment imposed on what is "an adequate response." He urged that indicators of success be formulated more creatively, and go beyond the simple enumeration of AIDS cases averted. With a deeper appreciation of how deeply into the fabric of society the hoped-for behavior changes penetrate, Muhondwa warned that "if we concentrate simply on changing behavior without paying attention to all these background factors we may only succeed in making false starts—manifested in relapses." He advocates the PRECEDE Model of Health Education formulated in *Health Education Planning: A Diagnostic Approach,* L.W. Green, M.W. Krenter, S.G. Deeds and K.B. Partridge (Mayfield Publishing Company, 1980).

Traditional medicine

In the wake of what is perceived by many as Western medicine's failure to cure HIV/AIDS, traditional medicine can flourish, making claims with impunity about cures that governments "dare not" contradict. And in truth traditional medicines may one day lead to some efficacious treatments [as was the case with quinine]. Muhondwa warned that resentment still simmers as a legacy of colonialism, but that Africa must grow its own infrastructure and encourage its own scientists to explore the possibilities of botanicals for effective treatments.

The international response

Muhondwa is a strong proponent of effective, coordinated multilateral assistance. He lamented a decline in financial and technical assistance from the World Health Organization in particular because many of Africa's national programs were essentially crafted under its aegis, and now are seriously undermined as that backbone is being weakened. Donors seem to prefer bilateral arrangements, but he hopes that UNAIDS will usher in a new era.

Training of national scientists

A central conundrum, according to Muhondwa, is the peripheral role granted to African scientists. He noted that "unfortunately the international community has not been keen to assist us in building local capacity" for performing HIV/AIDS research." He lamented that "one of the glaring failures of my tenure as Director of the Institute of Public Health was not being able to secure scholarships for staff development!" Even USAID seems to prefer indirect funding of research through American institutions, he observed, which perpetuated this diminished local capacity. The "numerous requests from Western scientists and institutions for collaboration in research" run up against this problem, said Muhondwa, because "they all wanted ready-made scientists!"

He reminded his colleagues that "the epidemic is going to be with us for a long time," and that his country really needs to build "local capacity for program design, planning, management and evaluation." Rather than sending expatriates to do these

things for us, he urged sponsors to instead to "assist us to do them." He is taking the long view, and urged the donor community to do the same by shifting their focus away from "short-term projects which are the hallmark of bilateral arrangements."

A wish list

Muhondwa cited four important areas for the future. He stipulated that condoms in their present form present problems, and wondered why "we have come to accept that man should change to suit the technology instead of changing the technology to suit man." He called for renewed technical support for the search for a "user-friendly" condom, and suggested—in light of our current plight—that a Nobel prize should be in order, given the savings of human lives that could result.

"I, for one, salute ACT UP," Muhondwa proclaimed, since he believes the history of the epidemic shows that "activists have played an important role in getting governments to take AIDS seriously" and prompting the scientific community to be more responsive. He believes NGOs could better fulfill this role, given the current state of many national control programs.

Activism is also needed, he contended, on the national level. The problem is not a simple one, though he sees a lack of "moral force" in many of the developing countries who seem to be more concerned with importing democracy into Africa. He calls such democratization "an import," definitely not "homegrown," and would like to see more direct pressure exerted. Finally, he worried about pressures on the USAID program funds and budget cutbacks, which have a demoralizing ripple effect throughout the region. He closed with a salute to USAID's J. Brian Atwood for his efforts to show the American taxpayer and the political leaders that Africa matters to Americans, and that foreign aid for HIV/AIDS has a direct and obvious benefit for the American economy.

EVOLVING RESPONSES, NEW BRIDGES, NEW PARTNERS: INSIGHTS AND CONCERNS FROM A PERSON LIVING WITH HIV

Jecenia de Jesus
International Community of Women Living with HIV/AIDS
New York, New York

"Good morning. My name is Jecenia de Jesus and I'm a 22-year-old women living with HIV.

In 1991 on my nineteenth birthday, I lost my mother to AIDS. Not knowing much about this disease, I believed my mother was somehow *supposed* to die of AIDS since she was a drug abuser. My mother's death, I thought then, was the hardest thing I would ever have to deal with.

Only 10 months later on a routine doctor's visit I was asked if I wanted to be tested for HIV. I recall being shocked and slightly offended. The doctor himself said that I was not in any of the risk categories. But to my surprise, two weeks later, I received the positive diagnosis.

I was 19 years old, HIV-positive, and all alone. I felt as many people do who test positive—isolated, and a heavy feeling of shame. I didn't exactly know why, don't remember anyone ever telling me, but I nonetheless felt I had done something wrong. I had a big secret, but I couldn't tell anyone. I spent many months feeling very much alone, and didn't share my secret with anyone. I was only nineteen, had not even begun to live, and I was waiting to die.

Although I did eventually find the courage ten months after my diagnosis to see another doctor, it was then explained to me that

I didn't have AIDS as I was originally told, that I was merely carrying the HIV virus. I still could not tell anyone.

In 1994, almost two years later, I finally met other people who were living with HIV. I couldn't believe that other people could actually live with this dreadful disease and

21

still be happy and live positive lives. Finding the support of other PWAs helped me to accept that I was HIV-positive and yet could still live a long and positive life.

This has not been easy. I am sometimes still very scared of this virus and what it could bring. Each day, I try to live my life to the fullest. Today, I take care of my thirteen-year-old sister, and try to teach her what she needs to make it in this world, especially how to respect herself and her body. I want her to grow up with enough self-esteem and self-confidence to make the right choices in life. And that includes protecting herself against HIV/AIDS.

This does not mean that I—or anyone else living with HIV—made any *"wrong"* choices. I only used the misinformation that I was given: That I couldn't contract HIV because I was in none of the risk categories. Someone was wrong.

Today I dedicate my life to educating others, especially young women, about HIV/AIDS. I try to educate others on how to avoid contracting the virus, and for those already infected, I try to teach them how to live positively with this disease.

There is still hope and we have to make the most of it. The greatest support that I have comes from others living with HIV, both at home and abroad. People living with HIV and those who are significantly affected by it know firsthand what a tremendous load this disease brings. This is why my involvement in organizations at home such as Stand-Up Harlem, and here in Washington, D.C., such as the AIDS Policy Center and the National Women's AIDS Project, is so important to me.

Most importantly, today I'm here to represent the International Community of Women Living with AIDS (ICW), which is an international organization based in London. A few years ago, at the Berlin conference, many women living with AIDS realized they were still being discriminated against, that they were very much alone and isolated. These women got together and decided to create an international organization to educate, support and most of all to empower other women living with HIV. Today ICW has fifteen key contacts throughout the world, three each in five different regions. I am one of those three in North America.

Unfortunately, we PWAs around the world still must fight discrimination. As if living with a terminal illness is not enough. I hope that at this meeting we as service providers, policy makers and—most importantly—people living with HIV can work together on prevention and care services for all of those who are affected by this disease.

I hope that I have helped to put a face on this disease, if one is still needed. I am only one of millions. I ask that all participants at this conference take the information you've gained back and share it with your communities. If we're going to work to halt the spread of HIV/AIDS, we must start working together as a community of the whole. If nothing else, let AIDS bring us together, to look beyond all of our differences."

HIV/AIDS ADVOCACY AND HUMAN RIGHTS

Dr. June Osborn
University of Michigan
Ann Arbor, Michigan

How do human rights considerations factor into the HIV/AIDS debate? They are absolutely *prerequisite,* says Dr. Osborn, for "without commitment to addressing human rights, we cannot get anywhere with our efforts to control and prevent the spread of HIV." Her conclusion derives from recognizing that the nature of HIV/AIDS' spread through the global village has made the notion of "others" dangerously quaint, and virtually moot. The human species is a single family, speaking a common language of caring, with a powerful common currency of human dignity. "When we realize that there are no *others,* then human rights become *our* rights, and we must advocate and respond with appropriate passion, urgency and compassion."

Dr. Osborn has been active throughout the years of the epidemic, playing the "intermittent role of evocative herald—trying to put my best words together to capture the attention of audiences not yet listening. I often feel an almost visceral wish that I could find a very tall mountain or building, climb to the top and shout, "Don't you all see what a threat this is? How can you be so detached? So restrained?" She attributes this societal blindness to three reactions people have resorted to in order to deal with the threat posed by HIV/AIDS: Denial, xenophobia, and the very strangeness of the disease.

The three horses of this apocalypse

"The advent of HIV was as profound a change in the world as [was] Hiroshima. Things would never be the same again; and much as we didn't like the change, it was our urgent duty [as caregivers] to respond—to care and prevent, to limit the harm, and to achieve control in the name of our children's children." But her academic colleagues, those living away from the coasts where the disease is most visible, and others continue to startle her with their "bland denial" and their ability to ignore the problem, even though "*every* kind of person has been included among the half million Americans diagnosed with AIDS...[which] has only just begun to overwhelm health care systems around the globe."

The denial phenomenon seized on early [premature, it now turns out] beliefs that HIV/AIDS was a disease limited to the so-called "risk groups" and to "marginalized communities: gay people, drug-using people, people from distant lands or from cultures perceived to be exotic; people living beyond their expected years by virtue of advanced blood coagulation and transfusion technologies." By "locating" the problem outside their actual and psychic neighborhoods, many people were able to avoid recognizing the truth.

Part of the explanation must be xenophobia (the fear of things alien or strange). "I don't know of a country in the world where the first cases of AIDS were not blamed on "foreigners," reports Osborn. "Always there has been the strong inference, especially from governments and powerful people reluctant to grapple with their own realities, that "Had we kept *these people* out (or imprisoned, or quarantined, or whatever), this certainly never would have happened."

Osborn is fierce on this point, putting her scientific, clinician's view forcefully: "I must dispute that! With the rapid social and ecological shifts of the late twentieth century, it was only a matter of time until this (or another) "genie got out of the bottle;" and it won't be the last time, either. We have gradually come to realize that mastery of infectious diseases was a wishful fantasy—that HIV is only a harbinger and that we must brace for more emerging infections soon to come." This is the "strange" part of the equation. "AIDS is a new and different illness for humans, and the human immunodeficiency virus seems weird and unearthly to all but

23

those few virologists who had toiled in the fields of "slow virology" or [had] studied animal models of retroviruses."

"Them" is us

But now fourteen years later, it is increasingly apparent that the lessons learned about the disease and its spread have universal relevance. Homophobia and racism have been (and continue to be) a smokescreen between those affected by HIV/AIDS and the "general population," who increasingly must cope with the threat as well as the treatment of the disease. What is now clear is that the general population can no longer be seen as "the rest of us," excluding the marginalized groups, but constitutes, in fact, *everyone* on earth. In three of every four cases, transmission is due to heterosexual intercourse. The ability to understand and engage in protective and healthy behaviors is unequivocally related to much more than "lifestyle; "now it is possible to assert without qualification that socioeconomic and cultural impoverishment *are* risk conditions for transmission of HIV *in and of themselves.*"

"What a mess!" laments Osborn. "The path to follow at the outset seemed so clear: We needed to find the cause of this strange new illness, learn to treat it, and devise means to prevent its further spread while working on a vaccine. How quickly that path became cluttered: tangled and overgrown by dense thickets of fear, alienation, marginalization, mistrust—all feeding off a swamp of long-term neglect of human rights."

Some useful precepts

In this climate, some recognitions are crucial to human rights as well as to any effective prevention strategy. A gender gap is yawning. "The inequality of women, so comfortably ignored throughout millennia, has suddenly loomed to mock simplistic advocacy of self-protection, as a massive impediment to epidemic control. If a woman cannot refuse unprotected sex, what then? If she does, but thereby loses her economic and social security, what then? As Jonathan Mann has so succinctly put it, we can see now if we didn't before that male domination of a society is inimical to public health! AIDS has, indeed, been a prism through which the world looks at once familiar but strange."

And then the problems of the generation gap, the mistrust youth always has for the older establishment, which complicates delivering trustworthy messages to adolescents. There may also be an analogy for delivering messages from the developed world to the developing world, where the pandemic is assuming frightful and threatening proportions. "Health behaviorists have described the problem tersely: "Just say 'NO!'" doesn't work! Health educators have perceived it too: fear repels; monotonic messages, however cleverly phrased, bounce off deaf ears; cross-cultural preaching evokes annoyance if not outright anger and rejection. The best of intentions about AIDS prevention are misperceived if the background is shadowed with mistrust."

And finally, one lesson that should have been learned, about regarding HIV as an instance of a sexually transmitted disease. "The fact that HIV is sexually transmitted does *not* mean we should deal with it like any old, familiar STD—for in truth we never did very well with the others, and the stakes here are too high to revisit old mistakes." Osborn recalls a former member of the U.S. Congress who "used to advocate that we treat AIDS like any other STD on the grounds that such approaches were "Tried and True." Tried? Yes. True? No—they hadn't worked! Much has been learned during the past fourteen years, and we must be sure we don't regress but rather take some of what we have learned from AIDS and try again with the rest of the STDs—not the other way around!"

Thus, Osborn insists, "human rights is a crucial consideration in all matters of health, and of course is inseparably woven into... prevention and control of the fearsome HIV/AIDS epidemic." What does this mean?

"When AIDS education has been vigorously pursued as a mechanism of prevention, [in gay communities, for example] its efficacy has been dramatic—but its ongoing effectiveness has proved dependent on perseverance and restatement and diversification of message—and, above all, the nature of the messenger." When the human drama continues to unfold "amid an awful static of mixed messages and half-understood warnings," AIDS cannot be isolated from its surroundings, even though this requires embracing the whole panoply of social ills and problems that beset those most at risk. "I don't mean that we must *solve* them all immediately, in defiance of history; but we must recognize their intrinsic relevance to the matters of prevention;" that is our charge and our responsibility to the world family of which we are an indivisible part.

HIV/STD AND REPRODUCTIVE HEALTH:
Challenges and Synergies in the Population, Health and Nutrition Sector

Duff Gillespie
Deputy Assistant Administrator
Population, Health and Nutrition
United States Agency for International Development
Washington, D.C.

Duff Gillespie has worked directly in the HIV/AIDS area, though he is presently involved in the wider concern of reproductive health for USAID; he wanted the conference to appreciate how that agency initiative "might influence and be influenced by the battle against HIV/AIDS." But as he spoke, he decided to change the thrust of his remarks to respond to a dilemma that he was hearing expressed over and again by other speakers. If the struggle against HIV/AIDS represents such a stirring call to arms for nations, societies and donors to respond to a crisis," he asked, "Why has that response been so inadequate?"

To be sure, he conceded, indifference and xenophobia are primary causes, along with the fact that "sexual behavior causes a lot of discomfort and hostility among many people." And there remains much ignorance about the true nature of the dilemma. But there are also, he suggested, rational reasons for the lack of resources being directed toward fighting the epidemic. In a strictly political frame, the question, he said, is "Why has HIV/AIDS experienced static funding, and why aren't policies matched by the funds" needed to make them successful? Gillespie believes the answer lies in the failure to compete successfully for funds in the political marketplace.

The pragmatics of funding competition

"First of all," he explained, "HIV/AIDS is in a very competitive marketplace for attention and funding." Gillespie's career has

25

taken him to many conferences, workshops and symposia similar in style and general content to the Prevention Conference. Go to a conference on tuberculosis, maternal mortality or family planning, he suggested, and you would hear many pleas and remonstrations similar to those heard here. "Why is there so much indifference?" Or, "Why aren't there sufficient funds?" The answer is obvious, he suggested: Money for social programs is limited, and the competition for it is fierce—not only in health, but in basics like education and infrastructure.

The funds are going to go to the applicants who compete the best to receive them, and Gillespie urged the HIV/AIDS prevention people to "get better at competing for these funds." Though we hear about "the need to document successes," he explained, what is important is to learn the language and how to appeal to a Minister of Finance, or a program officer from the European Union, for example. These people are comfortable with analyses that focus on the bottom line, and thus appeals for funds might be more successful if the internal perspective of those to whom the appeals are directed is considered.

Assume that resources are scarce; *assume* that there is much competition for the dollars you are after, in fact, said Gillespie, you may need to assume that it's "going to be an *either/or* decision." Then figure out how to show that your program is a good investment, from the social service point of view and from the demonstrable results point of view. Taking this perspective, a major key he believed was demonstrating that a project or intervention can be "upscaled" to serve a wider population. Getting funds is the "nuts and bolts" of our work, he concluded, and it "looms as the biggest factor inhibiting our addressing the HIV/AIDS problem on a global scale."

Reproductive health initiative

Gillespie also talked about the programs he was more directly involved in, as he believed they would have a major—if indirect—impact on HIV/AIDS. Though it had only been two years since the change of political winds in Washington, the "Clinton Administration came in with an obviously very different agenda than the previous two administrations" in the reproductive health area. This was evident at the population and international development meetings at Cairo earlier in the year. The USAID programs are now founded on a set of principles that represent a fundamentally "new approach," he said:

- People should have the ability to have sexual relations without fear of unwanted pregnancy or of contracting disease.
- Reproduction is now framed as guiding children to a successful outcome through infant and child survival, growth, and healthy development.
- People should have the capability to reproduce.
- Women should be able to go safely through pregnancy and childbirth.

"Programmatically," Gillespie said, these principles "have been translated into a program that still gives a great deal of emphasis to family planning and related fertility services. But there is renewed and enhanced importance given to safe pregnancy services, improvements to women's nutritional status, promotion of breast feeding, and prevention and management of STDs." He acknowledged that there was "always the danger that these policy shifts and pronouncements won't lead to real changes, but this hasn't happened, and we won't let that happen with this new emphasis on reproductive health at USAID."

There are a number of examples of bilateral programs where the new initiative is beginning to bear fruit, including Zimbabwe, Kenya, Uganda, Malawi, Niger, Ghana, Madagascar: "These all now have family planning programs with STD/HIV/AIDS activities incorporated in them," he reported.

PREVENTION OF THE SEXUAL TRANSMISSION OF HIV: A COMPREHENSIVE APPROACH PROJECT

Dr. Peter Lamptey
Director
Family Health International/AIDSCAP
Arlington, Virginia

AIDSCAP project director Peter Lamptey provided the conference with a coherent overview of the modern plague of HIV/AIDS, and demonstrated how and why current approaches to prevention revolve around sexual transmission, which accounts for nearly 90 percent of all cases. After placing HIV/AIDS in the context of the great historical plagues of civilization—the Bubonic Plague in 1346 and the Great Influenza Epidemic in 1918—he discussed intervention strategies that represent the current wisdom on preventing the spread of the virus, and how they have worked. Broadly speaking, four interrelated phenomena can be seen underlying the problem: individual, societal, health care and structural factors.

A modern plague

It is neither apocryphal nor extreme to cite the great plagues in world history as a context for understanding the magnitude of the HIV/AIDS problem faced by modern civilization. All three epidemics, asserted Lamptey, have in common "our limited knowledge of the causative agent, the absence of a cure or magic bullet, and our limited understanding of individual behavior and the environment." And the staggering numbers of dead, scores of millions, also provide a tragic link: "Even if a cure or a vaccine is discovered in the next five to ten years, the AIDS epidemic may eventually kill more people than both the Black Death and the Influenza Epidemic combined."

Lamptey noted the remarkably similar trends in society's reaction to these plagues, and pointed out that "ignorance, blame and victimization have all been a common theme...All over the world, people with HIV/AIDS are victimized by discrimination and fear. Our capacity for ignorance and our tendency to take inappropriate, ineffective and often harmful action against those with epidemic diseases has not improved much over the centuries. Society's reaction often hampers the control and prevention of these diseases."

But we can do better than our ancestors, Lamptey insisted, because: "We know what causes AIDS; we know how HIV is spread; and, despite our imperfect knowledge of sexual behavior (individually and in the society at large), we know enough to prevent its spread.

Status of the epidemic

The numbers are certainly shocking, though "of course, AIDS is more than simple global statistics. AIDS has a human face," insisted Lamptey. The initial outbreak of HIV infections was accounted at 100,000 in 1980; a decade later the increase was 100 times that number, 10 million; since then, it has doubled: 20 million people worldwide have contracted the virus.

And these numbers are not without race and nationality, without national character. "HIV continues its relentless spread in Africa," explained Lamptey. "In some countries, up to 30 percent of urban adults are infected. In Africa, as a whole, more women than men are infected, and as many as 40 percent of pregnant women are infected in some urban areas. The epidemic continues to spread throughout the world. By the year 2010, Asia may have more HIV infections than the rest of the world put together...and it is only a matter of time before prevalence levels in South East Asia reach those of Central Africa."

Looking at "risk behaviors"

"When policy makers and the public see these devastating and depressing figures," explained Lamptey, they often conclude that AIDS prevention has failed or is completely worthless, and that the only true

27

solution must come from a vaccine or a medical cure. "But *AIDS prevention has not failed,"* insisted Lamptey, who pointed out that—compared to other modern diseases that are killing millions and also require behavior change, heart disease, obesity, and the complications due to smoking tobacco—AIDS prevention looks fairly successful, especially considering the limited resources that have been invested and the fact that sex as the causal behavior, is so deeply rooted in human nature.

Intervention strategies

Lamptey cited a second aspect of the problem that may be rooted in human nature, a tendency to study the trees and miss the forest. In HIV/AIDS control and prevention, this takes the form of the relentless search for a technological fix. "Modern society has always placed the highest value on quick fix solutions; antibiotics and vaccines have revolutionized the treatment and prevention of several infectious diseases." The problem with this emphasis, explained Lamptey, is that it serves to substitute for examining other risk factors related to the individual or the environment. However, since there is as yet no "magic bullet for AIDS," other approaches must be seriously pursued.

Individual risk factors provide one wedge for intervention. The context and frame in which such interventions are pursued is daunting indeed. In addition to the intractability of human nature to permanent behavior change and the power of the sex drive, there is also Madison Avenue. Why do weight loss programs fail? Look at the dollars spent, suggested Lamptey: $50 billion on the diet industry, $366 billion to entice people to eat. The problem is worse when it comes to sexual behavior: $500 million on domestic HIV/AIDS prevention in the U.S., "probably hundreds of billions of dollars on sex-related advertising and sex promotion movies and magazines, *all* designed to entice people to have sex."

And yet behavior changes to reduce high-risk sexual behavior—such as abstinence, delaying onset of sexual debut in adolescents, reducing the number of sexual partners, and encouraging consistent and correct use of condoms—are possible, as Lamptey demonstrated by pointing to an AIDSCAP project in Thailand conducted by Dr. David Celentano [See Oral Session on "Integrating HIV/AIDS Prevention into the Royal Thai Army Reduces HIV and STD Risks among Young Thai Conscripts"].

But a second wedge is needed to support individual behavior change, noted Lamptey, for "without changes in societal risk factors that contribute to HIV transmission, new low-risk behaviors will be difficult to sustain." These factors enhance the context for the virus to spread: "Poor attitudes toward condom use, including the false notion that provision of condoms to adolescents will result in increased promiscuity; culturally sanctioned risk factors such as multiple partners; poor public and provider attitudes toward STDs that drive patients to seek ineffective treatment from the informal health sector, and the low social status of women, which limits their ability to negotiate sex with their partners and leaves them more vulnerable to high-risk behavior."

Explicit health care also provides a vital opportunity for intervention that is being underutilized, since the individual and societal changes called for will not by themselves be enough to prevent the spread of HIV. "No matter how motivated individuals may be to use condoms, they will need easy access to an affordable supply, as well as to effective treatment for curable STDs." Progress in delivering better STD services has been limited or nil, asserted Lamptey, "especially for women. This is primarily due to funding limitations."

The final link in the intervention strategy must address structural factors in the society at large. "These include adverse policies, such as the failure to commit adequate resources for AIDS prevention, formal or

informal discrimination against people with HIV/AIDS, and heavy taxes on condoms and on drugs for STD treatment.

Reasserting the primacy of prevention

By decade's end, Lamptey concluded, there could be 40 million people infected, maybe more. "The majority of these people will be women and children...The AIDS epidemic will reverse most of the advances that have been made in developing countries in child survival and in life expectancy over the last couple of decades. By the year 2010, child and adult mortality in some African countries will increase by a factor of one-to-three compared to mortality rates without AIDS.

"Even if we get a cure or vaccine in the next five to ten years, current AIDS prevention will continue to be the backbone" of efforts to control HIV/AIDS. These in turn demand "political commitment, relevant social and structural changes and a comprehensive prevention program that reduces individual risk of acquiring HIV."

The picture Lamptey paints poses a challenge for the modern world; diseases such as "heart disease, obesity and alcohol abuse have no magic bullets. Progress is often slow and difficult. Relapses are frequent. And AIDS is no exception. We need to be realistic in what can be achieved with the extremely limited and diminishing resources that *are* available, under difficult policy and environmental conditions. Despite these obstacles, much *is* being achieved, and U.S. technical leadership and support has made a substantial difference in AIDS prevention all over the developing world."

UNAIDS: Toward an Expanded Response to the HIV/AIDS Epidemic

Dr. Peter Piot
Executive Director
UNAIDS
Geneva, Switzerland

UNAIDS is the new project scheduled to begin a few months after the August 1995 USAID Prevention Conference, put together by six cosponsoring organizations presently involved in the war on HIV/AIDS. UNESCO, UNDP, the United Nations Population Fund, UNICEF, The World Health Organization (WHO) and the World Bank are launching the Joint United Nations Programme on HIV/AIDS—not to usurp the individual AIDS programs of its six members—but rather to "attempt to rationalize, coordinate and strengthen their support to countries in keeping with international best practice," explained its inaugural executive director, Dr. Peter Piot.

This international phalanx of aid and support organizations has been established to follow up more effectively the main lesson learned from a decade and a half of prevention efforts, explained Piot: "The HIV/AIDS epidemic is no outbreak. Indeed, HIV and AIDS at the same time are spreading epidemically and are becoming endemic. They have turned into a tragic new feature of the human condition." WHO projects as many as 40 million infected by century's end. And yet, an important second lesson must also be stressed—"we are not powerless against HIV. Some communities in the developing world have managed to stabilize or reduce transmission rates. In Australia and some northwestern European countries, this has even been achieved on a nationwide scale."

With each passing day, however, thousands of new infections develop, and "provide massive evidence," said Piot, "of our failures. In many places there is still political or cultural resistance to harm-reduction poli-

29

cies and interventions. Even where interventions are attempted, they suffer from weaknesses. Funds for development assistance are getting harder to raise and few developing countries are putting enough of their own money into the fight. Communities are insufficiently engaged.

Linking prevention with care and with people's lives

"We also have often made an artificial distinction between prevention, on the one hand, and care and support, on the other," said Piot, echoing a major motif of the conference. "We should be integrating prevention and care in a way that exploits the rich interface between them." But the broader context and environment in which people live is often inimical to effective prevention measures. Marginalized groups, women who are powerless due to cultural beliefs and practices, whole communities whose social norms put them at greater risk—to reach these groups we must expand our response to HIV/AIDS in both scope and magnitude.

UNAIDS' roles

It is this expanded response that UNAIDS was designed to facilitate, by assuming three mutually reinforcing roles: policy development and research, technical support, and advocacy. First, UNAIDS "will be a major source of the globally relevant policies and strategies that countries need" to expand their response. "We won't be an ivory-tower think tank," promised Piot. "Constant feedback from the field will help us identify promising elements of international best practice," which, we will then try to provide technical support for [the second role] to help countries respond with better policies, strategies and actions. Third, "at the global and country level alike we will be advocates for an ethical, effective and well-resourced multisectoral response." This should include a wide range of partners, NGOs, community-based organizations and people living with HIV. "Unfortunately, countering denial will be one of our major challenges," observed Piot.

Beware the pitfalls

Another challenge facing this undertaking is to learn from history and avoid at least three of the pitfalls that Piot cautioned against. First, there is the danger of oversimplifying the epidemic, of painting the trends and "truths" with too broad a brush. Every society and every individual has their own truths.

Second, though poverty and discrimination obviously underlie and complicate the HIV/AIDS picture enormously, we need to focus on "the concrete task of making the environment conducive to prevention and care. Let's not bite off more than we can chew."

Finally, "HIV prevention is not an exact science and probably never will be...while we have gained some insight into the kinds of guiding principles and action that can be effective, these are just glimpses." Warned Piot, "we haven't got the whole picture. To be perfectly frank, in some places HIV prevention has been successful and we just don't know why...Let's continue to experiment with an open mind. In short. let's avoid the straitjacket of AIDS orthodoxy."

HIGH-RISK SETTINGS: STRUCTURAL AND ENVIRONMENTAL INFLUENCES ON HIV/STD RISK BEHAVIOR

Dr. Daniel Tarantola
Director, International AIDS Program
François-Xavier Bagnoud Center for Health and Human Rights
Harvard School of Public Health
Boston, Massachusetts

Two important lessons learned in the struggle with AIDS over the last decade frame the possibilities for future prevention efforts, began Daniel Tarantola: "First, behavior change seldom responds only to the availability of preventive information and services; second, the societal context within which people are born, raised, initiated to sexuality and become sexually active strongly influences their perception of risk and their sexual behavior."

In the traditional framework of public health, the basic approach has been to deal with people, and not the "basic societal issues which are [really] the root of ill health." Thus, have we heard about biomedical or physical barriers to virus transmission, about efforts to persuade people to behave differently to avoid contact with the virus, and occasionally even about coercion. Though still the orthodoxy, this paradigm may have met its limits with HIV/AIDS. The lethality of the virus, and the heterogeneous complexity of the many societies it moves in—especially vis-à-vis sex—both compel public health planners to invent new and more effective ways to combat the disease. And yet, they must undertake this struggle within the limits of their discipline.

How has HIV/AIDS risk been confronted?

Tarantola defines HIV/AIDS *risk* as the statistical probability—due to risk-taking behavior *or* from an unsuspected risk-generating situation (e.g., the 65-plus percent of women who contract the disease from their sole partner, mistakenly believing themselves in a monogamous relationship)—of a person acquiring the infection or receiving inappropriate care once they have it. Since the mid-1980s, the traditional public health model has pointed toward a number of interventions, which, "all combined, have impacted on the spread of HIV, but to a varying degree, depending on the quality of messages, on the existence of accessible services and, more importantly, on the societal context within which prevention was taking place."

These variations among countries and societies are significant, though "nowhere is the HIV pandemic fully under control; every day, worldwide, more than 10,000 people acquire HIV infection." In North America, Oceania and the southeastern Mediterranean new infections seem to have peaked and begun their decline; in western Europe and the Caribbean they seem to have plateaued; sub-Saharan Africa may be nearing a plateau, despite the enormous proportions of some subpopulations who are infected; but in southeast Asia, "the incidence of HIV continues to soar," lamented Tarantola, "and the first peak of the epidemic is not yet in sight."

Given the mortal threat, it may be time to expand the scope of prevention beyond the framework of risk reduction because, explained Tarantola, "these strategies fail to address contextual issues in which the HIV/AIDS pandemic and many other communicable and non-communicable diseases are deeply rooted." By stepping beyond the concept of risk, "one enters the paradigm of vulnerability," which he defined as [a state of] "lack of control over one's health. In the context of HIV/AIDS, vulnerability builds on the notion that personal and collective factors influence the probability to be exposed to infection through risk-taking behavior or risk-generating situations and [also] that this influence may vary over time."

Vulnerability and context

Certain groups and individuals are thus at greater risk than others because they are vulnerable; these groups tend to be at the

margin of society and thus become an object of discrimination. The *motives* for this discrimination are many: "For reason of gender, age, race, sexual orientation, economic status, and cultural, religious or political affiliation," explained Tarantola. The *means* by which the virus is transmitted to these groups are also several (violence, use of substances, exposure to communicable diseases) but they are all "deeply rooted in discrimination" and show a disrespect of human dignity and human rights.

Tarantola believes the HIV/AIDS pandemic has been visited primarily on the young and the poor, and also on women. All three of these "groups" are vulnerable to varying degrees according obviously to the individual, but also to the societal and cultural context in which they live and try to make their way, sexually, psychologically, in every way imaginable.

Youth and vulnerability

Young men and women are vulnerable on a personal level, explained Tarantola. They take risks because at their stage of life they feel invulnerable and because they are trying to find and assert their autonomy. They seem never to get quite enough support from adults with the psychological and physiological transition they are enduring. On a societal level, they have no rights and are continually exhorted to conform; their confidentiality is not respected, their access to information is restricted, and their sexuality is suppressed or repressed. And they find no service institutions specifically designed for their needs; they are caught in limbo between the pediatric and adult health systems, with no holistic model designed for their wide array of needs.

Poverty and vulnerability

Poverty fuels the HIV/AIDS epidemic, but poverty less of nations than of individuals within a society. "What seems to be more critical than the overall level of wealth of a population," observed Tarantola, "is its internal economic disparity. In the deepening gap between those who benefit from economic growth and those who are left behind flourish violations of rights, withdrawal of entitlement, mental abuse, physical and sexual exploitation." The poor are more likely to fall into the "marginalized" groups, and then the cycle draws them into risk-generating livelihood strategies; they soon lose control over their circumstances, their destiny, and ultimately their ability to protect themselves from the virus.

Inequities of gender

The final group of those especially vulnerable to the virus are women. Tarantola believes the phrase "women's status" has outlived its value, since it "masks the dynamic and proactive process of gender discrimination behind a cloud of vagueness which conveys a feeling of passive permanency." What is now understood is the need for specific actions to bridge the gender power gap that exists in so many societies and at so many levels; such as "equal access to education, fair income distribution and sharing of ownership, equal employment opportunities and wages, and equity before the law." Such a menu may seem like nothing short of a social revolution in many societies, but Tarantola insisted on the need for both short- and long-term specific goals, so as to "create a manageable universe out of the daunting, seemingly overwhelming, challenges."

Risk reduction strategies today

Most of these strategies are necessarily short-term: providing HIV/AIDS-related information, advocating safer behavior and promoting prevention methods. If they succeed in generating behavior change, the measurable decline of the incidence of HIV and other STDs will be the result. Once they are seen to work, they should be expanded, adapted to local situations and needs, and replicated everywhere in the world they may be applicable. But a truly expanded response using risk reduction will also essay a longer-

term impact, and the only lasting way to accomplish this, said Tarantola, is for "health systems to integrate HIV/AIDS-related activities *with* (rather than *in*) other initiatives while retaining the ability to track the epidemic and account for what is done—and not done—about it."

Trying to reduce vulnerability

Casting the net deeper means working on the underlying causes of vulnerability, as described earlier. The effort would seem to offer several opportunities. First, by "relating behaviors and behavioral changes to some of their underlying societal causes, individuals" develop a better appreciation for the context and meaning of their risky behaviors. Second, people determine their behavior and make their choices as individuals; social science research that works at the level of the group may well miss some vital aspects of intergroup dynamics that have a significant impact on behavior. And third, the HIV/AIDS pandemic becomes understood and "redefined within the broader context of health and society," and leads to a wider range of both short- and long-term decisionmaking.

Ultimately, such an approach relies on "contextual" interventions directed at the structure and environment within which individuals make their decisions. The ultimate aim, said Tarantola, "is to enable people to exert control over their own health," in which concept the World Health Organization has embraced physical, mental and social well-being. But real short-term benefits may emerge (e.g., promoting and protecting human rights, changing laws, policies, regulations or practices that discriminate against specific populations, bridging gender inequity in relation to power, education, employment and entitlements to public services, and focusing ongoing human development schemes on most vulnerable communities). In the longer term, poverty reduction and cultural reforms may also emerge.

Vulnerability can be reduced, and the effort may alter society's basic orientation to health. It only takes the sustained implementation of innovative, dynamic and creative ideas. "It is our responsibility to articulate these ideas," concluded Tarantola. "If the ideas are sufficiently powerful, organizational changes and human and financial resources will follow."

SEXUALITY AND GENDER RELATIONS: IMPLICATIONS FOR HIV/STD PROGRAMS AND POLICIES

Dr. Geeta Rao Gupta
International Center for Research on Women
Washington, D.C.

Ms. Rao Gupta began by specifying the current meaning of the term gender, since so much of the subject can be hard to pin down: Gender refers to the roles, the rights and the responsibilities that society explicitly assigns to [or implicitly constructs for] women and men. The International Center for Research on Women (ICRW) has funded a number of studies designed to explore the social, cultural and economic factors that women face, providing a keen insight on the challenges for women in trying to protect themselves against HIV. She told the conference that she hoped to "push the discourse another step forward and to try to come up with concrete recommendations that can transform HIV prevention programs—to make them more gender sensitive and responsive to women's needs."

Background of discourse and action

For over a decade, discourse by and about women in the context of the HIV/AIDS epidemic has traced a distinct pathway, said Rao Gupta, that can be seen as three successive stages. At first, the epidemic was perceived and approached in terms of risk groups, and most of the women who came under this tent were commercial sex workers, often "portrayed as repositories of infection," said Rao Gupta. As it became clear that many people's human rights were being abused and ignored, there was a shift into the focus on "risky behaviors," though the change was more semantic than programmatic. The main intervention was an attempt to change behavior, specifically "the act of pulling a latex sheath onto an erect penis," reported Rao Gupta, with little attempt to grapple with "the complex issue of sexual behavior and the role that gender variables played in determining sexual interactions....Today, there is ample evidence to show that such an approach to AIDS prevention is short-sighted and will not result in sustained behavior change."

Next came the recognition that more and more women were becoming infected, women who did not identify themselves as sex workers. The rubric developed to refer to this stage of history was "women and AIDS," and a research program was undertaken to learn "more about the sexual lives of women and about the contextual factors that contributed to their risk...through qualitative and quantitative social science research, and its findings were overwhelming." They vividly illustrated that women were highly vulnerable to infection, and that their risk was in no small measure due to prevailing gender role definitions, prescriptions and constraints.

Currently, the most relevant term is "gender and AIDS," which signals a change in that the disease is "cast within a much broader framework of reproductive health," but it is incorrect to see it as a mere expansion of AIDS programs to include women, she insisted. For the "dynamics of gender relations provide the fulcrum of this discourse," thereby focusing on the root problem of all vulnerability, which is the power imbalance in gender relations.

Clarifying assumptions

Before offering any pragmatic or programmatic recommendations, maintained Rao Gupta, it is crucial to understand a few basic truths behind the debate.

First, "All women are not one." In particular, "women are at different points of the empowerment continuum, [and thus] there can be no one blueprint for action, no universal solution."

Second, "Social systems are not immutable—they can and often do change to meet different needs." But in order to bring

34

about such renovations in the HIV/AIDS care and prevention universe, there will have to be multiple interventions that mutually reinforce one another, "and a focus that goes beyond one behavioral act" as has too often been the limited horizon in the past.

Third, "in the long run we have to believe that empowering women is not a zero-sum game—[that] empowering them does not reduce the power that men have. Power is not a finite commodity—more power to one, ultimately [can] mean more power to *all*. Empowering women to protect themselves, to speak up and to access technologies," she insisted, "also frees men from the stereotypical role of sole responsibility for protection against infection. And that message must be communicated strongly without any caveats, ifs, or buts."

What can be done?

So with this understanding of how gender issues impede effective HIV/AIDS prevention, "what can be done?" she asked, and answered with three recommendations.

First, With regard to the core of traditional HIV/AIDS programming—providing information and counseling (on sex, HIV, STDS, safer sex, etc.); building skills (condom skills, negotiation skills, etc.); and providing access to technologies and services—"the very first step is to ensure that in doing each of these we are being gender sensitive." This, explained Rao Gupta, "requires that we first make sure we know what women need and that our programs respond to their needs—at the very least AIDS prevention programs must not hide behind the belief that women are powerless."

Second, "the information we provide must foster gender equality and not reinforce gender stereotypes for short-term gains." Too often, she noted for example, condom social marketing campaigns couch their sales pitch in an image of male sexuality that is predatory, violent and irresponsible....No amount of data on the increase in condom sales as a result of such campaigns is going to convince me that such educational efforts are not damaging in the long-term," she said. "Any gains achieved by such efforts are unlikely to be sustainable because they erode the very foundation on which AIDS prevention is based, [which is and should be] responsible and respectful sexual behavior."

Third, "we must not presume that the availability of a service, commodity, or information ensures its accessibility equally to women and men." For example, she offered a list of obvious opportunities to provide "women-friendly" services: "Provide services at timings that are convenient for women, integrate services so that the time costs to women of using multiple services are minimal; make condoms and STD diagnosis and treatment available in places where women can access them without fear of social censure; and whenever possible provide community outreach services so that distance does not act as a barrier to women's use of a service."

Breaking through to the social roots of gender inequity

In the final analysis, women's vulnerability to HIV is rooted in deeper contextual issues that frame their entire existence; as a generalization, they step up to the plate with two strikes against them, poor social supports and insufficient economic resources. Can HIV/AIDS programs begin to deal with these root causes. They can, should and must, believes Rao Gupta. "First, they can and should explore the possibility of linking up with economic interventions that are already in place—such as credit programs, agricultural extension services for women farmers, women's cooperatives, or savings schemes. Linking up means providing AIDS information and services through those channels rather than setting up another parallel, vertical program just for HIV/AIDS...This requires collaboration with other non-HIV/AIDS groups, including women's groups, and a strong conviction that economic empowerment is essential for sustained effective prevention."

35

"A second way in which AIDS program practitioners can influence women's socioeconomic status is to advocate for improvements in women's access to education and productive resources. Because AIDS has fatal consequences for women and entire communities, it tragically provides an opportunity, like never before, to push for policy changes to improve women's socioeconomic status. And who better than AIDS service organizations and program experts to undertake such advocacy—because improvements in women's social and economic status are essential for the success of HIV prevention efforts."

Her last word broke her appeal out of the medical and the socioeconomic realm into ethics. "The focus on women's needs and gender issues is often motivated by a need to combat the epidemic. But there is a need to meet women's needs for another reason as well: It is simply unfair that women are more vulnerable to the virus than men. Let us not forget the very *injustice* of women's vulnerability to HIV as we continue to work on containing this epidemic."

MEANINGS OF SUSTAINABILITY FOR HIV PROGRAMS: FROM FINANCIAL INDEPENDENCE TO LONG TERM BEHAVIOR CHANGE

Elizabeth Reid
United Nations Development Programme
New York, New York

The concept of sustainability has become a central aspect of HIV/AIDS prevention interventions. As the pandemic tears through and decimates succeeding generations of people, the human response needs to go beyond an ad hoc reactions to crisis, explained Elizabeth Reid, speaking from her current experience with the United Nations Development Programme and some years as a Senior Design Officer for USAID. Desperate times call for desperate measures, it has been said, and Reid characterizes the current world as one of intense upheaval and "rapid socioeconomic transformation: Decentralization, urbanization, the globalization of market forces, ecological awareness, civil unrest and communications revolutions."

To meet these changes, to survive them and grow with them, she believes that new skills, attitudes and approaches are required. Can all of the social and economic stakeholders come together? The prospects for developing a coherent, concerted, cooperative, synergistic concern about HIV/AIDS are problematic; what must be overcome, she insisted, are mistrust, competition and indifference at the human level. And not only rapid changes in society, but also increasingly scarce resources make the challenge even greater. Put in the context of development or assistance programs for HIV/AIDS prevention, these complex factors may be best approached through the lens of *sustainability.*

What is sustainability?

Traditionally, the term has referred to financing for a project, and especially who will pay for it once the original executing agency withdraws its support. Ideally, this is

considered before implementation, Reid explained, and the question is usually posed as follows: "If the recurrent costs cannot be met and/or cannot be foreseen to be met at project end, then will the project intervention (a finite but non-sustainable action) bring benefits without causing damage? That question isn't always forced onto an analysis, especially in times of intense or chronic crisis, but it will not go away, for the underlying conditions (social, technical, economic and financial) must ultimately be solved.

Reid laid out a sequence of thoughts that she hopes may move us towards a new and lasting (in the current and future world of HIV/AIDS prevention) definition of the concept of sustainability. The first step is to focus on a nation's recurrent costs for the basics of social life and its infrastructure; one boundary condition for sustainability should probably be the ability to meet these recurrent costs. But what about the broader issues. As she put it:

"How can the complex and interrelated problems of achieving growth, of moving between the local and the national, of dealing with complexity, best be addressed? How can collaboration be achieved amongst all the social actors involved? How can institutions be created and strengthened through networks, movements, and organizational structures that have the flexibility to learn, to experiment, to innovate and to translate these insights, the fruit of processes of reflection and assessment, into new approaches? How can the skills of building partnerships and strategic alliances be enlisted to achieve a shared vision? How are old patterns and habits changed and new ones created, wherever this is required?"

A first step already taken

The development literature reflects some movement in this direction, in particular the fruits of "the Brundtland Commission, which argued that development can only be sustainable if it meets the needs of present generations without compromising the needs of future generations." And while Reid noted that the concept as strictly conceived "applies to all exhaustible resources...this epidemic is forcing us to realize that these exhaustible resources also include human life and human regeneration, perhaps even the human spirit."

An operational test to apply this concept is whether a development pattern or program perpetuates existing inequalities—if so, she asserted, "it is neither sustainable nor worth sustaining." Development in the future must look to a different underlying standard: "What must be sustained is human life of a certain quality within generations and between them. Thus sustainability requires that human agency be a central concern. It will lead to a new global ethic, a clear understanding that the world cannot be made safe for anyone, now or in the future, without the willing cooperation of everyone. Concern for a common survival will lead to policies for a more equitable world order."

The fruits of change

Such systems will work when they become inclusive, participatory and empowering; sustainability then becomes easy to perceive, if not achieve, Reid predicted: "Thus we come to the simplest possible definition of sustainability. Things continue, are sustained, when those concerned want them to continue. People will contribute their resources, even scarce resources, to those things that they want to happen. They will change themselves in the ways required by the situation and will support others to protect their health and well-being when the recognition of need comes from within."

But the real problem is "How." Reid believes that "old habits die hard" in development programs because change is fraught with uncertainty, and the "implications for national and external actors of an approach based on the catalyzing and strengthening of processes of social change are profound." Almost everything will need to be renovated and rethought, she said. "It is the shift from

delivery to dialogue, from institutions to social movements, from vertical to horizontal consultation and structures, from didacticism to partnerships." Another barrier is bureaucracy and accountability. "Such processes are difficult to capture in annual reports, surveillance systems and statistics. They are difficult to stimulate by the conventional focused approaches to national development planning and development assistance. Thus accepted ways of doing things are being challenged. Sustainability requires good programming and practices, but of a different kind."

One way to begin to see this alternative future for sustainable development is to switch the lenses of metaphor used to talk about it. Currently, she stated, the dominant metaphor revolves around an intervention, social engineering by laser beam. "The central moral issues are all associated with performance and outcome, to do with malpractice or good practice. Questions relating to free and informed consent, to the best use of human resources, are considered secondary, if relevant at all. The nature of the relationship between two human beings is outside of the frame of reference. The patient is the passive and (it is expected) appreciative object who is acted upon."

Metaphors for the future

Reid thinks there can be a better way. "I wish to explore whether or not there are alternative metaphors." By listening to the "discourse of the activists, those working face to face with the epidemic" she hears "new metaphors emerging. They are metaphors of transformation or conversion, of a quest, a journey, of agency, of a trembling flame of hope. There are images of growth, of spaces, of silences, of togetherness." The alternative metaphors "that are emerging are more organic, more participatory, nourishing, facilitative, inclusive, mobilizing and tentative. They allow doubt, require humility, accept the untidiness, the bit-by-bit-ness of life. They are metaphors of a quest, of being on a journey. They are about moving forward," she pointed out.

How can these images be made concrete? Reid believes that "the new metaphors require skills in systems thinking or appreciation, [where] the traditional metaphor required linear, deliberative patterns of thought. Conclusions had to be reached so that they could be passed on, advocated." The standard model "involved the transmission of information that was preconceived, believed to be a given. These new metaphors are not just about transmission but about making something happen. They are more than cognitive, in that they strive to produce, and enable—not just knowledge but change. They allow for dissonance and dissidence." They require performance, Reid concluded, but in conducting such relationships people often become transformed as well. Certainties and rigid control must be left at the door; the intervener becomes instead part of a process of transformational social change, an *agent* for such change.

To facilitate this process, one must establish:

- the spaces where people can come together, that is, gathering places and excuses for gathering;
- the inclusion of all affected and involved, no matter what their differences or perspectives, in such a way that each person has a sense of ownership of the processes;
- open and transparent processes of dialogue;
- the stimulation of processes of introspection and reflection through, for example, charismatic leadership and creative inquiry, and through strategic questioning rather than directive discourse; and
- support to those affected and concerned so that they may find the courage to speak, whoever they are.

Sustainability in this new and dynamic sense comes from creating change processes that arise naturally from within collectivities

of mutually involved and committed individuals. These processes require a form of social re-engineering, where:

- value is placed on people being able to come together, face to face, to interact in a myriad of ways;
- decisions are made as a result of consensus-building between competing forces, not by force or authority;
- free expression and discussion, doubt, imagination, reason, and feeling are all able to shape the outcome;
- words, metaphors, and images are not bearers of state power, of religious or corporate concerns, or of gender, class, patriarchal, or ethnic privilege, but rather are expressions of desire and dreaming and instigators of change; and
- networks are extensive and inclusive and alliances and acquaintances stretch across differences; and emphasis is placed on the nature and quality of human interactions, rather than on individual advancement, so as to create and strengthen relationships of thoughtfulness, generosity, and caring, the bases for trust.

THE NEW UNITED STATES INTERNATIONAL STRATEGY ON HIV/AIDS

Timothy Wirth
Under Secretary of State for Global Affairs
United States Department of State
Washington, D.C.

Former Senator (D-Colorado) Timothy Wirth is now Under Secretary of State for Global Affairs and is responsible for a number of global issues, including HIV/AIDS. As the Conference began, he unveiled the Clinton Administration's new multi-agency strategy to implement its role in the worldwide struggle against the HIV/AIDS pandemic. Citing a "deep kind of political organization that's moving in exactly the opposite direction from the goals and responsibilities that are shared by so many of us in this room," he pledged that under the current administration the United States would "make the kind of investments in the future that are going to pay off with the sort of prevention and a dramatically more peaceful and more rational world for future generations."

A changed world

Wirth was able to chart what a different world we now have from the one he knew as a private in the U.S. Army in 1961. As the Berlin Wall went up, he was put on high alert and believed along with his buddies that they were headed to war in central and eastern Europe. Now democracy is taking root in that region, and Wirth's kids thirty years later sat atop that same wall along with "650,000 other young people from the United States and Europe, listening to a Pink Floyd concert."

He signaled several changes that augur most profoundly the new American role:

- a foreign policy, once dominated by political and military concerns, "that now has running through it a series of other threads and other concerns of such great importance. And probably

- 39'

the word prevention is the most important one of all;"

- an awareness in the medical community that, "if you can keep people well, it's a heckuva lot better and a lot cheaper and a lot more productive, than it is trying to fix things after people get sick;" and
- a recognition that the global future depends on stabilizing the population, and that "a key to that is the empowerment of women."

A global strategy to meet it

It is upon these changes that a new world will be built, and Wirth insisted that President Clinton and his Administration were determined to meet their international responsibilities in HIV/AIDS prevention by providing the kind of leadership the rest of the world looks to the United States for. "As I travel around the world as an American citizen," he recounted, "I am struck by how much the world looks to the United States for leadership and for help, and how much of a partner we can and should be. Over and over again, we are asked what are you going to do, what is the United States going to do? And it is our job as Americans—those of us who have the responsibility to bring this [message] home—to explain to the American public what the world expects of us, and what we should expect of ourselves as well. In the public health area this is enormously important."

The Strategy as published runs to over 50 pages [and the next day at the Conference, Anne Keating Solomon would articulate some of its details], but Wirth hit some highlights, saying it was crucial for the United States to:

- bring whatever weight America has to urge other governments to talk about and to deal with HIV/AIDS as honestly and openly as possible, and to join various United Nations and other international efforts to enhance the dialogue;
- encourage the nongovernmental sector, which has become an increasingly important component of the conduct of foreign policy, and to enhance the partnership between the private and public sectors;
- develop and disseminate examples of programs that have worked well;
- maintain the importance of the military as they shift their priorities away from the Cold War and begin to renovate their approach to an entirely new concept of national security;
- safeguard blood supplies;
- expand and concentrate research on a vaccine and other technical approaches to the problem and coordinate efforts at the NIH, the FDA and the CDC;
- focus on reproductive health, and expand that approach to embrace the legal and human rights status of women;
- appreciate the complexity and the needs of extremely mobile populations, under current world conditions; and,
- urge Congress to develop the necessary understanding and provide the required assistance to support and to accomplish these actions.

A final note

"You all are terrific to be here to be engaged in this cause," Wirth told those gathered at the conference. "You carry our respect and admiration for the work that you do, and I'm delighted to be able to have a few minutes to share with you this one other effort that we are undertaking. We look forward to working together with all of you. Thank you very much for asking me, and to all of you, congratulations on a successful conference, and, most importantly, on the work that each of you does."

Plenary/Closing Session

EVOLVING U.S. RESPONSES TO HIV/AIDS IN THE DEVELOPING WORLD

A panel of the past and present AIDS coordinators from USAID and representatives from the State Department

Dr. Jeffrey Harris
Associate Director
Program Development
National Centers for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
Atlanta, Georgia

Dr. Jeff Harris was one doctor who "was very interested in HIV/AIDS;" yet when he came to work at USAID in 1986 he was told he would spend about 20 percent of his time on the issue. A staggering journey of awareness has been undertaken since that time—by the Agency, and by the world, which can no longer ignore what may one day be recorded as the most devastating plague in human history. And yet history will also record the attempts of mankind to grapple with the virus, and perhaps the center of that effort, at least from the prevention perspective, can be found at the agency.

Harris remains deeply involved in the issue, and when he stops to reflect will ask himself, "Have we made a difference?" He promised the conference to tackle this question from four separate perspectives: Our awareness of the epidemic; our knowledge of the modes of transmission; strategies for intervention; and programmatic approaches. For him, the question and its challenges symbolize and "certainly guide my life in public health. I suspect they are what guides all of your lives as well," he remarked to his audience, "or you wouldn't be involved in this work."

Awareness of the epidemic

It wasn't only USAID that took a part-time approach to HIV/AIDS back in the epidemic's dark ages of 1986; Dr. Jonathan Mann began the World Health Organization program on a temporary assignment styled as a communicable disease program, and he had two part-time assistants, a secretary and a public health advisor. Most of the world, even in the public health sector, remained stubbornly unaware of the significance of the disease which, at the time, was often perceived from the epidemiologic view, centered in marginalized populations.

Harris recalled the Second International AIDS Conference in 1986, in Brazzaville. It was, "I think, the first that really focused more on programs than on science," he said. "The thing that stuck out most—there was a lot of denial at that meeting—was a colleague from a very large (unnamed) West African country who stood up and said, "'My government's policy is that we have no HIV-infected people and we have no AIDS and that's the end of what I have to say.'" Since this gentleman knew and was friendly with most of the people in the room, he paused, smiled knowingly, and went on to say [reported Harris], "'But if you want to know more, I'll talk to you in private.' And that's where we were in those days with people talking about HIV infection."

Knowledge about transmission

Time tends to obliterate the memory of how things were, and nowhere is this more apparent than with science and technology. "Some of the things we take for granted," Harris reminded his audience, "weren't always here." Again early in his tenure, he recalls attending an advisory committee meeting (not on AIDS, nor even on public health, just the general area of research) and watching a couple of public health school deans go at each other hammer and tong over "this issue of whether or not men and women could actually transmit." He remembers with chagrin the general view that

"there was something special about men who had sex with men." Even more embarrassing is an article that appeared in the British journal *Lancet,* "I think it was 1987, that said that Asians—this wasn't a cranky letter but was a legitimate article—had a different blood type from the rest of us, and that they were immune to HIV infection. We have," indeed, he observed, "come a ways."

Intervention strategies

Two of the basic tenets that now overarch our current thinking about prevention were once, Harris reminded the conference, then heretical and controversial topics: Heterosexual transmission and HIV/AIDS as a sexually-transmitted disease. His training and instincts in the mid-1980s reflected those of many other public health officials, who were inclined to focus on blood-borne modes of transmission because at least that was an area their intervention paradigm addressed. When Harris met Jon Mann, the latter had just returned from research in Zaire. "Jon said 'You know the data really tell us that sexual transmission is very important, and that's where we really have to put our focus.' And I said, 'Yeah, but we don't know how to stop sexual transmission.'" Within a year the two researchers had reversed their positions; Mann had changed jobs and found himself in a much more political environment where he discovered that "countries aren't interested in sexual transmission." Harris meanwhile recalls that "it wasn't until 1989—several people in this room were there—that we actually scheduled an all-day session at a hotel in Reston, Virginia, where at least AID hammered out that we were going to put the majority of our efforts into sexual rather than blood-borne transmission."

From the beginning USAID found, as did others around the world, that there was "adamant resistance to having an STD component in our efforts," Harris remembered. But the virus paid no attention to this cultural blindspot, and soon the epidemiologic data were overwhelming enough to convert even the most hidebound skeptic. "But it wasn't until 1991," Harris said, "and the beginning of AIDSCAP, that [the STD designation] actually got any formal recognition in anything that AID did, and we [began to] bless people to spend dollars on STD approaches."

Programmatic approaches

Back in the early HIV days at USAID, there was no formal program, but this "wasn't as unreasonable as you might think," said Harris, in part, "because the AID missions in the field were saying 'You know we don't know how to do that. We have no experience in preventing HIV infection, so we're not going to get started in that. Leave that to somebody else, because we want to do things that we know how to do.'" In 1987 AIDSCOM and later AIDSTECH were established, and Harris insisted that "they were always conceived as [and designed to be] *learning how* projects." And they succeeded, he insists. "But I think that our missions learned how. They clearly felt that they didn't know how to do this, though by the time AIDSCOM and AIDSTECH were done, many of the important missions *did* know how, and I think the private voluntary organizations learned how, and with them the nongovernmental organizations in developing countries, and the community-based organizations learned how. We have *all* learned how to do this, but" Harris thought it was important to remember the historical perspective, "we did not know how to do it nine years ago."

Cut to 1991 and the advent of AIDSCAP, shortly before Harris gave way to Helene Gayle as Chief of USAID's HIV-AIDS Division. He says he is often asked "Why did you create *just one* AIDSCAP?" What he emphasized is the realism of his situation at the time. "I was running a $90M program, with 13 staff, and two-thirds of them didn't really work for me. They worked for Johns Hopkins or for CDC, and they were just on loan to AID. There was little prospect of being able to add

42

real employees, and we really didn't feel we could handle the management burden of managing this new larger project, so we decided to delegate a lot of that to AIDSCAP. The idea was that AIDSCAP would then manage a decentralized effort by countries, by missions, by PVOs, by a host of characters working in about 15 countries, to try to make an impact on HIV transmission."

"Have we made a difference?"

The answer to the question Harris originally addressed seems clear. "Absolutely," he proclaimed. "In the awareness area, the world now knows the huge tragedy that we suspected in 1986. In the knowledge area, we don't think that Asians are immune anymore. In the strategy area, I want to remind you that our focus on sexual transmission and on condoms at AID was not easy to reach. We got hit from both sides, and neither of those strategies has been politically popular." And of course the program universe has seen the most dramatic revolution of all: "We have progressed from no program and no intention of having one, to the largest program in the developing world. And," he would argue, "one that has set the pace, at least from a technical standpoint."

But the world hasn't stopped spinning nor has the virus surrendered. "I think we're left with a tough question," Harris said. "I answered the 'Have we made a difference?' question but we're left with what seems to be a tougher question: 'Are we *making* a difference?' The answer to that one I would put something like this: Having raised awareness and figured out what to do, and gotten the funds to do it, are we slowing this epidemic?

And I think to answer that question is that we've actually got quite a bit more to do." But, he concluded, "we've got to do it, because we've got to know that we're making a difference."

Dr. Helene Gayle
Acting Director
National Center for HIV/STD/TB Prevention
Centers for Disease Control and Prevention
Atlanta, Georgia

Following Dr. Harris as a speaker, Dr. Helene Gayle had also succeeded him as Chief of the HIV-AIDS Division at USAID in the early 90s. She was able to pick up where he had left off, and "we were coming to grips with the reality that we were faced with the challenge of a sustained response... and having to [in fact] put a program in place. We were moving quickly from the idea that we were going to 'make this a world without AIDS' to accepting the fact that we had to prepare for living in a world with HIV and AIDS."

Moving past the epidemiological model that Harris earlier characterized, Gayle began her tenure with the growing recognition that HIV/AIDS "is a biologic and sociologic and sociocultural vulnerability. I think the primary focus on HIV prevention—which has always been USAID's major emphasis—was beginning to broaden to embrace the interrelationship between prevention and care." This meant that they were going to need to consider, she realized, "the many broader societal and economic factors that are both a cause and a consequence of the HIV epidemic."

Evolution of a wider view

A number of themes and motifs that characterized this year's Prevention conference had their genesis as program elements during this era at USAID, she observed: "The increased vulnerability of women to HIV, and the recognition that this is both a biologic and sociologic and sociocultural vulnerability, thus a greater focus on women and women's issues; an increasing role for NGOs and building new partnerships beyond our more traditional partnerships; a much greater focus on behavior; the importance of engag-

43

ing a broader range of sectors, the multi-sectoral response that so many people have talked about; and developing models that would incorporate prevention as well as care."

"Miles to go..."

Meeting these challenges, said Gayle, made the Agency grow and evolve. But there remain a hit list of issues that still remain problematic. A lack of flexibility, she insisted, was one of the prime impediments, as she contemplates having to deal with unwieldy bureaucracies, and endure long project start-up times. The importance of sustainability she believes, "can't be overestimated." She also believes that the recurrent debate over the dichotomy between short- and long-term goals is a dead end. "We often talk as if there was an either/or—you either address the societal factors, or you address the biomedical and short-term factors. We can't afford to think in those either/or terms. We have to think about putting in place short-term activities and looking at short-term objectives but doing so in a way that doesn't preclude the type of long-term activities that we know are necessary to make long-lasting and fundamental change.

Also on her list of priorities is the increasing need to demonstrate a project's impact, "not only because our funding depends on it, but also because I think it gives us a sense of whence we've come and where we're going—a sense that we are accomplishing something." For her this means "consolidating what we know, and being more aggressive about sharing it. Information dissemination" she said, may be a current buzzword, "but AID has a lot to be proud of...I think we need to show the world and also to demonstrate to ourselves that we have had some successes."

She saluted the accomplishments of those gathered for the conference as well, and noted that it was "also particularly gratifying to see that there's still a lot of enthusiasm, a lot of dynamism and vitality and commitment. This is hard work that we've all involved in, and it's wonderful to see that there is still a core group of people who feel that this is important, and have not gotten burned out, which would not be unexpected. " She sees such conferences as an important part of the process, not only cognitively but spiritually as well. "I think we've also shared a sense of commitment, a renewed commitment. These conferences, in addition to all of the information that we pass among ourselves, I think really do serve to send us out again regenerated, reinvigorated, and I know I leave here feeling that I can go back to my work with a renewed commitment and a renewed energy. So I want to thank you all for that."

"All things are possible once we come to recognize and believe they are necessary," she concluded. "And so I think we must push the envelope. We've come a long way, but we can go a lot further."

Dr. Jacob Gayle
Chief, HIV-AIDS Division
United States Agency for International Development
Washington, D.C.

As his sister before him had succeeded Dr. Harris, Dr. Jacob Gayle became the current Chief of the HIV-AIDS Division for USAID in 1994. He paid tribute to his two predecessors, but declined to take the time to go into much detail about his view of the job thus far. "I still have a way to go yet, I hope," he joked. "And I think that actions really do speak louder than words." He made a pledge about the future of his tenure: "I hope that in the next few days and weeks and months and years, we'll be able to show that the words we've uttered today, the offers that we have made during this time, will turn out to have been sincere and true. Will have been actualized."

He then surrendered his time to two commentaries that had arisen from participants not scheduled to present, one from South Africa, and a second from a group of nongovernmental organizations and individuals from Brazil, Haiti, and the Dominican Republic.

He was asked to read this latter one to the conference, after it had been translated from the Spanish.

To the Oganizing Committee of the Third USAID HIV/AIDS Prevention Conference:

Dear Colleagues,

The nongovernmental organizations signing this document wish to thank you all for the opportunity to participate in this conference. We believe it is representative of the worldwide efforts at stopping the spread of HIV/AIDS. However, we wish to seize this opportunity to express our great concern for the dramatic reduction in funds [that are being] made available to support efforts and initiatives [such] as the ones we are actually conducting in our countries, when instead there are growing needs for closer attention to be given to the problem.

We are halfway through the second decade of the AIDS epidemic. As committed organizations, we have been the designers and constructors of innovative methodologies that have proven effective and [have had an] acknowledged impact. We have a moral commitment [to] populations that need the attention we provide. We have developed experiences from which lessons learned are being shared [throughout the conversations in] this very conference. But today we need to take this a step further.

All [of] this indicates the importance of taking the unsatisfied needs—of those human groups and populations that have not yet been reached by governments and nongovernmental organizations—very seriously. Therefore we solicit:

1. To hold an urgent consultation with USAID Washington so as to be heard in a more detailed manner, and to share our points of view through a collaborative agenda, and the common objective of controlling the epidemic in the Americas.

2. To establish a date and a time in the near future so as to be able to have a significant representation of the countries signing this declaration [who have] attended this meeting.

Thank you.

signed,
Individuals and organizations
representing Dominican Republic,
Brazil and Haiti

Secondly, Bernadette Hadden from South Africa requested the opportunity "to make a response on behalf of those from the region."

Bernadette Hadden:

"Members who are present here at the conference from Africa met today at about noon to raise a few issues and concerns, and to make some suggestions also about our continued partnership with USAID.

There were about 21 of us at the meeting, and while we do not claim to be representative of all the Africans here at this conference, or of all Africans on the continent as a whole, we felt there were some issues that we needed to raise, and that we should use this opportunity to raise them.

We are also aware that some of the issues we raise here are already under discussion, at the country level, by USAID. The issues we dealt with, (in order of priority as assessed by the group) are:

1. ZIPS for Africa. Those are Zero Incidence Projects, which we regard as critically needed in Africa. We were going by Celentano's study, which indicated that among Thai Army recruits, there was a zero incidence in HIV infection [in the study group for that intervention]. In the light of this achievement, with all that is known about HIV/AIDS in developing countries, we should have the capacity to bring about zero incidence in various countries, if not in the continent as a whole. We see the above as the ultimate in integration; this we believe to be the issue and the way in which USAID should be going. Suggestions were made that USAID sponsor at least one of these ZIP projects in each country. The proposal for ZIPs needs to be appraised against achieving zero incidence without vaccines, as against what vaccines alone could do for the continent.

2. Integration. We agreed that the idea in principle was fine, but that achieving effective intersectoral action may be difficult unless the responsibility for coordination and management is at the cabinet level. It was recommended that:

(a) Integration should be country-specific and program-specific.

(b) Integration needs to be gradual and accompanied by ongoing evaluation to ensure that current successes are not undermined.

(c) Decisions on the how and when of integration must involve all stakeholders and real event participants.

(d) That there should be an increase in the capacity to deal with HIV/AIDS prevention and care in the non-health sector as well.

3. Increased emphasis should be placed on clinical care, both inside and outside of health care facilities. Given that more than 60 percent of worldwide AIDS cases occur now in Africa, the continent needs increased emphasis on research related to AIDS care and support, and not only on preventive and vaccine research.

4. USAID needs to coordinate its activities with those of the United Nations Programme on AIDS.

5. Capacity building is needed at all levels and sectors. Finally, that youth prevention programs should not be ignored and should receive more emphasis. USAID's record on capacity building has to date been poor, and the agency should include this aspect in all future research projects.

Dr. Gayle expressed his appreciation to these commentators for sharing their views, and pledged to respond to their concerns. He then led the conference in a moment of silent observation.

"I would ask that we do something we would be amiss if we neglected; that is to remember that—before we leave here and call this all a success—we must remember those who have gone before us, upon whose experiences and emotions we have been able to build our successes, to learn our lessons, and to really prepare ourselves for the future. If you would one last time indulge me by standing, for a moment of silence, to remember those who have

already left our company in the battle against HIV/AIDS, and to remember those of us who struggle with the epidemic, both within our own lives as well as within the lives of our loved ones and the people close to us.

[All stand silently]

"In cultures all over the world, we realize that if we take out a moment for silence and listen to the wind, many times we can find the solutions for the current dilemmas and for he future. As we listen to the wind now, I hope that we will be able to bring together our resources, our energies, and our commitments to continue to work toward a future that helps us to live with HIV/AIDS, to prevent the further spread of HIV, and most of all, to strengthen ourselves as a people without borders, worldwide."

Eric Sawyer
Co-founder, ACT UP! New York
Co-founder, Housing Works
New York, New York

"We've heard in detail from all of the rapporteurs the outcomes of each of their groups, and so rather than try to expand on the great job they've already done, I'd like to instead spend my five minutes up here directing some comments toward USAID.

What I'd like to do is to urge USAID to take the suggestions that have come forward from these working groups seriously in their process for reorganizing their programs in the future, bearing in mind that these are only eight areas of many that those of us who are fighting on the front lines have comments, opinions and suggestions for, and I'd like to remind USAID that the process for community involvement and for seeking contributions from those of us on the front lines must not end with the close of today's session, but must continue every day that USAID is operating an HIV/AIDS program.

I'd further like to charge USAID to take these comments and concerns into consideration to ensure that every action taken by USAID and the program not just pay lip service to people living with HIV/AIDS, but actually contribute toward making a difference in the quality of life for people living with HIV and AIDS. USAID must ensure that all actions taken contribute to advancing and protecting the human rights of those of us living with this virus, for any HIV/AIDS program that does not include a human rights component is a failure.

USAID must also recognize that prevention and care are inseparable. And USAID must do everything in its power to increase access to care and to treatments for all PWAs everywhere, especially those PWAs living in developing countries.

USAID must also recognize that prevention activities should include efforts to delay people living with HIV from develop-

ing AIDS, by expanding access to prophylactic treatments, especially in the developing countries, for this is crucial to allowing those of us living with HIV to live longer, more productive lives. I know that resources are limited, but it is also the responsibility of USAID to join us in the fight to advocate for more resources.

And all of us who are fighting this disease must recognize that HIV is not going away any time soon. We must all continue to find the energy to fight this disease for a very long time. Thus we must continue to also find more creative ways to keep individuals not yet infected from becoming infected. We must learn to work better together as partners, so that we can join the efforts of those of us living with HIV/AIDS with the efforts of those individuals fighting this epidemic who are lucky enough not yet to have been infected.

For without a coordinated, cooperative global response, HIV disease will just continue to kill hundreds of millions of our brothers and sisters."

Anne Keatley Solomon
Deputy Assitant Secretary, Science, Technology and Health
United States Department of State
Washington, D.C.

As one of the Administration's most versatile technical and policy experts, Ms. Solomon addressed in some detail the U.S. International Strategy on HIV/AIDS that was unveiled earlier in the conference by Under Secretary of State Tim Wirth [and can be located on the DOSFAN network]. The United States Government response to the pandemic has been the concerted effort of a handful of agencies, with USAID taking the lead for the last decade through the investment of over $700M. For nearly a year strategists and others in these agencies have been convening with planners, Congressional staff, representatives from the NGO community and people living with HIV/AIDS in order to develop the most informed and comprehensive strategic plan possible.

Four working groups were established to consider research, prevention, security interest and the coordination of donors, and to come up with areas of high priority; and their results were funneled through the lens of foreign policy at the State Department. The resulting document was circulated throughout the NGO community for comments, and after changes were included was finalized as the International Strategy.

What does the Strategy say? "There are three overarching goals," said Ms. Solomon: "To prevent new HIV infections, to reduce the personal and social impact of HIV/AIDS, and to mobilize and unify national and international efforts on HIV/AIDS." She pointed out that the goals are consistent with those of the World Health Organization's global strategy. The involved U.S. agencies are committed to an agenda of program activities in support of the goals, including education, research and the coordinating of donors.

48

Actions abroad

Ms. Solomon stressed that much of the plan was devised to be activated through the foreign policy community. Specific goals are to:

- increase the political commitment to combatting HIV/AIDS by national leaders;
- persuade other governments to increase their contributions to the global AIDS prevention effort;
- focus world attention on the special needs of vulnerable groups, including women, children, refugees and homosexuals;
- advance the concept that sustainable economic development and stemming the spread of HIV/AIDS are inextricably linked;
- improve international cooperation on AIDS research and vaccine development;
- support the efforts on AIDS in the United Nations; and,
- address the human rights implications of HIV/AIDS in all appropriate fora.

The State Department

Ms. Solomon and her colleagues at the State Department are pledged to play a key role in the implementation of the Strategy, and will follow an ambitious Action Plan to do so. Its primary goal is to heighten awareness by raising the profile of the issue at every opportunity. Diplomats will proactively raise the issue with foreign officials, urging them to address the issue openly and to commit as much to it as possible. At appropriate international meetings and conventions, the U.S. delegates and representatives will strive to put HIV/AIDS onto the agenda. In their own foreign policy analyses and deliberations, they will try to factor the impact of global AIDS everywhere appropriate, and to assess its impact on business interests at home and abroad, and also on humanitarian and peacekeeping missions. Already, this has been done by drawing on the document to prepare for the Chinese-sponsored Conference on Women in 1995 and for the 1994 Paris AIDS Summit.

Ms. Solomon assured the conference that "this is not a Strategy that will sit on the shelf. Our intent was to develop a useable and dynamic document...which we expect to review in two years time...to examine our progress and reassess the Strategy itself." In the meantime, she promised to galvanize the Action plan through the forum of interagency meetings, and reaffirmed the Administration's deep commitment to the cause of international HIV/AIDS prevention.

49

Closing Remarks

Sally Shelton
Assistant Administrator, Bureau for Global Programs
United States Agency for International Development
Washington, D.C.

As she rang down the curtain on the Third USAID HIV/AIDS Prevention Conference, Chief Administrator for USAID's Global Bureau Sally Shelton observed that by convening the leadership from HIV/AIDS from all over the world, the agency has created "a unique opportunity for the community at large to share experience and needs. It has also been a time," she noted, "for all of us to shed our titles and our affiliations and roll up our sleeves together. HIV demands us to join together to seek ways to share our resources and our strengths." Shelton's position, she believes gives her "the chance to try to make a difference in terms of the world's response to this terrible disease, [since] we are the world's largest bilateral donor to HIV/AIDS prevention programs."

Shelton had recently been elected chair of the program coordinating board of the newly established UNAIDS effort, working with co-chair N.C. Zuma (the Minister of Health from South Africa) and Executive Director Peter Piot. "It's a great honor," she acknowledged, "but also a great responsibility...to help shape UNAIDS' focus in its operations and activities." She was determined that—even beyond their presence on the board, nongovernmental organizations would be involved at every level, "in the programmatic decisions and in the leadership."

A beleaguered budget

In the midst of debates and votes on Capitol Hill, Shelton said that "budget issues are very much on everyone's mind," and she described the situation as truly "terrible." Cuts in funds for development assistance of 30 to 40 percent (on top of a 20 percent operating expense account cut for each of the next two years, on top of a 20 percent cut in development funds the previous year) have seriously threatened the ability of USAID field offices to carry out their mission. These are draconian, radical cuts." And though she conceded that "everything is on the table," she averred that development assistance "is a Clinton Administration priority. Let me assure you, though everything will be on the table, that if I have anything to say about it, there are certain sectors that we must try to protect. And our commitment to HIV/AIDS must count as one of our priority sectors of activity."

A memento mori

Shelton relishes her role in the corridors of power because she believes in the mission, but she said that "my hat goes off to the foreign service officers in USAID who have dedicated their lives to helping people out in the field, while the rest of us sit in Washington basically moving paper and money around and—I hope—making a difference from time to time. But it's the foreign service, who are out in the field, who are really making the difference." Because of this, she feels that "it is extremely important for my colleagues and myself to get out to the field from time to time to see how these ideas actually impact real people on the ground."

On one such recent trip to East Africa, Shelton visited a USAID-funded HIV/AIDS prevention center in Kampala, Uganda. As she recounted her experience, her voice betrayed a vivid recollected emotion:

"There was a handicraft center attached to the prevention center, and I went in and began to talk with about a dozen Ugandan men and women who had the virus and were in different stages of the disease. As we talked, I struck up what I believe I can legitimately and honestly call a friendship. It was with a woman who was not in very good shape. She would be leaving several children behind, and yet she pressed on me a basket that she had made at the center, by hand,

which would long outlast her on earth. I brought it back to Washington, and I now have it in my office. Each time I look at it, I am reminded of the reality of HIV/AIDS, of what our mission is all about.

"So, in closing, I want to assure you that as we go forward in this next horrible budget year, we are going to do everything we can to protect this program."

51

Roundtable Summaries

52

Roundtable Summaries

The Third USAID HIV/AIDS Prevention Conference was designed to promote dialogue among participants and to encourage them to bring the widest possible range of their experience to the discussions. The Roundtable sessions in particular benefitted from this structure.

After much informal discussion with key people in the prevention community, a set of eight key "Issues for the Second Decade" were established as priorities. A chairperson was identified and a background paper commissioned for each of these subjects, in order to lay out the range of issues and questions that the conference discussion would use as a point of departure. Each paper was sent to a selected group of a dozen or so interested people whose backgrounds gave them some experience in the particular area under consideration. This collection of people—the pre-conference roundtable participants—came to Washington on the Friday before the conference proper began for two full days of working sessions, to refine the framework in which that particular subject might best be approached.

Once the conference began, sessions were scheduled for this core working group to continue deliberating and debating their topics, and these sessions were opened up to all conference participants. Over the course of three days, many hours were devoted to each of the eight topics, not only by the original working group members but by any participants who wanted to join those working sessions.

At the closing/plenary session, each of the Roundtable chairs presented to the entire conference the results of each group's deliberations. The summaries presented below are more elaborate versions of those reports, drawn from tapes, transcripts, rapporteur's notes, and working group reports. While they do not represent USAID policy, they do provide an invaluable collection of insights that the Agency is using to inform that policy. It is hoped that they embody the collective wisdom of the many people who worked on them, and are presented here in a form designed to be most faithful to the actual discussions that occurred. As with the Oral session summaries, they reflect the discussion held among professionals grappling with real solutions to the many dilemmas and challenges of HIV/AIDS prevention.

Issues Cutting Across the Prevention and Care Continuum

PREVENTION AND CARE: IMPLICATIONS FOR PROGRAM IMPROVEMENT AND SUSTAINABILITY

Moving into the second decade of struggle with the HIV virus, societies are beginning to rethink the concept of *control.* As the number of those with HIV/AIDS fast approaches 20 million worldwide, according to the latest estimates from the World Health Organization (WHO), a central distinction is blurring—between caring for those directly affected by the virus and preventing its spread to others. The pandemic unleashes its insidious effects far beyond those who become ill. Caring for those affected must now be considered a crucial tactic in the struggle to contain HIV/AIDS, and basic concepts on which programs and policies are founded must be rethought.

Two reasons make this conclusion inescapable. First, the adverse social and economic impacts on families, communities, and the health care and social systems of countries throughout the world has become staggering, and also better documented and understood. Second, care makes sense from a prevention point of view: Only when communities truly *experience* HIV in their midst by acknowledging and participating in the care of those infected with it will they have embraced the problem, and can then begin to effectively think about HIV prevention.

Care and Prevention on a Continuum

Who is affected?

What becomes increasingly clear is the ripple effect, outward from the individuals infected to specific groups and communities at risk, to larger components of society. A composite picture emerges with a number of identifiable affected and infected communities: donors; governments, agencies, departments and ministries of health, development, social welfare, labor, and finance; the workplace and business community; the military; religious institutions; the private/public health sector, and traditional care institutions. In earlier social models, the relevant elements of these sectors of society were separated into the two largely distinct realms of care, and prevention.

Components of Care

Care for people living with HIV and people affected by HIV involves a wide range of service providers who meet a broad spectrum of HIV-related needs.

Such as:

- Medical care—includes appropriate diagnosis, rational treatment and planning for follow-up;
- Traditional care—includes local healing practices and alternative and complementary therapies;
- Nursing care—includes providing health care, health maintenance and palliative care, promoting hygiene and nutrition, counseling and educating family members on prevention as well as on how to care for the afflicted family member;
- Counseling—includes facilitating informed decision making (e.g., whether to get tested), reducing stress and anxiety, promoting positive living and planning for the future, and facilitating behavior change;
- Social support services—includes providing information, referral to support groups, welfare services and legal advice;
- Self-care practices—includes the care people provide for themselves when they make healthy lifestyle choices.

Components of Prevention

HIV prevention involves numerous sectors engaged in improving the quality of

life of individuals and the capacity of communities.

Such as:

- Sexual and health education that occurs outside health or service deliver systems (e.g., in schools, work places);
- Teaching social or life skills that lead to empowerment and enable people to care for themselves;
- Providing information that enable people to make informed decisions;
- Promoting activities that provide people with the tools, resources, capacities, and empowerment to prevent disease.

Prevention as part of the continuum of care

The new paradigm breaks down the distinction between these two main categories. Prevention education can be seen to be a vital aspect of caring for people's well being. Conversely, care can be an entry point for discussing prevention. The separation between the two has always been artificial at the community level, and tends to complicate and can hinder the implementation of both.

Health workers can effectively employ a range of prevention tools, depending on a person's needs for care.

For example:

Treating an STD (providing care) prevents it from getting worse and becomes an entree to teach about HIV/STD transmission.

For example:

Immunizing children prevents their getting sick and becomes an entree to teach about hygiene and using sterile injection equipment.

Also, analyzing the problem from the point of view of the target group can indicate the appropriate approach to prevention.

For example:

People living with HIV/AIDS have different prevention as well as care needs than do uninfected youth.

Issues linking prevention and care

Integration

So far, discussion (among experts and in the literature) about integrating prevention and care has been primarily limited to health care economists and planners. Traditionally, care and prevention are seen as having separate objectives, areas of service, target populations, and resources. This distinction can help with evaluation, but remains generally artificial when it comes to implementation, and can actually be an obstacle. The traditional concept of care—meeting the biomedical needs of infected individuals—leaves behind gaps, which CBOs and NGOs have taken the initiative to fill.

For example:

Meeting the psychosocial needs, basic physical needs, and the prevention needs of people within affected communities.

True integration of prevention and care entails the collaboration of numerous levels of society (each of which already discharges special responsibilities): not just providers, but also family, donor, government, and community members.

Fear and stigma

Three important issues must be faced before anything like an effective integration can develop. First, as HIV/AIDS cases increase in number, the sheer magnitude of the care dimension is intimidating. Prevention seems more approachable. Second, moral judgments and negative attitudes toward people living with HIV necessarily buttress resistance to providing care to them. Finally, uninfected people perceive the stigma experienced by people living with HIV, and tend to deny (often unconsciously) the serious threat of HIV/AIDS in their own lives, and thus prevention efforts suffer.

Limited resources

It is a regrettable given that the resources to deal with HIV/AIDS are both limited and

55

inadequate; thus, many experts try to protect the limited prevention funding from being eroded by the equally acute need for HIV care (for which resources are also entirely inadequate). Donors have developed the preference to support and fund programs with discrete objectives rather than the more comprehensive goals of integrated prevention and care services. Despite this institutional preference, those who conduct STD, family planning, and HIV/AIDS education have already begun to view theirs as integrated, full-time work.

Two pieces of a solution for this dilemma are training greater numbers of providers and helping organizations and communities to build capacity—generating their own income and developing additional sources of support—and to become self-sufficient.

Evaluation

Evaluation performs a critical task of identifying whether programs are achieving their objectives and having the desired impact. The difficulty in measuring social as well as medical/clinical objectives is related to data availability and accurate measurement tools for sociobehavioral interventions. Conflicts can arise between the donor and the community over the value of identified outcomes.

For example:

A community can reach its objective for care without having prevented illness, which may have been the donor's objective.

Communities often come to feel that evaluations are conducted without useful results and are usually not received in time to provide feedback into the actual programs. Donors, on the other hand, like the sense of coherence that evaluation can provide to the process of allocating substantial resources. Given the present balance of power, communities need to embrace rather than to resist performance evaluators.

The issue of control

The community's definition of care is necessarily driven by its own pressing needs, and is preoccupied pragmatically with the problems and clinical realities it faces in a relentless present tense. These pressures can push prevention lower on the priority list. Consequently, health care providers and donors develop the institutional perception that setting HIV/AIDS priorities should not be left to the community, which conflicts with one of the commandments in the movement: namely, that programs should be community- rather than donor-driven. Thus it becomes incumbent on policy developers and planners to try to achieve community buy-in for prevention by remaining sensitive to their local needs and demands for care.

The role of people living with HIV/AIDS

People living with the virus have an important role to play in HIV/AIDS-related care, but a number of complications arise in their assuming that role. Foremost perhaps are the dramatic cultural variations among world cultures, which impose diverse and powerful pressures on those living with the virus, even when they are asymptomatic. The premise that openly publicizing one's serostatus confers authority as to education and prevention matters may have a distinctly *Western* cultural bias. Treating this as an inviolable commandment threatens another important principle: namely, that cultural values, traditions and belief must be respected, even at the expense of compromising the impact of an intervention.

Nonetheless, it seems evident that people living with HIV/AIDS can be powerful messengers for prevention education; programs often recruit people living with HIV to speak in the community. Organizing these HIV-infected peer educators again raises the perspective of cultural diversity. The process will take its own time and cannot be forced; it is important to allow people and communities to develop at their own pace.

For example:

In Kenya, people living with HIV formed their own organizations and came

together in a movement to provide both help and counseling for others who had contracted the virus, as well as prevention information to those who were not infected.

Notwithstanding the cultural framework, ultimately assuming the activist role is a personal decision. The individual as well as the social problems of people contracting the virus revolve around stigma and fear. The most effective way to deal with these has been shown to be integrating asymptomatic people into the community's dialogue about HIV/AIDS. Magic Johnson provides a striking example in the United States.

But the pioneers who must blaze the path are faced with the reality of the stigma. Thus as programs evolve to encourage people living with HIV to lend their testament and effort to supporting others—or to the education of the community—most people who are newly diagnosed will feel pressure to disclose their status and join the movement. Yet their apprehensions are not unfounded: disclosure of HIV status can lead directly or indirectly to the loss of jobs, housing, insurance, abandonment by the community, and even one's family.

What lessons have been learned about integrating care and prevention?

A mixed picture

Functioning on largely separate tracks, HIV/AIDS prevention and care programs have each been successful in certain ways, limited in others. The prevention camp has learned how to generate resources, develop innovative approaches, and improve access to underserved populations. But these accomplishments have happened more despite existing services, rather than in concert with them.

Increased access for underserved groups is undeniably a gain, but it has nonetheless produced an overwhelming caseload for the public sector. And as local resources have been successfully developed, donor funding has in many cases diminished. Local NGOs that succeed are building their own capacity, and as they do, they take on more responsibility for both care and prevention. But if their inherent deficiencies in skills, resources and training aren't addressed systematically, the long-term prospects are less favorable.

Another factor reflected in the changing demographics of who is being treated can be seen in the involvement of people living with HIV/AIDS. Earlier in the epidemic, these activists assumed an important role as advocates and constructive critics of programs. The face of the epidemic worldwide is changing as more disempowered populations are affected, and such groups are not assuming the same type of leadership. In the light of these trends, it could be useful to take stock of some lessons that have been learned.

Integration

- **Prevention and care must be integrated.**

The operational linkages of prevention and care must be reinforced, and governments must be involved in the linkages. Although HIV prevention and care services currently are distinct in most communities, the goal should be to improve the level of coordination between services, and ultimately to have full integration in a single program. A crucial cornerstone is to establish coordination and linkages between the services provided in communities and in health facilities.

Skills building

- **Training across various skills areas is the most effective way to improve the provision of HIV-related prevention and care.**

NGO staff: Need training in planning for sustainability (which includes cost recovery measures, utilization of seed money, entrepreneurial and fundraising skills, and networking), and training in personnel management (which includes providing support for staff as well as dealing with staff turnover).

All staff in health facilities, including administrators: Need training in all these subject areas as well as information about standards of care, information about existing resources and services in the community, and skills in discharge planning (before someone is discharged from a care facility) and in basic counseling. An important but intangible value to emphasize is a sensitive and humane approach to caring for people living with HIV/AIDS: "People don't care how much you know, they want to know how much you care."

Members of the community (volunteers, retired people, school and church groups and other youth workers, and traditional healers): Need training in clarifying misinformation, advocating skills for HIV prevention (condom negotiation, communication, role playing), and HIV prevention strategies for youth.

Family care givers: Need training in providing care.

Parents: Need information and skills in communicating with their children.

Self-sufficiency

- **Community self-sufficiency promotes sustainability, for all types of social programs.**

For most uninfected people in a community, HIV/AIDS is not the most urgent issue in their daily lives. Sensible programming will first address a community's basic unmet needs, which may focus on food and adequate shelter. If communities are to maintain HIV/AIDS programming with little or no external support, they must be able to sustain themselves. People who are recruited and trained for leadership roles should be handpicked to select for those who are the most motivated and able to deliver. Perhaps the glue that holds together successful communities is their ability to network and to share information, and this principle can extend even to the national level. South to south collaboration enables neighboring countries to share HIV-related information and resources.

Continuum of care

- **A coordinated process based on a continuum of care model is needed.**

If the structure established for prevention efforts is utilized to provide care—such as outreach efforts, grassroots activities and mobilization of resources at the community level—then artificial distinctions and stigma tend to fall away. If comprehensive care is provided within a single service agency, it is more likely that the needs and concerns of all affected persons and everyone in the community will be registered.

For example:

Instead of a health center providing pre-test and post-test counseling and referring a person elsewhere for ongoing counseling, one person at the health center could do all the counseling and provide ongoing support.

To be comprehensive the model should address the sociocultural dimensions of HIV/AIDS, such as the impact of gender and culture on behavior, the need for advocacy, and protection of human rights including confidentiality.

Involvement of PWAs

- **People living with and affected by HIV/AIDS must be involved in all decisions affecting their care**

People living with HIV/AIDS should be involved in the planning, implementation and evaluation of HIV prevention and care services and programs. Moreover, to the extent that they choose, they should be informed about their own situation and treatment, and involved in decisions affecting their individual.

Image

- **The image of HIV/AIDS must be changed.**

The reluctance of many communities to provide care and support is a direct consequence of negative images associated with HIV/AIDS, and the consequent stigma those with the virus must face. Changing these

images requires work. Nothing less than a transformation of cultures, at whatever level the stigma is found, will lead to the necessary change in the society at large.

An important piece of this positive image follows from the demonstration that people infected with HIV can continue to lead fulfilling lives. Conveying that message successfully requires education at all levels—first with health care provider attitudes, and then in the community at large, including churches and other religious institutions, the workplace, policy makers—and people living with HIV/AIDS have an important role to play.

And the necessary renovation of how we look at HIV/AIDS must also happen at the most basic of our institutions, the family level. Existing opportunities for education (health service visits, women's associations, churches/religious institutions) should be expanded, and families directly affected by HIV/AIDS also have a potential role in conveying the model for positive attitudes and beliefs to other families in the community.

Identifying and transferring models of care

There is a natural process of response to the HIV epidemic through which each country or community must mature: Denial is often the inevitable first reaction, eventually (and sometimes with great difficulty) comes recognition, and then finally the national, political, psychic resolve to attack the problem. When a community arrives at the point of constructively addressing the problem, it begins to establish priorities, structures, roles, and responsibilities, and then to identify resources. One challenge faced by those working in HIV/AIDS prevention and care is trying to import the wisdom and successful strategies developed in other cultures as early as feasible into this societal process, possibly shortening the denial stage and helping to establish a solid foundation for a country's national AIDS program. Many valuable lessons have been learned and a wide range of models has been developed in the prevention and care universe; communities and countries should not have to "reinvent the wheel."

Common characteristics of viable models

Effectiveness, affordability, acceptability and feasibility are the signal characteristics of models that seem to work. Most successful projects also seem to include openness, leadership, respect/trust, community design and ownership, and an incisive understanding of—and commitment to solving—the problem.

Transfer stages

Successful transfer, expansion and sustainability of a given model depends upon the model's attractiveness to three key constituencies: Those who will implement it (providers, community leaders, people living with AIDS); those who will benefit from it (people living with HIV/AIDS, families, communities); and those who will pay for it (government, private sector donors, communities, people living with AIDS, society at large). These things happen in the following stages:

- Learning about or observing the model in its original context
- Reflecting on the components that make the model viable
- Attempting to adapt the model to the new context
- Fine-tuning the model to the conditions of the new context.

Mechanisms

There is something of a science to effectively diffusing good models, planners need to:

- Translate research and evaluation results into a format easily understood by non-specialists
- Forge local, national and international linkages (networking)
- Channel emotions through creative means (e.g., the Names Project, theatri-

cal expression, art exhibitions, music)
- Appeal to the spiritual and ethical values of a community
- Tap existing channels of communication (the media, the grapevine)

Recommendations

1) Health care providers should be trained to provide appropriate care to people who are affected by HIV, and also appropriate HIV prevention services to the entire community.

- Education and training for health care providers should be structured around providing their HIV-positive patients a full range of alternatives for treatment. The importance of a human approach to care must be stressed, not just the technical aspects of providing treatments and services.
- Protocols for HIV/AIDS care should be developed and disseminated to primary health care providers. These protocols should also be readily available to people living with HIV/AIDS and their families.
- The protocols should be comprehensive, covering not only medical treatment but the mechanisms that will promote healthy behaviors (i.e., proper nutrition and alternative therapies).
- HIV/AIDS counseling should be incorporated into the training regimen of all health educators and health promoters.
- Those providing HIV/AIDS prevention and care services should be taught to respect cultural values, traditions and beliefs; this can require accepting the paradox of having less impact, especially in those communities where disclosure creates fear and isolation.

2) People living with and affected by HIV should be involved in all aspects of HIV prevention education.

- People living with HIV/AIDS can assume an important role as counselors and health prevention communicators in a community, but not until that community has "licensed" that role as legitimate.
- "AIDS in the workplace" educational programs should target employees and employers alike; the goal is to keep people living with HIV/AIDS working as long as they wish.
- Popular sports figures and artists who are living with HIV/AIDS can effectively communicate HIV messages as can other leaders and business people who have the respect of the community.

3) People living with HIV should be involved in all aspects of their care.

- Primary health care services should be modeled as a *partnership in care*, with providers, patients and their families collaborating.
- Donors should conduct needs assessments to establish what the care recipients and providers want and need *before* projects are designed.
- Policy dialogue should include exploring options (such as government policies and tax breaks) that would support families providing home-based care to family members with HIV/AIDS.
- Policy dialogue could support microenterprise for village banking/credit scheme models to provide loans and savings schemes to groups of people living with HIV (small businesses, etc.).

4) Community capacity should be strengthened toward the goal of making HIV prevention and care services self-supporting and sustainable.

- Because the burden of care often occurs at the community level, it is there that capacity must be developed, by training more people to provide prevention and care and by training community-based organizations in management and fund raising.
- Partnerships should be formed between communities and funding agencies to

establish the priorities for pragmatic and "locally owned and conceived" needs and services. Ownership at the community level nearly always lies behind sustainable programs and projects.

- South-to-South collaboration should be promoted, by: Developing and supporting centers of excellence in developing countries/regions; strategically disseminating evaluation results; and supporting study tours and workshops at the regional level.

PROTECTING, RESPECTING AND STRENGHTENING HUMAN RIGHTS: ETHICAL DILEMMAS IN CLINICAL PRACTICE

Citing the central importance of human rights, whether for those with HIV/AIDS or in any other context, courts the danger of reification—conveying reality to a mental abstract. Those living with the virus, however, confront a very real social world where their rights are constantly under siege. Thus it is useful to reaffirm not merely that they deserve to be protected—ever since the World Conference on Human Rights in Vienna (in 1948) this has been a prerogative based on the Universal Declaration—but rather how they are systematically stigmatized by HIV/AIDS, and how political processes might be renovated to restore to them basic, inalienable, societal rights. More pragmatically, can a set of working concepts be developed that everyone could begin to use for the effort to restore and protect these rights, not only policy makers and programmers, but also caregivers and other service providers.

What Does Human Rights Signify in the HIV/AIDS Context?

However pragmatic and political the context, it is important to never lose sight of the basic principles invoked when we defend human rights. The form the principles may take will vary, across countries, cultures and even eras. But the content of the principles remains inviolate: basic human rights are universal and indivisible, and the nation state is but the steward of their care. Humanity employs ethical reasoning to insist that these rights must be protected. The question isn't whether but *how* to implement this goal in the context of HIV/AIDS prevention and care programs.

Freedom to Speak and To Associate

Open expression and communication are preconditions for successful HIV policies, strategies, and programs, but this must be

61

achieved at the community level. When civil society is constrained (due to war, civil strife, or dictatorship, for example) the potential for an effective community-based response will be diminished.

For example:

In societies where public meetings are prohibited, it is difficult for communities to mobilize HIV prevention and care. In countries where mass media is censored, effective health communication messages are difficult to deliver.

Self-determination, providing for basic needs

Cultures have differing beliefs and values, which may create disparities in how power is wielded and who is vulnerable to its misuse. HIV/AIDS risk factors can derive from such constructs, which lead to social and economic vulnerability and to a greater incidence of infection. Effective prevention programs are thus especially and intricately tied to human rights issues for marginalized and subordinated groups (such as indigenous peoples, street children and women in some cultures).

For example:

Children and youth who are forced to exchange sex for shelter and food are at increased risk for HIV infection.

For example:

Women's ability to negotiate safer sex—and thus to reduce their exposure to infection—can be constrained in communities where cultural norms and power relations take away their voice, or punish them if they use it.

Stigma and Discrimination

People living with HIV/AIDS face the specter of discrimination and stigmatization at every turn, and thus special care must be taken to ensure their access to services. Their personal experience with HIV/AIDS gives them an expertise which should be consulted at all stages of policy and program development and implementation, to ensure that interventions are appropriate to, and effective in, the communities at risk.

For example:

Certain employment situations stipulate HIV/AIDS as a "notifiable medical condition" and deny those infected with the virus their right to confidentiality. This categorization can be pose grave consequences by threatening access to services, insurance, basic health care and even employment.

For example:

Participation in policy- and program-influencing forums is often denied de facto to those living with the virus as a consequence of their being unable to move freely, energetically and anonymously in society.

Reasoning from an Ethical Foundation

Trying to respond to such inequities poses dilemmas that come to be framed as moral in nature. Human rights issues often arise as a conflict between the claimed rights of individuals (or communities) who are at risk or already infected with HIV, on the one hand, and the presumptive rights of other individuals (or the broader community) on the other hand.

Ethical reasoning provides a framework that can help analyze and resolve these human rights dilemmas and conflicts by applying ethically based theory, principles and rules to a conflict situation. Guidelines can be developed across a wide range of political situations and philosophical orientations.

For example:

A feminist orientation brings women's perspectives and experiences to the ethical framework in order to develop a rational justification for women's self-determination.

The core ethical principles

In most health-related situations, the issues should be framed around four fundamental principles:

62

- Autonomy—respect for all peoples
- Beneficence—the intervention should do good
- Nonmaleficence—the intervention should do no harm
- Justice—equality of opportunity

Ethical theory, principles, and rules are applied in local and specific situations, even though they are based on universal principles. Bridges may need to be built just to begin to discuss the situation, so that the necessary diversity of viewpoints and frameworks can be considered. Sometimes a new language of dialogue must be found. As the various stakeholders engage one another, it becomes apparent that ethical dilemmas are not static; therefore *interim* solutions and *iterative* debates are inherent to the process of successful conflict resolution.

Developing Sustainable Policies and Programs—A Process

If human rights awareness is to be woven into the very process of developing policy and programs for HIV/AIDS prevention, certain basics would seem to be essential. These principles are not obscure, since they provide a primer on how to bring people successfully together in a participatory process. It should be noted, however, that maintaining a spotlight on the rights of individuals prevents a uniform application of these basic elements. If individuals are to have a truly relevant impact on the development of policy/programs, then that process will necessarily unfold differently as different groups of these individuals negotiate the basic issues and paradoxes. And though the sequence and relative importance of the principles may vary, it is essential that they be heeded.

Basic principles that yoke human rights and HIV/AIDS

Several givens frame the entire process: Basic ethical principles are sacrosanct at both the personal and organizational levels; appropriate human rights components should be incorporated into all prevention and care activities; and finally, all stakeholders understand the implications of protecting human rights. One practical way to establish this basic context is by building bridges with the mainstream human rights organizations (e.g. Amnesty International, Human Rights Watch, Save the Children) and other related movements, including women's organizations.

There are also predictable difficulties that must be overcome. A good place to begin is by identifying the existing barriers to a successful human rights environment, especially in the policy and program development implementation process. What are the entrenched interests or processes that lie behind them? What catalysts can be identified to break the predictable cycles that recur? In most cases, progress lies through improving both the environment of—and people's individual skills for—conflict resolution. Once people begin to look for new ways to relate to each other and to frame the problem situations, opportunities develop to build a consensus around these new patterns.

People as the key resource

It is tempting to say that the mere act of bringing all of the affected parties into a genuine dialogue and providing them a meaningful role in the process is sufficient to craft a successful human rights environment. This of course begins with those individuals and communities at risk for and affected by HIV/AIDS, who deserve to have a central role in all stages of policy programs, from design and development, through implementation and evaluation.

And there are other stakeholders whose expertise is not certified by a graduate degree or a lifelong history "in the field" but is nonetheless vital to an inclusive awareness of the environment in which programs will succeed or fail. When previous experience is regarded as a source of wisdom, a rich repertoire of do's and don'ts can be developed. This information can be gleaned from many diverse sources once the channels of communication are established: the perspec-

tives of people living with HIV/AIDS, the media, parliamentarians, medical institutions, government bureaucracies, political status quo, the church/religious communities, public perceptions/opinion, the private sector, NGOs, CBOs and private voluntary organizations, health care workers, military and other law enforcement agents.

Defining Human Rights Responsibilities—Promoting the Ethical Capacity

The Roundtable Working Group concluded that protecting and strengthening human rights is critical to the development and implementation of sustainable HIV/AIDS programs and policies, both for prevention and for care. They believe this will happen only when the process is truly open and participatory and when it develops the capacity—through ethical reasoning—to equitably resolve conflicts between individual and community rights.

How to develop an ethical capacity

There is a process (as well as a content) to ethical behavior in organizations: Define a starting point; clarify and record the known biases of individuals and organizations, and the circumstances where they tend to arise; identify the stakeholders and try to develop a common framework by consensus; look closely at every aspect of communication and try to facilitate it; develop strategies; establish education programs, and erect a serious and meaningful system for accountability.

Beginning with USAID—Recommendations

It is important to remember that the process of protecting and strengthening human rights is dynamic and is the shared responsibility of every individual and organization concerned. Roles will differ based upon local circumstances, but the success of this approach requires that all parties accept and fulfill their particular roles. A survey of cultures and systems around the world makes it painfully apparent that participatory systems are not the norm, and that many barriers must be overcome. These will differ from one community to another, but within each one the battle must be waged, the common language forged, and the participatory process begun. Only thus can the principle of human rights assume its critical place in HIV/AIDS prevention and care programs everywhere.

As a model and example of establishing roles and responsibilities, the group sent a series of recommendations to the United States Agency for International Development:

- The principle of participation of affected communities must underpin all phases of USAID activities and supported programs.
- USAID should support programs that facilitate the development of a common framework for approaching ethical dilemmas in the epidemic.
- USAID should actively seek to identify and engage all stakeholders in ongoing participation in, and dynamic review of, policies and programs.
- USAID should utilize mechanisms that ensure appropriate consideration of ethical and human rights issues during the design, implementation and evaluation of HIV/AIDs programs.
- USAID should be accountable for protecting human rights within its HIV/AIDS activities and programs.
- USAID should support the development of mechanisms to promote human rights accountability.

PROS AND CONS OF MERGING HIV AND/OR STD SERVICES INTO OTHER HEALTH AND FAMILY PLANNING SERVICES

Integration in the health care context is the decision to merge two or more existing activities. The motives are efficiency and a more potent delivery system. The twin provisos are that—whatever the resulting structure—new common goals will be embraced by all of the formerly distinct entities, and both (or all) of them will benefit by the change. In health delivery the idea is not new, as services and administrative functions have often been rearranged in this way.

The HIV/AIDS epidemic poses a new challenge for the proponents of integration, and an opportunity as well. The issue can be directly framed: Can existing HIV/STD prevention programs be enhanced and empowered by integrating them with family planning and other kindred programs? Whether this turns out to be a fertile idea to explore will depend on many local factors. The context for such an integration could be the policy arena, mass media and communications, and/or community outreach programs.

Much has been learned about integration in the health universe, but there is no magic recipe that will guarantee a perfect outcome. Integration should be seen as a means rather than a goal in itself; efforts to assess the indications for integration need to be situation-specific. The challenge in each situation is to determine whether, how, why, when, where and what to integrate. Many of the pragmatic questions that should be asked are raised below.

The Basic Approach to Integration

Assumptions

The history of integration in health care yields some important basic notions. Though not formally validated, they do represent a good catalogue of the principles that should be considered when proposing to integrate with HIV/STD activities or programs:

- Integration should be undertaken when it will serve the greatest good for the greatest number of people.
- Services should serve those who need them, not those who provide them.
- It is neither necessary nor possible to reach everybody for every service.
- Men and women need different approaches, so gender perspective should be incorporated into all activities and programs.
- In order to increase effectiveness of HIV/STD prevention, the underlying issue of sexuality bears exploring in many different facets of society.
- The basic goals of any program integration should always include cost-effectiveness and quality of life, as well as the explicit objectives of all of the elements to be integrated.
- The basic staff circumstances of the community and the affected providers should be assessed before design or implementation of integrated programs. Assessment of community and provider needs and resources should be ongoing.
- Interventions targeting both individuals and populations should occur simultaneously.
- Evaluating a new integration begins by addressing the quality of services and clients' satisfaction; then a medium term analysis of cost benefit and cost effectiveness; finally, a long term assessment of how the new structure has affected the quality of life.

Pros and cons

Decisions about what activities to integrate should be made on technical and not ideologic grounds. Certain predictable aspects of integrating HIV/STD prevention efforts will probably be perceived as an advantage from one perspective and a corresponding problem from another.

65

- Policymakers and donors have an institutional preference for vertical programs and funding mechanisms because they can usually be evaluated by fairly specific indicators.
  However,
  Integrated programs could achieve multiple objectives. They should provide opportunities for dialogue where opposing views can be brought together.
- The possible stigma associated with HIV/AIDS and STDs could "spill over" onto other programs; family planning clients may avoid, for example, from facilities where STD services are delivered.
  However,
  Integrated programs would tend to destigmatize individuals, who could gain access to HIV/STD prevention messages and services without fear of being identified as members of a "high risk group."
- Start-up costs (such as renovating facilities, procurement of equipment and drugs, etc.) may be difficult to justify as cost-effective, depending on how long-term and how comprehensive the frame of analysis.
  However,
  Merging services or programs could actually provide cost sharing and cost recovery opportunities by sharing facilities, staff and other resources.
- Providers may feel taxed by an increase in their workload, responsibility, and time with each patient. This could be viewed as a dilution of their effort.
  However,
  They could also take advantage of opportunities to broaden and increase their skills, and become more empowered to respond to clients' demands; therefore, more satisfied. The new environment could be seen as offering an enhanced quality of service, with better utilization, access and impact. A positive synergy can be achieved.

For example:

Family planning programs would benefit by adding discussions of sexuality and gain better access to men, while HIV/STD prevention programs would gain better access to women.

- Supervision and accountability may be difficult.
  However,
  When supervisors receive training in multiple areas, they may be able to develop a more balanced view and shepherd a less fragmented approach.
- Evaluating integrated programs may be more difficult because of a lack of indicators and the diversion of a targeted focus away from one specific health issue.
  However,
  Perforce evaluating such programs will redirect attention to the broader problems and needs of many clients.
- Vertical programs appear to have a motivated constituency as they focus on the (unilateral) needs of their clients.
  However,
  Most clients seem to prefer and often request a more holistic approach.

Integration Policy Issues

Integration can be undertaken in a variety of settings, which can be defined either by the site where they take place (interventions in facilities, communities, schools or the workplace) or by the channels through which implementation occurs (e.g., cultural/folk/mass media, policy). But the de facto nature of the process must be emphasized; integration is always situation-specific. What makes sense at one time or in one place might not work in another. Changing disease patterns, resources, and social situations require continuous evaluation. Data and information—not assumptions—must drive these analyses. Integration is a dynamic process, and requires ongoing assessment and decision-making. Services could benefit

from integration at one time and in one circumstance, and yet need to be shifted back to a vertical programming structure should the situation warrant.

Policy considerations

In contemplating the integration of HIV/STD prevention programs, several key crucial policy elements must be addressed. First, a national policy on integration of HIV/STD/FP and other programs must establish the basic framework by setting priorities, organizing administrative work, and allocating resources. Second, the basic issue must be faced by developing a policy to harmonize the objectives of family planning and the control of HIV/STDs. Ministries of Health must reconcile traditional modes of family planning policy with HIV/STD prevention policy (e.g., dual method vs. IUDs). Finally, health care workers need to be given clear policy guidelines on professional practices.

For example:

Policy could be promulgated to permit nurses to prescribe treatment for STDs according to national guidelines. This would increase clients' access to care in facilities where STD services were integrated into family planning services that were staffed by nurses.

There are a handful of other issues that will probably factor into any policy exercise considering the integration of HIV/STD services. All programs, vertical or integrated/horizontal, must be given clear and forceful guidelines to assure privacy and confidentiality. Gender equity must be achieved, and policy help to assure that education and counseling services and messages are appropriate for both women and men. In an integrated setting, family life education is the correct context for sex education and sexuality information. Policy planners must face the fact that adolescents have the greatest need for integrated FP/HIV/STD services, and assure them access. Drug injection intervention policy may be a difficult piece of the puzzle, but an appropriate setting must be established for it.

The questions that should trigger a constructive discussion of the key policy issues are:

- What are the key policy issues (at the national level and programmatic level)?
- What are possible steps for integration at the policy level?
- What support do countries and programs need to integrate activities and programs?

Interventions in Different Contexts

In facilities

To work effectively, integration should be extended to all levels, national, regional, district and community. At each level, assessment should include the following components:

- The potential impact upon the community and its members.
- The synergistic relationship of services: how can integration best strengthen what already exists?
- The burden of disease (not just the prevalence of a problem).
- The potential public health impact.
- Administration of the facilities.
- How the infrastructure and staff at the facilities are likely to accommodate the proposed change: physical space, confidentiality; staff competencies, attitudes, workload, and training needs;
- Cost and financial feasibility; donors need to appreciate that high upfront costs could pay off over time, and that both short- and long-term analyses must be made. What are the opportunities for cost recovery? What can clients can afford? What does the community want and need, and what level of involvement can be expected?

Key questions to be addressed

Integration in facilities poses a number of common issues. From a practical per-

spective, it is important to make an honest evaluation of the current elements in the facility and gauge how to capitalize on advantages and overcome inherent disadvantages.

- What steps are necessary to integrate STD/HIV management and screening into both family planning and other health settings?
- How can men be accommodated in the family planning process? How can women be accommodated in HIV/STD services?
- What steps are needed to integrate primary HIV/STD prevention? Where should this service be provided?
- How are sexuality and a gender perspective best addressed in family planning and STD/HIV programs?
- How are the principles of targeting and segmentation maintained in the integrated setting?
- What support do countries/programs need in order to integrate?

Interventions in communities

Communities are where the need to integrate HIV/STDs services and family planning is most obvious—and also most urgent. *Integrated community intervention* can be accomplished when certain important concepts are built in. This means that the intervention is defined by its processes, not by its physical location (or the home base of the provider staff person).

For example:

A health worker who was sent from the Ministry of Health to give an HIV/AIDS prevention lecture in a town meeting room would not necessarily be considered engaging in a community intervention. True integration in the community context has the following characteristics:

- Community integration is a "bottom up" approach; decision-making should be participatory—on what interventions are wanted and needed; how to make them acceptable, and how to maximize community input into the design of programs and services.
- Ideally, the process steers community decision-makers toward the most pragmatic interventions. When the new system manifestly improves reproductive health services, community members have been willing to pay user fees, as at Kenya's FLPS clinic, for one example.
- Community integration must build ensibly on opportunities that already exist, and respond to manifest needs.

For example:

In an income generation project in Honduras, women took time out from program activities to learn about HIV; at a fair held to sell their wares, they also disseminated HIV/AIDS information.

For example:

In the Bahamas, women used a church as a meeting place for HIV/STD/family planning question and answer sessions.

- The best and most enduring systems utilize two-way feedback mechanisms, including monitoring and evaluation.

For example:

In one Kenya clinic offering family planning and HIV/STD services, exit interviews are conducted to assess the quality and content of the patients' visits.

At a more pragmatic level, the issue of HIV/AIDS invariably seems to raise a few recurring dilemmas that each community must thrash through: How to utilize those living with HIV/AIDS as teachers; which media can best communicate the desired messages to people; whether to charge for condoms. The gender issues that surround the epidemic make the involvement of men a difficult though important element in many programs. Ways must be sought to bring more men actively behind the integration process.

For example:

In Honduras, drivers for the family planning program became very enthusiastic HIV educators. In Kenya, men were effectively trained as CBDs.

Key questions to be addressed

Primary care services already being delivered to a community are the main context HIV prevention programs will have to fit and work within. Pragmatism requires that planners bring a creative viewpoint to capitalize on existing advantages, and concentrate on the disadvantages, rather than designing some grand plan that can take on a bureaucratic life of its own. Specific groups that are currently targeted or segmented for care can become casualties of integration and ultimately make programs fail. A good place to start is by maximizing community input before too many new service plans are finalized; this tends to focus early on a basic challenge—how to make integrated services acceptable to the community? Throughout the life of the program, though it may be more difficult and diffuse, evaluation should be as effective as it can be made to be.

Challenges in other settings

Primary HIV prevention can be integrated into many other potentially valuable settings, including folk/mass media, schools, and workplaces. The questions raised for communities and facilities serve as a starting point to inquire further as to whether integration is appropriate and how it can be brought to pass, in certain other contexts; for example, **In:**

- **Cultural/Folk/Mass Media**:

  The difficulty of dealing openly with personal sexuality and crafting prevention messages that will take on a cultural life.

- **Schools**

  Problems are inherent with the whole area of sexuality and gender in school settings; where in the school setting is integration most effective and appropriate; and, what steps will lead to integration of primary HIV/STD prevention in this environment.

- **Workplaces and other institutions:**

  Is primary HIV/STD prevention appropriate to integrate with other messages in a workplace setting? Cost-effectiveness is more likely to be a theme of this discussion, and cost-beneficial interventions will probably be a major goal. Still, there are the recurring problems of addressing sexuality, maintaining a gender perspective, targeting, segmentation and how to evaluate what is happening balanced against a "bottom line" mentality.

BENCHMARKS, PERFORMANCE INDICATORS, AND EVALUATION OF HIV/AIDS INTERVENTIONS: How Do We Measure Intervention Results?

Evaluation is the systematic assessment of how successfully services or their components fulfill stated goals. Without it, you cannot prove that an intervention for HIV/AIDS prevention, care or support is working, no matter its evident impact or its reputation.

Evaluations can be formative, where context is both defined and designed; they can be process evaluations that look at the delivery of interventions for content and quality; or they can be outcome studies—by far the most common evaluation—that try to measure the actual effects of an intervention.

Outcome evaluation may assess *efficacy* (whether interventions under ideal circumstances can produce the desired outcomes) and *effectiveness* (whether interventions provide results under usual practice conditions).

The demands of data collection and analysis are seen to vary significantly from one type of evaluation to another—from routine weekly or monthly reports of numbers and types of services and clients, to costly, dedicated cohort studies in intervention and control sites, in which special biologic and behavioral data are collected to measure and explain intervention effects. One of the crucial insights has been that the nature, scope and expectations of each distinct evaluation must be widely, clearly and effectively communicated. Confusion about the different goals and demands (including costs) of varied forms of evaluation is a prime cause of evaluation problems at all levels of HIV/STD programming.

When done well, evaluation has a crucial and positive role in HIV/AIDS prevention interventions. It is one of the most useful sources of feedback, and helps service providers monitor their efforts, learn from experience and improve them, and then provide stakeholders with an account of them. Planners and implementers must be able to identify the consequences of their actions—evaluation can provide them, and funders, with the empirical foundation needed to decide how to allocate resources.

Evaluation is a hot topic these days in the social and health services universe, with widespread and increasing interest from many quarters in the skills, models and other basics that seem to work. This interest in part has been generated by the correct perception that evaluation can enhance and demonstrate a program's success. But the field is also in turmoil, as a number of problems persist, and a number of opportunities to address them are being energetically debated. An overview and recommendations follow.

What is working well in HIV/AIDS evaluation?

The very nature of HIV—with its long asymptomatic latency period, modes of transmission and the stigma often associated with the disease and the behaviors linked to it—make the evaluation and implementation of HIV programs very challenging. Frequently, the best that can be elicited are indirect measures of effect based on reported (rather than observed) behavior. The epidemic presents a different profile in each setting, and thus limits the application of a single intervention or evaluation instrument across many different settings. Despite these complexities, HIV/STD program evaluation history has recorded a number of successful and strong developments, including:

A broader array of approaches and tools

The use of qualitative data is on the increase—in baseline descriptions, formative research, ongoing monitoring, final evaluations of service quality, and interpretation of quantitative measures of service effects. Planners more frequently conduct formative research in the field, searching for a deeper understanding of conditions and constraints service providers are (or will be) facing.

70

A range of diverse data collection approaches seem to work well if the setting is right; such as small group discussions and in focus group exercises, periodic structured surveys at the service site, and on-site use of mathematical models to illustrate and project the effects of service statistics. The selection of methods depends on the evaluation purpose, and on the nature of the service or project itself.

Linking evaluation methods to an explicit theoretical model of the program's effects, as in the I/A, E/A, C/A model, has shown promising results. No single tool, however, is sufficient for all purposes, whereas *triangulation* of data from several, complementary methods permits service providers and other stakeholders to capture the range of information required.

Increased participation

Increased participation is a factor in the HIV/AIDS evaluation picture in several forms. By including project staff and managers in evaluation processes, lessons are lessons learned more cogently. Staff increase their commitment to the process and develop greater faith in its results and recommendations. Participatory evaluation is itself a mechanism for promoting rapid feedback of results to the people involved, an important feature of useful evaluations. This is one of the primary advantages of *internal* evaluations, where service or project members systematically review and assess their own work. But *external evaluations* can also use this participatory approach. In either case, it is not just funders and staff who need to be included, but service recipients as well as the communities served. Community participation is crucial in creating a sense of ownership and in strengthening quality and the relevance of service.

Capacity building

Closely linked to the benefits of increased participation in evaluation is the benefit of training project staff, community, and especially mid-level project managers, in evaluation skills. A number of projects have been successful in building internal capacity for evaluation, in private sector and public sector HIV/STD programs. Local evaluation personnel have a broader understanding of the context, have lower travel costs, and often have more enduring commitment to the project and accountability for the evaluation's consequences.

Creative uses of failure

It is not only the successes that can improve HIV/STD services. The idea that projects can learn from *failures,* perhaps making good use of unintended directions or events in a project's history, is a promising one. The common image that errors in project strategy or implementation are invariably *bad* must be limited to certain situations only.

Increased dialogue with donors

More consultation between donors and project participants, early in the process and on an ongoing basis, helps improve cooperation in the name of project success. When donors show flexibility and willingness to review and discuss evaluation constraints with the project staff, more realistic and useful evaluations often emerge. Consultation can help to coordinate and to avoid overlap and wasted time and effort. (The image of "the Germans are leaving today and the Swiss [evaluators] arrive tomorrow" clearly struck a chord.) Evaluation plans should be *negotiated with* donors, so that the purposes of the project are more likely to be achieved.

Current measures of performance and success

Program evaluation involves the *systematic* assessment of performance and achievements; thus yardsticks for measuring performance must be explicit. Good performance criteria are usually realized in a set of *indicators* that serve to mark or measure project performance. Indicators are often thought of as continuous variables (i.e., proportions;

scores from -10 to +10, or tallies such as number of attenders) but they can also be operationalized as a sequence of critical achievements or milestones, or binary items (true/false, present/absent).

Three dimensions of results

Quality, quantity time frame provide the axes on which most indicators are plotted. The quality dimension should be translated into concrete terms that can be recorded reliably, and measures of quantity should make the denominator explicit.

For example:

An indicator for a safer sex negotiation skills training workshop for women at a family planning clinic might be the quarterly percent of women served at the clinic who report having spoken with their spouse about STDs in the previous 3 months. The measure of success might be the ratio of successes among respondents who did receive the training divided by the number of successes among respondents who did not receive the training.

Such an outcome measure may not reflect all the subtle skills and changes that the workshop sought to convey, but it has the advantage of being a *reliable* measure that is meaningful *per se* and applicable across a wide variety of cultural and socioeconomic settings.

Indicators and milestones should be used to make project goals operational. Whenever possible, they should be understandable to people outside the project, and comparable with measures from other projects with similar objectives and activities. In this way, valid comparisons can be made across projects that multiply the value of lessons learned. It is best to identify indicators of program or project performance during the design of the project so that the systems for data collection, analysis and reporting can be built in from the start. Such a plan poses a dilemma for project planners: whether to spend the time required to develop and test indicators *from the ground up*; to select and apply indicators and measures that have been developed and tested by others; or, to attempt some combination of these strategies.

Current indicators

Four sets of indicators are currently in use or under development for evaluating HIV/STD projects and programs; these include:

- Core Prevention Indicators (PIs) (see Table 1). The World Health Organization Global Programme on AIDS (GPA) PIs were specifically developed for national/regional-level users. They are focused on the long-term view and on national populations.
- Care and Support Indicators (CSIs). The GPA CSIs attempt to address some crucial features of health systems and the social environment relevant to HIV/AIDS care and support that were not included in the original set of PIs.
- Reproductive Health Evaluation Project (EP) Manuals. The USAID Office of Population Evaluation Project has drafted a series of manuals for programs in the area of reproductive health, including one for HIV/STD programs. Unlike the WHO/GPA PIs, the EP manuals provide indicators suitable for users at the project level. They include measures of program inputs (resources invested); process (activities or services provided); outputs (results at the program level); and outcomes (effects and impacts at the population level). Since 75 are under consideration, no single project would use all the indicators. Rather, program developers can review the list for indicators appropriate to their planned goals and activities. The EP indicators are now undergoing technical review and comment, and will be available for field testing soon.
- USAID Bureau and Mission Strategic Objectives Indicators. As part of the

72

agency-wide re-engineering process, USAID is implementing strategic planning at the agency, bureau and mission levels. USAID operating units at each of these levels have a framework of strategic objectives and strategies designed to achieve those objectives. An integral part of the planning process is the development of performance indicators to show progress and success toward the objectives.

Pre-packaged indicators have some obvious advantages, including the development costs saved, but adopting and using measures that were derived outside the context of particular projects can bring problems. Available sets of indicators may not adequately capture or reflect all of a project's important outcomes, or the subtleties of program accessibility, quality and other process-level, programmatic concerns. Using the available sets does not obviate the need for individual project-level planning, defining the measurable objectives of the project, and deriving the necessary and sufficient set of indicators required to see if, when, and how well those objectives are being met. Resolving the inevitable trade-offs between completeness, local appropriateness and the cost of development of these essential evaluation tools is the challenge, which some suggestions raised below can help meet.

Issues of current concern

Costs involved in evaluation

A persistent concern is the cost of evaluation in both money and other resources, including staff time.

- Programs often set targets that cannot be achieved with the available resources in the available time.
- Duration of funding is often too short to enable evaluators to determine program impact.
- Collecting evaluation data costs time and money—often more than people project.

Users have different purposes and needs

Individuals and organizations at many different levels are the consumers of evaluation data; such as the communities that require and rely on effective interventions; grassroots agencies providing a service; district and national bodies that are responsible for projecting service needs, effects, and costs; and government and private agencies that provide the funding and must justify their funding actions to constituents and other stakeholders.

The interests and needs for information of these various parties will vary. For example, a community level service agency will most likely find specific and detailed implementation data most useful in trying to document and improve their services; a funding agency may require an account of the services supported by their funds, but may also seek answers about longer-term intervention effects to help determine the kinds of programs to fund in the future. Identifying and meeting these diverse needs in a timely and efficient manner is the challenge continually faced by HIV evaluations, or any health program.

Complex causes

Attributing planned results directly to a specific program intervention is difficult. Program interventions must be analyzed within the context of all the factors that influence individuals in the community, including other HIV prevention interventions initiated by local, regional and national governments and private organizations. The multiple actors involved in HIV/AIDS prevention, such as local, regional and national governments (as well as external donors) make such attributions dubious, at best. Attempting to prove causal links is time-consuming, expensive, and fraught with methodological difficulties.

Other issues

The results of evaluation are often not shared from one level to the next (e.g., national to local). This can lead to duplica-

tion of effort or to gaps in data collection, leaving policy makers and program managers with incomplete or incomparable information on which to base decisions. Linkages in the field could be better established across sectors, levels, and technical specialties.

Though not considered in any detail due to time constraints, the Roundtable noted that a number of issues also surround

Measurement
Validity
Subjective dimensions and meanings

Need for additional types of indicators

The actual indicators in use and the measures that have been developed to date are less than comprehensive. Inquiry into HIV/AIDS prevention evaluation could benefit from:

- A wider range of indicators. The most familiar and widely used performance indicators (PIs) come from WHO/GPA, and are not intended to capture all aspects of all programs.
- A means to capture unexpected outcomes. Unanticipated or adverse outcomes often emerge from a program. Currently, no indicators or guidelines exist to detect and record these outcomes in a timely manner.
- A means to measure the context. Factors beyond the level of the individual (such as contextual factors) have a significant, sometimes a determinant, effect on programs, but are often overlooked.
- A means to measure intermediate outcomes. Programs could thus be refined if legitimate process indicators (such as attitude change) were applied during program implementation.
- A means to measure community, behavioral and psychosocial factors. Factors such as steps in behavior change and measures of empowerment are critical to HIV prevention and care; better ways are needed to document and/or measure them.
- A means to capture and interpret linked, interdependent outcomes. Related factors such as condom distribution and condom use must be better analyzed interdependently.
- A means to assess project structures and operational issues. In addition to evaluating the effectiveness of available technical strategies and program content, it would be useful to learn about the effects of different management designs and project structures on effectiveness, cost, and sustainability. Current evaluation methods (to take one example) do not lend themselves to systematic comparison of centralized vs. decentralized management structures. In the absence of indicators or guidelines, evaluating important structural choices (such as giving power to a community advisory board) may thus be left to anecdotal and impressionistic assessments.

Need to better understand the value and usefulness of evaluation

Programs need a strategic framework to proceed in an orderly manner. Evaluation is one component of the larger process of program design and implementation. Having to specify concrete indicators of program outcomes helps to focus on desired results and how they are to be achieved. Basic framing questions must be posed: What outcomes are sought? What change or impact is expected from this program and how will it be achieved? How will we know when we have achieved it? When developed along these lines, the evaluation and monitoring process will be alien to the project but not integral to it, and all stakeholders can share in the more comprehensive meaning it conveys. Some important lessons have been learned:

- Evaluation is often perceived as a process of grading *how good* a project is, or *how effective* its staff is. This generates anxiety and resistance among project staff.

- Even when comprehensive evaluation plans are incorporated at the planning stage of a project, they may not be fully followed through; when resources run short, the perception may develop that delivering service is more important, and that a choice must be made about where to invest limited human and financial resources.
- Program managers and staff not infrequently perceive external evaluations as an imposition from the outside, which demands their time and effort yet produces insufficient value to the program.
- Also donors and other external observers sometimes view internal evaluations with unfounded suspicion. On the other hand, evaluation may not be accorded the objectivity or seriousness that is required by in-house staff.
- With inappropriate indicators, programs may generate unfulfilled expectations, and cause frustration and even disillusionment without positive feedback about the impact of the work carried out.
- Unfulfilled objectives, in their turn, can lead to dissatisfied donors, can jeopardize future funding, and potentially alienate the intended beneficiaries, whose expectations will not have been fulfilled.

Shift the paradigm

In the health and social sciences, evaluation is too often framed as an external activity imposed or inflicted from the outside, which opens the door to negative and even painful results. By contrast, many other professions consider basic evaluation to be a routine part of conducting high quality work. The health and social sciences could use *paradigm shift* to put evaluation skills and processes in their proper perspective. Evaluation is a *practical* endeavor that provides accountability, allows programs to learn from experience, and demonstrates progress to beneficiaries, donors and other stakeholders. To achieve this shift, evaluation must be demystified (so that anyone can learn and participate) and normalized (made an essential part of high quality work). A number of steps could begin to frame evaluation not as a punitive process, but rather as a useful component of professional work.

Be realistic and open about the costs and benefits

- More realistic objectives should be set.
- More effort should be made by donors to effectively use qualitative evaluation research and to integrate qualitative and quantitative research.
- More funding and more time should be allowed for formative or qualitative assessment research at the baseline and at identified milestones. Project design should include adequate time and staff for internal monitoring.

Promote participation

- Communities should have access to an in-country or regional documentation center; or access to resources through means such as a newsletter, meetings, e-mail user groups, and other modes of communication.
- Common goals and objectives should be developed and emphasized.

Inform and educate all stakeholders

To bring about the needed paradigm shift, the various stakeholders must be informed and should come to perceive their participation in the evaluation process as a prerogative and also an opportunity.

- Stakeholders at the community level can be taught to systematically record and tabulate conditions and events that document program activity and impact, and to use the results themselves.
- Decision-makers need to learn the various types and uses of evaluation, what they cost, and how to perform and use them. They need to examine activity and project management structures and learn how evaluation may be operationalized in a positive (not punitive) way.

- The program implementing agencies should understand the need for evaluation, should have (or be able to achieve) the capacity to implement it, and should have the ability and develop the process to utilize it.
- Donors need to understand the need to provide resources and evaluation guidelines; such as what the minimal reporting requirements are, and in what forms?
- In some cases, significant changes in approach to the project or service activity will be required to clarify the purposes of evaluation. Defining specific objectives and outcomes in advance is a prerequisite for evaluation; this is an orientation that cannot be taken for granted.
- To sustain staff and community enthusiasm for evaluation, information on program process and outcomes must be fed back to the people who need it in a timely fashion. As the stakeholders become better educated about evaluation, better ways to communicate program results can be developed.
- USAID should host a week-long ATSP project development workshop for its implementing agencies to better appreciate and learn how to implement these suggestions.

Provide guidelines for development and implementation of appropriate evaluation indicators

Currently available evaluation systems, such as the GPA PIs, stress the need for contextual data and for projects and programs to develop their own context-specific indicators. To do this, and to develop context-specific indicators, clear guidelines and clear criteria must be established for what should be recorded. Otherwise, decision-makers will have difficulty interpreting the additional data. These guidelines should clarify and promote consensus on:

- The kinds of context data required, in what units and intervals, and the methods for data collection
- The constructs that are *expected* to vary across social and cultural program settings, and how to locate and use them
- The data collection and analysis methods currently available and what they cost and require in resources
- Explicit instructions on how the additional data will be used and on how to ensure timely delivery to users input from collaborating agencies, NGOs and communities, national-level evaluation plans are needed to spell out the roles and relationships that benefit the commonweal.

Provide other necessary guidelines

Design and development needs include:

- Performance indicators for/at the project level
- The standards, rationale, and methodology for identifying and recording essential contextual data

Build capacity at the community level

In order for organizations to be involved in HIV/STD prevention and care project evaluation, they need technical support, and should:

- Develop ways to institutionalize capacity for each type of evaluation at national/organizational levels
- Focus on capacity to assist communities in evaluating their own programs for internal purposes
- Work on building understanding of, and thus demand for, evaluation at the community level
- Ensure that evaluation results are provided quickly and in understandable and usable form to program staff, community and donors
- Establish mechanisms for both project staff and the community to evaluate and thus provide feedback to donors

Clarify linkages

Evaluation will meet different needs and goals for various stakeholders in differ-

ent projects (and at each level and for each time frame for which there are performance indicators). New ideas and approaches are needed, however, to share insights and lessons from one level to another (e.g., national to local). An evaluation network is one approach to consider. Pressure from donors to rapidly implement a program can lead to decisions to skimp on evaluation. Policymakers and donors should educate partners and the public about the managerial benefits, insights and economies that can come from effective evaluation, which can be the most useful tool in management's kit.

Simplify and systematize the process

The basic pieces of evaluation should be reconsidered:

- Evaluation should measure only what stakeholders really need to know. The problem is how many stakeholders have these needs. Success and its costs must be taken into consideration for the various levels of evaluation.
- Research should be identified and conducted to simplify and strengthen evaluation. For example, STD markers have been discovered to be predictive of other trends.
- The donor/external evaluation processes should be streamlined and coordinated.
- Project structures need to be effective and sustainable—planners and policy makers need to focus on this "bottom line" of evaluation.

Communities and the Context of Interventions

COMMUNITY PARTICIPATION AND SUSTAINABILITY: INCREASING PARTICIPATION OF AND ADVOCACY FOR BENEFICIARY COMMUNITIES IN HIV/AIDS PROGRAMMING

Resources for HIV/AIDS prevention programs, whether they originate from governments, private sector organizations or donors, are intended to flow through the system to the hearts and minds—the behavior—of people. But to make sense of how societies accomplish this, we must look through the lens of communities, since the resources usually flow through intermediaries to NGOs and community-based organizations (CBOs) in particular. *Community* turns out to be a very versatile concept, which—for each place and for each collection of individuals and groups—people must eventually evolve and define for themselves. Through years of trying to fashion a workable and effective system, an important lesson has been learned: **Communities must participate at every level and at every step of the decision- making process**. From this basic idea flow a number of issues. Why is local participation so crucial to providing resources effectively? How can CBOs establish it as a goal and also use it as a strategy to organize around? What are the most productive relationships among the various participants? How can these be developed?

What Is Community Participation—Why is it important?

What Participation Means to Beneficiary Communities

A community can be viewed as a web of relationships among groups and organizations. All of these are made up of people, but many of the pieces that must fit together do so as organized institutions. To fairly capture the reality of an organization you must look inside, at its leadership, its institutional dynamics and at how it actually solves problems. And all of these features are dynamic, always in flux. The crucial recognition is that an organization is just that, an organized means to accomplish an end. The key to effective prevention programs is for communities and the people who make them up to deal with the reality of organizations—their own and those whose HIV/AIDS resources they are receiving.

Thus for communities to participate effectively in the delivery of HIV/AIDS prevention resources, they must work with organizations as well as form their own CBOs. If they are to assume a meaningful role in the delivery of services, it will most likely come from having perceived and defined it for themselves. Community *ownership* is the ultimate goal; when this is achieved, making the programs work becomes the acknowledged responsibility and primary role of the community's organizations themselves.

Why is community participation so important?

Because without it, interventions often don't work. When communities are consulted, problems become better defined and specified, and solutions are better designed and refined. The collaboration enhances community awareness of the problems to be solved, and sets the foundation for their "owning" the problem and helping to devise the solution. Thus a common agenda emerges, making the design, implementation and evaluation of the intervention more relevant to what is really happening "on the ground."

Governments by their very structure often work ineffectively with the more needy and marginalized communities; there may be a clash of social and political currency. And as public resources are squeezed, the programs that do survive are under greater pressure to

78

work effectively. CBOs that assume this important social role, those who have been instrumental in devising the interventions up and down the bureaucracy, will be more equipped and motivated to make them work.

Thinking About Goals and Strategies

Community participation as a goal

A core issue with many social and health services is sustainability: how can a successful program or process be kept going? Pragmatically, this usually translates into finding the resources to continue a particular program once a sponsor's funding expires. But looking at this problem from the community point of view provides both a wider vision and a powerful incentive. Once a community has formed the habit of getting involved at all levels of service delivery, and established the alliances and the network to do so, that community will inevitably find a way to endure the vicissitudes of social and political support. Sustainability thus becomes the very process of a community maintaining its overall momentum of community action on HIV/AIDS.

Such a community-wide goal will flourish only when a supportive environment has been established. Individuals from diverse communities must come to see HIV/AIDS as their common issue; they must perceive it to be in their interest to join forces. Partnership is the cement that makes communities cohere. Each of the disparate community organizations needs to develop the appropriate skills, resources and capacity to become a full and legitimate partner in the common enterprise of solidifying the infrastructure, whether for program implementation or for service delivery.

Community participation as a strategy

The more traditional rationale for community participation is that organized efforts can work the system in order to engage the struggle with HIV/AIDS. As mentioned, programs and interventions have been found to work better when community organizations are elaborately involved. In most cases, this entails a series of steps: conceptualizing—defining the specific local causes and consequences of HIV/AIDS, and the specific priorities most relevant to this community; designing interventions—defining peoples' roles and responsibilities and the methods, strategies and approaches they should use; implementing—mobilizing the key actors to accomplish the target tasks; and evaluating—deciding how to proceed, measuring local success, communicating results and then elaborating subsequent steps. Ideally, the local actors proceed through these phases by collaborating and forming partnerships, which tends to evolve a shared ownership of the problem and its solution.

Context Matters: No Two Communities Are The Same

Social movements and programs are more likely to flourish in areas where the local culture and political environment provide a favorable context. Communities thus develop an institutional history. This legacy of success or failure of community programs also influences the prospects for future social action. It is for these reasons of context that no blueprint can be imported that will ensure full community participation: there are no universally valid or appropriate theories or methodologies. And though the particulars of the context may establish certain inherent constraints and obstacles, so too do they point out the channels of well-conceived opportunity. But originating a functioning organization in a community can be a bumpy road; it is useful—as the process of identifying possible program needs unfolds—to recognize *meaningful responses* from the community, rather than knee-jerk (but wholly understandable) reactions to outside ideas.

Capacity

Communities possess some basic characteristics that affect their ability to absorb and support new programs, and it is useful to identify their existing strengths. The

process of articulating their needs can provide an opportunity to train them in the methods of participatory research and the conventions that govern formal needs assessments. "Every community has its own experts on the subject," that is, people living with HIV/AIDS. For them to speak openly and assume roles in the process is invaluable, but this happens at the cost of potential stigmatization, and can pose a threat to their individual rights.

Change

Communities are not monolithic entities but represent often fragile coalitions of interested individuals whose circumstances and commitments may change. The early life of many CBOs and programs in a community can run up against certain predictable problems, such as inexperience in community organizing and a lack of consensus among members (who may arrive with differing political agendas). As the organization grows and gains institutional experience, major differences within are usually sorted out, but as a whole they may face competition from other NGOs in the same community. Targeted donor funds can be limited, and exacerbate this competition.

With more experience and growth, more issues arise. Valuable time that once was available for solidifying linkages with community bases may be diverted to dealing with the donor bureaucracies. It seems to be a human tendency for people in positions with specified roles to be reluctant to share responsibility, and also to resist taking on more. Some organizations are triggered into existence by the availability of a particular source of funding, which may eventually dry up. At that point the group is tested because their commitment to the issue must take over as a primary motivation.

Low-prevalence contexts

In countries and contexts where HIV/AIDS is less visible (i.e., the infection rate is comparatively low), communities tend to be less "ready" to give prevention programs high priority. In these arenas, government officials and social and religious leaders need to become more sensitized to the problem. A workable strategy has been to promote HIV/AIDS sensitivity through existing primary health care and education programs. Where seroprevalence is low, the problem of HIV/AIDS is more likely to be framed as a sensitive or taboo subject; here staged community dramas and targeted media can be effective if developed with culturally-specific and -sensitive approaches.

Relationships Must Be Grown

The nature of the community begins to emerge from the collective effort to work through these issues. Participants in HIV/AIDS prevention programs begin to relate to one another both as individuals and as organizations. A crucial layer between donors and the CBOs and NGOs who will implement the donor's resources are what are known as intermediaries. These organizations perform a vital function, since they provide the technical and management support the donor doesn't have. They essentially certify the NGOs according to the donor's requirements. Their mission is to manage the transaction between donor and CBO and keep it smooth, clear and efficient, in the process remaining as transparent as possible. Obviously a power differential tends to exist here, and the CBOs need help in redressing the imbalance.

A number of features can improve the effectiveness of the relationships that develop among these various actors:

- *Flexibility:* Donors should develop guidelines rather than immutable prescriptions; requirements must be understandable, as well useable at the community level.
- *Dynamism:* Ongoing consultations can help clarify the mutual and evolving roles and responsibilities of all parties.
- *Transparency:* Opportunities should be established for constructive critical

feedback from CBOs to donors; e.g., monthly meetings or bi-annual in-country workshops to assess processes and progress, openly and carefully.

- *Mutual learning:* Donors can be sensitized to the needs of communities by constant exposure to, and dialogue with, CBOs.
- *Creativity:* Creativity is crucial, especially in finding ways to communicate and publicize the value of community participation to programming processes and decisions.
- *Time-intensity:* Community participation can only happen at the pace the institutional and social context permits; full implementation requires time.
- *Pragmatism:* Communities have their cleavages, politics and problems; these need to be acknowledged and addressed if the project is to be sustained.

BUILDING BRIDGES AMONG COMMUNITIES TO INTRODUCE NEW HIV/STD PRODUCTS

It is one thing to stipulate the common objective—inhibiting the spread and reducing the incidence of STDs/HIV/AIDS and improving the lives of the people who are affected. It is quite another to establish a system for delivering products that all of the diverse stakeholders (defined as anyone concerned with that common objective) can unite behind and participate in. Each of the following major groups will bring their own set of characteristics to the early stages of consensus building:

- People groups (Includes people living with and affected by HIV/AIDS, women; residents/potential users; advocates; community representatives, formal and informal; local NGOs/voluntary groups; traditional healers)
- Health care providers (Includes family planning; leaders and personnel at every level)
- Industry
- Research
- Government (Includes regulatory agencies and ministries)
- Bilateral and multilateral development agencies
- International NGOs
- Media

The essential thing to emphasize during these formative stages is that all of the stakeholders need each other—the key words are interdependence and complementarity.

For example:

Scientists bring one type of expertise to the collaboration, while so-called people groups bring another. Communities—while embodying the best possible awareness of what will work—need the technology and expertise that industry and researchers can bring. Clinicians and service providers add an invaluable store of practical knowledge and insights.

But the process of coalescing these diverse perspectives under a common purpose, the effective delivery of certain useful products, entails significant negotiation and communication. An effective blueprint for consensus building begins by acknowledging what distinguishes the various stakeholders from one another. Only from a starting point of rationally sorting out of differences and intrinsic motives can a workable consensus be approached, plans devised and implemented, and the system be evaluated.

Acknowledging the distinct identities of the interested parties

Though the stakeholders come together around the common purpose of providing effective STD/HIV products, most of them begin with one or more fundamental, intrinsic driving motives that serve to define the playing field. As the political collaboration proceeds, the more obvious of these will appear:

Differential interests

- Industry: Profit potential
- Research: Intellectual challenge
- Advocacy groups: Accountability to constituency
- Government: Regulatory agency; congressional pressures
- Consumers: Availability and cost
- Users: Ease of use

What further special concerns do these distinct stakeholders tend to bring into the process?

People groups

- Residents and potential users are concerned about:

Safety, availability, cost, efficacy, ease of use, as well as with cultural, human rights and other traditional issues.

- Advocates, community representatives, community leaders, and local NGOs are concerned about:

Organizational issues (agenda, capacity and time) and political issues (the political environment, turf concerns and the liability of engaging in certain collaborations, political posturing with rival groups); also the availability of funding, their accountability to constituency groups and, always, the fear of being co-opted by another group or by the exigencies of a reformed system.

Health care providers

- Health care providers are concerned about:

Organizational agenda, capacity and time; funding and availability of supply; safety and efficacy; familiarity with the system and the concomitant need for training; the political environment and turf concerns outside the organization as well as within, e.g., issues of prestige and the potential for career advancement.

Industry

- Industry groups (corporations, other providers) are concerned about:

Profit potential, liability exposure, the regulatory environment, patent potential, how a new product will work in the context of their current product line, the public relations implications, and opportunity costs compared to other investments.

Research scientists

- Individual scientists conducting research are concerned about:

The intellectual challenge, potential for career advancement, availability of funding, the pressure to publish, the patent potential, how novel or new the line of inquiry is, and professional rivalries and prestige.

Government

- Regulatory agencies and their staff are concerned about:

Their mission and mandate, precedent, bureaucratic turf issues, pressure from the public, and (for instance, in the U.S.) from the congress, and the inherent bureaucratic tendency toward self protection.

92

- Ministries and the people who run them are concerned about:

Financial constraints, competing priorities, the political environment, prestige, professional rivalries, the relevant interest groups, and the potential for career development.

- Bilateral and multilateral agencies, and the people who represent them are concerned about:

The mandate and mission of the group or nation, public needs, competing priorities, financial constraints, bureaucratic turf issues, political and public pressures, prestige and the potential for career development.

Organizations

- International NGOs are concerned about:

Their mandate and mission, public needs, competing priorities, financial constraints and funding sources, bureaucratic turf issues, political and public pressure, prestige and the potential for career development.

Recognizing power differentials

Participants not only bring different experiences and motives, they also wield different levels of power, of several distinct brands—economic, political, and knowledge (both the academic and experiential varieties).

Large institutions are different in a number of ways from small grassroots groups, for example, and to deny or minimize the power differentials that exist between them can sabotage collaboration before essential dialogue has even begun. Some groups and individuals do not possess the resources that others will bring to the process, and the implications of this inequity must be acknowledged and compensated for. And while mainstream groups are becoming increasingly aware of the need to involve traditionally excluded perspectives and groups, there is a real—and often overlooked—distinction between inviting someone to participate in "your" panel, attend "your" conference, or serve on "your" committee and truly sharing power with new and diverse constituencies.

Costs of building consensus

These inequities can be felt (among other ways) in the time and money required to fully participate. Meeting locations should be carefully considered to maximize stakeholders' participation. Adequate time for preparation, communication, discussion and feedback should be built into the process, without assuming each participant group has a dedicated individual exclusively managing the project, as may be the case in some of the larger or more involved groups. Full participation costs money, and funds might need to be earmarked to support stakeholders whose resources for international collaboration are more constrained.

Conveners

The choice of a group or individual to serve as the convener can make or break a collaborative process. These "sponsors" should be as neutral as possible and be likely to (or already have) earn the respect of all participants. A convening agency that is seen to be more "on the side" of one group or another can greatly complicate laying the cornerstones of collaboration: open communication and the building of trust.

On any topic, there are generally one or more groups that are well-positioned to bring even highly divergent perspectives to the table. Another approach is for two or more groups each representing differing perspectives to co-convene a collaborative process; each will use its reputation with its own constituency to bring them effectively to the table and into the process. Since some groups will respond differently to any one single convener, the latter method where organizations collaborate as conveners may gain the trust of a larger community of potential stakeholders.

The key questions at this vital early stage are: Who sets the agenda? At what stage is input sought and what are the conditions of these engagements? Are women's groups, consumers or HIV-positive people involved from the beginning of the process, or "invited to participate" only after all of the important decisions have already been made? Are the stakeholders initiating the process truly open to incorporating the suggestions of new actors?

Building Consensus around a workable agenda

Defining an agenda

This issue of full participation comes into play at the first crucial task:

- **Setting the agenda.** All collaborators should participate in a spirit of partnership that reconciles the different interests and needs of each group. As the process evolves, some individual stakeholders may tend to maintain a better focus and sense of purpose about certain of the objectives than about others.

The agenda should be reviewed from time to time, to check that all aspects remain relevant to the goals and objectives originally defined—or, if need be, formally modified—by the group. In some if not most cases, the agenda must serve for many steps and stages and for a long period of time. Benchmarks for accomplishing the necessary steps along the way are thus very useful, and also serve as opportunity levers to recurrently reflect on the relation of the short-term objectives to the long-term goals.

Most important, good objectives are pragmatic and not a place for esoteric language; they should be distinguished from idealistic or long-term goals. Adequate resources must be established and maintained to meet all the objectives. These should be set realistically so as to establish a legitimate context for success.

Communicating

Next comes the oxygen to keep the process alive and viable:

- **Establishing safe and honest communication.** The key here is to create a "safe" space and a viable context for open and honest communication. What this will require may vary, depending on the nature of the collaboration. Generally speaking, dialogue must be unrestrained to be effective, and thus confidentiality must be protected. Traditional and cultural sensitivities should be respected.

All individuals embody a culture and speak a special "language," no less so when it comes to their professional or activist lives than their tastes in food. It is important to appreciate and to discuss how these disparate languages can affect the collaborative process. Small variations in language may reveal (or be interpreted to reveal) large differences in perspective. It is important to recognize that there exist dangerous or insensitive words, such as target, research subjects, Latino vs. Hispanic, prostitute, risk groups, acceptability, etc. Open and frank discussion is the only effective way to resolve these language issues, and such a conversation can also serve to build bridges to other levels of the process.

Acknowledging history

The process can only move forward in the light of the past:

- **History cannot be erased.** Whether real or imagined, the past behavior of institutions becomes an active force in any attempt to collaborate on bridging the different perspectives of the stakeholders. All groups at the consumer or implementation end of the process—and especially those traditionally excluded from the corridors of power—tend to harbor particularly strong memories of the historical instances where the government and/or the scientific establishment have betrayed their trust. In turn, these stakeholders tend to become understandably frustrated with any suggestion of "responsibility" for

incidents that happened before they became involved. No one likes to be stereotyped, especially individuals who bring a sense of integrity to their work.

A crucial recognition is that individuals or groups who believe they have long been denied access to full and honest information—and in many cases the concerns and suspicions of such groups are justified—will have hurdles to overcome to place the needed trust in those who develop and "hold" that information.

Building trust, resolving conflict

The underlying activity on which the entire process is built:

- **Connecting with people.** The best way to handle tensions between groups is to build personal relationships between the groups' members.

For example:

Many women's health advocates have had scarce real-life interaction with the scientists who develop new contraceptives since their experience has usually been confined to testing the new products that appear in their countries. From this perspective, it is a short step to the perception that all scientists view them as mere cogs in a deeper agenda to control the fertility of third world women.

Personal interaction will start the process of breaking down the tendency to cast all scientists in this role, to divide the world into "us versus them." But people from the larger, more powerful institutions must recognize that—despite their personal politics or morality—the ideology and actions of the institutions they are representing may conflict with the interests of other groups. This important recognition is a prerequisite to individuals' acknowledging and accepting these realities without becoming defensive.

The cornerstone of consensus building is to resolve conflicts as they arise; collaborators should recognize that individual participants and groups all have unique experiences, identities and insights. The collaborative process is not trying to deny or invalidate the distinctiveness of each participant. Rather, the goal is that each institution and individual be allowed to maintain personal or organizational integrity, while developing the concomitant motivation to achieve their common purpose.

Achieving the Common Purpose—Implementation and Evaluation

Improving current, developing new products

An effective participatory approach that involves all stakeholders must be continued in establishing research questions and priorities. This entails information about what the needs are at the community level, the relevance and importance of informed consent in research, controlled trials, identifying target groups and subjects, scientific integrity, ethical research concerns, and the fact that those most at risk often stand to gain or lose the most.

As the implementation progresses, all stakeholders are assuming various risks. The experimental subjects have the most to lose when safety becomes an issue; scientists have the most to lose if the study is flawed; industry has the most to lose if the product is shown to be ineffective. Failures at any stage of implementation will leave their mark on all stakeholders, subverting their common purpose and their ability to work together.

Product development, testing and diffusion requires broader community involvement and participation. The worldwide network of NGOs provides an established framework to achieve it. The pressure is ongoing to expand research in support of products that are acceptable to different groups (of women, for example) and to people in different regions.

Sharing and disseminating of information

Comprehensive information, delivered through effective communication channels, should be conveyed to all stakeholders at

85

each major stage. To make the system work, each stakeholder's feedback needs to nurture the common purpose. Some useful types of message that need to be reconciled concern: user perspectives, resource availability, technical limitations, and other similar issues.

Product "expectation fatigue" must also be avoided, where the expectations for a product are raised prematurely and repeatedly, though the product may not be available for years.

Distributing products to potential users

Demand is created by a "pilot introduction." Once full distribution gets underway, accessibility for all potential users becomes important, and a well developed health infrastructure can be the key. This points toward adequate roads, access to remote areas, and availability of clinics that carry the product.

Effective distribution requires policies that reinforce demand and access. Where it is needed, training should facilitate the goal that end users understand how to use the products. This can be applied at many levels; such as the provider who makes the product available; nurses, doctors, health care workers; and other distributors. All stakeholders in the process need to appreciate that better knowledge will enhance use and satisfaction, and to support the effort to inform potential users about the benefits and expected effect of products.

Utilizing products

Planners must take the social conditions and individual circumstances that surround the use of these products into account. The complexity of the users' lives—including the financial, behavioral, and interpersonal constraints they face—will determine whether any treatment or prevention product is actually or successfully used.

Evaluation

Finally, evaluation should be applied not merely to product use—to development, provision, utilization and satisfaction—but to the entire process of stakeholders' coming together to plan for and produce the product. Important to evaluate is whether collaboration is working, whether each stakeholder is being heard adequately, and whether all stakeholders continue to be committed and involved in the process. Pragmatic evaluations can be based on short-term objectives, but not to be overlooked is how they contribute to achieving the common ultimate goal.

Specific Strategies and Components of Behavior Change

HIV COUNSELING FOR BEHAVIOR CHANGE: AVAILABLE APPROACHES AND THEIR REQUIREMENTS AND USES

From the beginning of the AIDS epidemic, communication has been a vital piece of HIV-related health promotion efforts. One of the original insights however—if people were provided with the facts about HIV, substantial behavior change to reduce sexual and injection-related risks would follow—has proven unfounded. Notwithstanding, in the past 12 years much knowledge *has* been gained about which interventions are most effective and also most appropriate in various settings. Each community is different and thus no definitive practice guidelines exist to guide implementers, though some basics do seem to apply throughout:

- The approach must stress reduction of risk, rather than complete, immediate change of risky behavior; reduction of harm rather than total elimination of risky behavior.
- The approach must address not only an individual's behavior, but also the larger context of the cultural norms of that individual's society.
- All relevant communities must be involved in the design, implementation and evaluation of communication programs.
- Communication interventions must focus on behaviors rather than on groups of people.

Current wisdom suggests that communication strategies are but one component, and must usually be integrated with other program elements (such as services, policy-making and structural factors) for an HIV prevention strategy to be comprehensive. It is unreasonable to expect that communication alone can bring about far-reaching social change. Also, expectations about what communication strategies might work must be related to the context in which they will be applied. When this is done, realistic (usually scaled-down) objectives can be met, and demonstrably so with ongoing monitoring and evaluation, using intermediate and process indicators. Outcome variables such as behavior change are also provable.

A broader debate relates to how best to link HIV/AIDS risk reduction messages with the often conflicting messages of other health programs, such as STD, MCH, tuberculosis control and reproductive health. Also framing the issue are how communications flow through the channels of the infrastructure, through both formal and informal, institutional and local structures of leadership and authority. But the Roundtable was able to identify seven principles that do seem to apply universally.

1. Target gatekeepers and opinion leaders

(to pave the way for behavior-change communication strategies about HIV-related prevention and care)

Gatekeepers and opinion leaders have a critical role to play in community mobilization. Targeting them to ensure that their influence is tapped and wisely mobilized is thus important, and three factors will help, as follows.

Finding the right people

There is strong evidence that intervention efforts will fail without the political will to act and the concomitant mobilization of community resources for prevention. The leaders, who are also potential funders for programs, require education regarding the concept of community-organized interventions, the need for continual evaluation, and the need for bottom-up community participation. A planned intervention should be consciously targeted to the appropriate levels of leadership.

- 87

The roster of influential gatekeepers and opinion leaders who should be identified and perhaps utilized must be compiled from many different corners of society. The qualities being sought are status and persuasiveness, which translate into some degree of influence in a particular community. Some examples: church leaders, chief executive officers, politicians, health workers, media personalities, or teachers.

Using language well

The language used to deliver and discuss communication interventions should be culturally appropriate, yet also be familiar and comfortable to people.

For example:

Program content that may not be appropriate under the title "Family life education" in one community may be accepted in the same community under the title "wellness program"—the exact opposite may be true in another community.

Some forums are well established, and often an ongoing debate within the community can be used to publicize or simply discuss certain views related to HIV/AIDS.

To the extent that business leaders mold opinion and act as gatekeepers to certain resources, they also may be viewed as community leaders. They in particular present a challenge to public health professionals who must adopt their language in order to communicate effectively about AIDS prevention and care.

Research

To effectively develop behavior change strategies, research must be directed toward understanding the community, and becoming familiar with the demographic, economic, political and cultural environments that influence and constrain the gatekeepers and their constituents. Some of the important factors are political events, ambition, social pressures and money. The data collected can help with plans to encourage, enlist and visibly promote these gatekeepers' positive views.

Research must serve as a basis upon which to build communication strategies as well as a reality check throughout the process of design, implementation, monitoring and evaluation.

2. Involve communities

(in the design, implementation and evaluation of risk reduction communication programs)

Community involvement may be the paramount principle underlying the effectiveness of communication programs. The best place to begin is by involving the intended beneficiaries early on in formative and baseline inquiry to establish the interventions most likely to be acceptable, appropriate, relevant and sustainable. Investment at this stage paves the way to successful program outcomes. Communication materials should also be "field tested" by getting input early on from those toward whom the intervention will ultimately be aimed.

Exactly who is the community?

No communication program will be effective without a target audience, and so the constituents of the intervention must be identified. Communities may be defined in various ways: as the people who live in a specific geographic area, an age-defined cohort, or a group of individuals who share a common occupation or interest, such as injecting drug users or commercial sex workers (CSWs). In most situations, an important group are the adolescents and young adults who often comprise the majority of the target population within a community. A special effort must be made to involve them and to identify with their needs and problems so that solutions can be found that *they* believe will make a difference. Peer education can be a vital strategy with this age group.

Once the larger community has been identified, it is important to understand the identity of sub-communities or sub-popula-

tions that have the most significance. Many individuals put forth several social identities, and can identify and relate more as a member of one of the groups than as part of the larger community.

For example:

In the case of a community of men who have sex with other men, while most may identify themselves as gay men, some may not.

There may be women who exchange sex for money, but do not define themselves as CSWs.

Communication specialists must deal with the complexity of human nature by devising strategies that will penetrate the distinctions and categories to reach the target—which is always composed of real people, all of whom may be at risk for HIV/AIDS.

Other strategies

Incentives can be valuable in attracting people to participate in the design, implementation and evaluation of communication programs. Volunteers need to be given special roles, perhaps as intervention advocates, in order to prevent their developing problematic feelings about people who are employed.

The more channels of communication that can be used, the better the chance of effectively reaching target audiences, beginning with existing local and traditional networks. Using both interpersonal and multimedia communication strategies has been found to be mutually reinforcing—a strategy that should be encouraged and expanded.

3. Ensure the full and active participation of people living with HIV/AIDS

(in the design, implementation and evaluation of risk reduction programs)

People living with HIV/AIDS should be fully and actively involved in the design, implementation and evaluation of risk reduction programs; this is the best way to ensure the appropriateness and success of those programs. While people living with HIV/AIDS are frequently invited to be educators for primary prevention purposes, they are less frequently given a central role in the design of these programs. When they have been involved, a number of issues have arisen. Experience thus far indicates the following:

- Program implementors often utilize people living with HIV/AIDS in educational capacities without actually involving them in design, or consulting them about their perspectives or issues.
- People living with HIV/AIDS may prefer to focus their sometimes limited energy on care rather than on prevention.
- Certain people living with HIV/AIDS may not have developed the communication skills that are important for AIDS prevention programs.
- Program implementors may fear that by including people living with HIV/AIDS into their programs in a public way, they will invite a negative reaction from community members, and thus compromise a program's success.
- Physicians sometimes feel that certain service and treatment programs "belong to" the medical community, and that patients have no role in the design, implementation and evaluation process.

Cultural constraints and problems

The cultural milieu of the country or community forms an integral context for the experience of people living with HIV/AIDS in that locale. Certain communities (and societies) have problematic stigmatization and discrimination issues, making it difficult for those living with HIV to disclose their serostatus. In these contexts, protecting confidentiality assumes even greater importance. Other recurring problems for those living with HIV/AIDS assuming more of a role in programming are the lack of legal protection and the persistence of negative community values.

In order to encourage the full and active participation of people living with

HIV/AIDS, program planners should understand that:

- People living with HIV may need social, moral and financial support.
- Programs that offer incentives are more likely to ensure the active participation of people living with HIV/AIDS.
- Family understanding and support are crucial for giving people living with HIV/AIDS the confidence to be publicly involved in AIDS communication activities.
- People wanting to contribute may require training in communication and teaching skills.
- It may be easier to involve people who have a group identity, such as gay men or HIV-positive women.

Efforts to involve people living with HIV/AIDS must deal with the everpresent dangers they face from stigmatization. A number of circumstances contribute to the climate that discourages them from becoming more involved:

- Health care workers not disclosing the HIV status to the individual and the family
- Communication messages carrying the implication that "bad behavior" causes HIV transmission (messages such as: "Don't go to prostitutes" or "Children are innocent victims")
- Governments denying the existence of HIV/AIDS in their countries
- People living with HIV/AIDS accused of "choosing to engage in" the behaviors that led to their infection; hence it is their "fault."

4. Develop communications programs

(to bring about changes in broad based community norms and values)

To be successful, a prevention program must ultimately conform to the community's value system. This is easier said than done, since communication specialists often find themselves doing some or all of the following:

- Imposing their own values on the community
- Asking communities to define their own needs when they may not be in a position to articulate what those needs are
- Utilizing behavior and communication theories that are not applicable to the communities they have been imported into
- Assuming—rather than learning—what the community wants
- Supporting what exists, rather than facing the change inherent in active efforts to reduce risk
- Deciding that risk reduction messages shortchange the prevention message

Facing the challenge of change

Because behaviors are deeply rooted in cultural traditions, it is difficult to assert the need to change risky behaviors. The communication expert must assume a number of roles at different stages in the process, and in different cultural contexts. But they should nearly always seek to become *facilitators* rather than *creators* of change. Certain practice guidelines can help in maintaining that focus:

- Providing clear messages that are appropriate to each different community
- Being willing to be honest about not having all the answers
- Working from a healthy sexuality model
- Knowing the target community
- Being persistent
- Continually assessing whether messages are being received accurately
- Addressing their own perceptions and issues before talking about risk reduction to others

5. Use communication sensibly and strategically

In daily human life, behavior change much more often occurs in gradual phases rather than in a single, dramatic moment.

The message that "all risky behaviors must be eliminated" may be technically correct, but practically unobtainable. A more strategic way to deliver the same message is to suggest that people substitute safer behaviors for those that are risky.

Knowledge in and of itself is rarely sufficient to ensure or sustain substantial risk reduction. That knowledge must be translated into practice, and this requires supportive and favorable environmental and structural conditions. This in turn requires that economic, legal, regulatory and environmental factors be modified to enable individuals to adopt and maintain safer behaviors.

Specific strategies to emphasize safer behavior vary by culture, values and communities. But what is universal—grounded in theory, practice and experience from around the world—are the two components of the overall gestalt required: interventions need to persuade as well as enable individuals to adopt and maintain safer behaviors.

6. Build and sustain capacity and in-country ownership

(of risk reduction communication programs)

The country or community must make an investment to ensure that successful programs can continue indefinitely. To build and sustain the capacity and in-country ownership of such programs, planners must:

- Acknowledge the different types of groups that exist within a country (NGOs, local/district/federal government, experts, and groups of HIV-infected people)
- Respect the needs and perspectives of the local people and involve them wherever possible
- Orient funders and institutions to the program and educate them to the realities of the situation
- Understand multisectoral linkages and the various levels of networks and gatekeepers
- Coordinate between relevant partners to avoid duplication and cross-over
- Build partnerships, linkages, networks and coalitions among different groups, decision makers and local and technical experts
- Be sensitive to the culture and the language; understand and validate community values

7. Establish linkages between programs

(Such as HIV/AIDS and STDs, family planning, tuberculosis)

Even the most persuasive communication strategies are likely to fail without the appropriate resources and services. For example, efforts to promote safer sex require the availability of condoms; STD care-seeking behavior can work only where such services are accessible.

HIV/AIDS services should be linked into the larger framework of health services. Then the challenge becomes improving reproductive health services, not just HIV/AIDS services. Strong leadership is needed to create a vision of how the issues can be addressed through linkage. Creating a supportive framework and a mechanism for linkage among donors, ministries, and NGOs will reduce duplication and increase quality and access to services. Resources and services must be available and dependable. Joint planning is required by linked organizations, services, and the population, and their needs must drive the design and development of services.

Communication specialists face the challenge of trying to understand the strengths and limitations of other sectors while guiding them to appreciate the realities and complexities of HIV/AIDS. If they succeed, "international best practices" in AIDS prevention will become more prevalent.

BEHAVIOR CHANGE COMMUNICATION:
SELECTING STRATEGIES TO SUIT SPECIFIC AUDIENCES AND SETTINGS

HIV counseling is a difficult phenomenon to examine in isolation. The interconnections among counseling, testing and evaluation run together, and any attempt to pinpoint exactly when one activity ends and another begins is fraught with uncertainties. What is clear is that counseling is the primary context through which social scientists and other evaluators can get a handle on behavior change. Even more compelling is the personal nature of counseling since it necessarily entails a relationship between a counselor and a client. Whatever draws people into the counseling domain, they almost certainly emerge as changed; whether these changes are strictly behavioral, or can be pinned down as efficacious (for the purposes of evaluation) is less definitive.

Nonetheless, virtually all HIV counseling provides vital information to clients by assessing the risk of HIV infection, developing a plan to reduce that risk (or to seek care and support if infected) and by offering a framework clients can use to begin to cope with psychological (emotional) reactions to HIV-related issues, and to the interpersonal challenges that arise.

Some further basic observations can be supported:

- HIV counseling is useful for prevention as well as for care and support of affected individuals and families; it can be provided to both the infected and the affected.
- Counseling is an essential component of testing; counseling and testing is a subset of HIV counseling.
- Testing per se for the HIV antibody can be seen as an agent of behavior change, but it also seems to be more effective when accompanied by counseling.

Yet controversy continues to swirl around the core issues—the effectiveness of HIV counseling, how best to deliver the service, and its proper role within particular HIV/AIDS control programs. Evaluators have yet to "decide" which is the more important goal—influencing behavior (in a demonstrable sense) or meeting the clients' avowed needs. Ultimately, it may be impossible (and unnecessary, some would say) to demonstrate that counseling causes behavior change, as long as the two seem inextricably associated.

Given these conditions, providers nonetheless continue to approach HIV/AIDS counseling interventions with the conviction that they can be accomplished more or less effectively. The research on evaluation may be less definitive than social scientists would like, but they persist in searching for measures to reveal the best way to help people who come for HIV counseling.

Designing and implementing effective HIV counseling interventions

Selecting Interventions

A body of knowledge derived from more than a decade of HIV counseling experience provides a number of choices and factors to consider when deciding on intervention. Such an analysis involves certain procedural basics, such as the role and relevant context for counseling, whether to integrate the counseling with other STD services, and whether to target the intervention at specific individuals within the population. Once an intervention "type" is selected, a number of factors will affect how it is designed and implemented; such as

- the goal of the intervention (e.g., behavior change, change in behavioral intentions, care and support)
- the actual counseling techniques used (e.g., discussion, education, skill-building)
- who participates in the intervention (e.g., individual, groups, couples, families)

92

- who conducts the intervention (e.g., peers versus professionals)

Counseling can be delivered through various modalities, which are indicated by considering the definition of counseling in the local context, the target group, the demand for services, available resources, and other factors such as the seroprevalence in the community. The lines between counseling and health education often become blurred; as, for example, when the term *community counseling* is used to describe discussion of HIV issues within a community intended to expand awareness of the HIV/AIDS problems and how to address them.

Considering Context

Counseling always takes place in some environment and in a particular community, and should be designed and modified accordingly. The context will suggest the nature of the service that can realistically be delivered, as well as the likely effect it will have on the individual. Behavior change is generally constrained by limitations of particular circumstances.

For example:

Counseling the use of condoms in a setting where they are either unacceptable or unavailable would be inappropriate counsel.

Such structural limitations offer important input for program planners and counselors alike. Recommendations as well as options presented to clients must factor in such environmental limitations; such as: social discrimination based on HIV status, access to appropriate information, gender inequality, availability of materials (condoms/syringes, testing) and services (trained counselors).

The Role of HIV Counseling

If clients are to disclose personal issues and problems, they must develop trust in the system and the provider. The inner core, as it were, of counseling is to help clients develop insight into their personal situation, in the service of making decisions about change.

This insight is directed toward clients' ability to recognize the reality of their situation and gain some perspective on it—to become the protagonist of his or her destiny. These steps are vital to a person's self esteem and sense of empowerment, which, when they are enhanced, usually lead to healthy and protective choices.

Counseling services are not the proper milieu to recruit affected and/or infected people as advocates, or to disclose their serostatus. These things should happen naturally and spontaneously, which they tend to do as people's needs for support and care are met.

There is no single, canonical model of counseling. Multiple types of counseling are called for, to respond to different populations and contexts, and to work within the available resources and the applicable cultural context. The best prescription for service providers is flexibility, trying to meet their goals and do the best they can.

Integrating HIV Counseling Interventions

HIV counseling can be and often is successfully integrated with other ongoing HIV/STD prevention activities. As discussed in Roundtable 6, the procedures for integration should be carefully defined. Perhaps the most obvious example would be the inclusion of HIV counseling and testing activities in an STD diagnosis and treatment program.

But integration can present tricky issues, for whenever HIV prevention counseling is wrapped into a comprehensive plan for HIV/AIDS services, the danger arises that the more apparently urgent situations will abrogate the usually limited resources that could go for counseling. Thus it becomes strategically important to clarify that decisions about when and whether to use counseling can *not* be determined by outcome measures or cost-effectiveness alone.

When HIV prevention counseling is provided at several sites in a community, the counseling in these different sites needs to be coordinated. This includes sharing information across sites about which services are available where.

Targeting HIV Counseling Interventions

Are HIV counseling interventions more effective (from a cost as well as a clinical efficacy view) when they are targeted to specific individuals within a population? Current research has not answered this important question definitively, though logic suggests that targeting may be particularly relevant to counseling programs because of the relative cost and the intensive, individualized nature of the intervention.

At least two basic factors should be considered when deciding whether to target interventions: what the most common mode of transmission is, and HIV seroprevalence. If targeting seems to be indicated, it is important to consider the process by which it is decided *who* will be the target group. A basic conundrum that hasn't been definitively resolved is whether to target those with the greatest *need* or those most likely to *use* the service? An important corollary question then presents itself: Would it be possible to increase the *accessibility* of the services to the groups who most need them?

Evaluating the effectiveness of HIV counseling

What are the best ways to effectively and appropriately measure the impact of HIV counseling interventions? The specific procedures and content of counseling interventions are rarely described, making it difficult to determine efficacy and/or to make comparisons across studies. Researchers and program planners should always attempt to describe, as explicitly as possible: procedures of the intervention; the expected outcomes/ goals; the actual outcomes of the program, including negative outcomes; and structural limitations (such as access to condoms, stigma, and economic constraints).

Counseling is established to provide a useful service, not to serve as a proxy for health education. Its objectives focus on individuals, not society. It is as a service—not as an IEC program—that it must therefore be evaluated. But it turns out to be fairly complex to try to determine the effectiveness of HIV counseling interventions.

Outcomes should include more than the client's behavior change, since various other beneficiaries (individual, couple, family) are clearly affected by the results of counseling. Clearly other ways to assess are possible, other issues, other outcomes (risk reduction, increased care, increased support, improved quality of life), and various levels of change (cognitive, behavioral). Counseling has both immediate and long term impacts—positive and negative—and these should be monitored and anticipated. Human rights issues frame the entire undertaking (Roundtable 4), as do issues of cost-effectiveness.

Goals of counseling

Counseling can be better conceptualized as a service that provides individuals with necessary and varied coping strategies—as opposed to mandating behavior change designed to decrease HIV incidence. When the goal is thus revised, measures of success change and would seem to be more approachable by evaluators. But a danger exists, seen in an analysis of motives: the reasons agencies provide counseling may be different from the reasons that individuals seek counseling. Does the counseling intervention emanate from the recognized needs of the community, or from the needs that the planner identifies? The answer to this charged question will also tend to influence evaluation: Is its purpose to justify the program to the funding source or to provide effective services to the client?

HIV testing does not necessarily raise these questions per se: The technology is available; individuals would have the right

in most societies to know their serostatus and to receive testing services, even if testing's demonstrable impact on behavior was slight.

The effects of mandatory testing

Mandatory HIV testing exists and is increasing. In most societies, it is being driven by the value and economic benefit it brings to employers and insurers. Questions about immigration also are more easily framed in the context of mandatory testing. Unarguably, mandatory testing is generated for the benefit of those doing the testing, not for those being subjected to the tests. Counseling comes into the picture as a way to possibly redress this inequity and bring value and some benefit to those being forced to undergo the tests. But should it? Such a plan would seem to endorse the premise that people can be subjected to mandatory testing, which many activists and civil libertarians challenge.

Providing HIV counseling—not only to those tested but to the entire community—could help mitigate the harmful effects of mandatory testing. An analogy can be made to the concept of "harm reduction" as it plays out in syringe exchange programs to intravenous drug users. The question planners have to ask is whether (and if so, how) it is possible to reduce the harmful effects of mandatory testing without endorsing its existence?

Confounding counseling with testing

Most studies of HIV counseling are conducted in the context of combined counseling and testing programs. Thus, the counseling—and any attempt to evaluate it—occurs in the inevitable and hypercharged context of clients having recently discovered their HIV serostatus. And, since most studies take place in communities with a high incidence of HIV (where HIV counseling and testing is only one of numerous interventions), it becomes impossible to disentangle the effect of the counseling intervention from the effect(s) of the other contemporaneous interventions.

More technical evaluation issues

Process versus impact evaluation

Process evaluation provides a way to assure that projects are functioning effectively, and should be required for most counseling programs. The value of impact evaluation is less demonstrable and should probably be limited to discrete, well planned, and well funded research projects, where it is feasible to evaluate the outcome effectiveness of specific counseling interventions, or of counseling under specific circumstances.

Variation in human response

Researchers face the Sisyphean task of reaching universal conclusions in the face of the staggering diversity and complexity of the individuals exposed to counseling interventions. Inevitably, their conclusions manifest a necessarily generous margin of error. If behavior change is a primary indicator, consider how variable is the population: Some individuals will manifest change as an immediate and direct result of testing, while others may require years of intensive counseling before behavior change is evident.

Selection bias

Selection bias issues raise a number of dilemmas for the interpretation and generalization of study results, for which randomization is a necessary but not sufficient response:

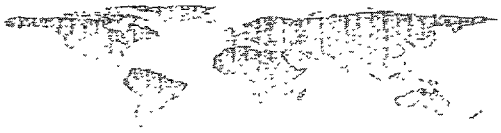
- Who arrives in counseling, and thus in the study?
- Who receives which type of treatment; how do those who receive only counseling differ from those who receive medical treatment only? How do those receiving pre-test and post-test counseling differ from those receiving post-test counseling only? It becomes problematic to standardize the intervention, or

make it independent of the type of person receiving the counseling.

- On target for evaluation is counseling's sustained effect, but selection bias related to follow-up can confound this measure; there may well be a determinant difference between those who drop out of the study and those who remain.

Is behavior change a useful proxy?

Behavior change is the most often-deployed measure for the effectiveness of HIV counseling, based on the premise/assumption that behavior change will lead to decreased morbidity (which can in turn be measured by decreased incidence of HIV or other STDs) at the community level. However, a close review of the literature reveals the relationship between behavior and HIV/STD incidence to be less straightforward. Behavioral intentions (which are more easily assessed) are used to proxy for behavior, which in turn is used to proxy for HIV incidence. Clearly, a "harder" conclusion could be based on the actual disease incidence variables.



Oral Session Summaries

Oral Session Summaries

It is important to emphasize the following points about the material gathered under the heading of Oral Sessions.

- The 90 studies gathered here were chosen from some 350 abstracts submitted for presentation and consideration at the conference. Studies were selected for their relevance, applicability and general interest to the international HIV/AIDS prevention community.
- Since the studies were already completed or underway, no specific goal or agenda was or could be imposed beyond the criteria just mentioned. Each of the researchers defined and approached their study with their own questions. **The 15 groupings into which they were organized for the conference are strictly retrospective, and based on the need to organize abstracts for discussion and consideration. Thus, the session "titles" should not be taken as properly comprehensive descriptions of the goals of either the individual studies, or of the conference oral sessions where they were discussed. They serve merely as "pointers" to a general area of discussion.**
- The oral sessions thus provide a snapshot of an important, but preliminary stage of the process of developing conclusions and wisdom; when behavioral science meets the world of anecdotal and experiential knowledge, a rich but often provocative dialogue may ensue. By their very nature, such discussions may be controversial; ideas are being tested and examined; they either survive and grow in importance or begin to be refuted in a way that will require them to be refashioned and rediscovered in more relevant, appropriate and acceptable forms.
- USAID believes that this necessary, exciting and important dialogue should be held, in the interest of sorting out the more useful, appropriate and relevant ideas for HIV/AIDS interventions. It is not the Agency's intention to endorse or to refute any of these ideas at this preliminary stage. They were selected on the basis of their apparent relevance and interest to the community in 1995. Whether they will withstand the necessary tests of time and operational and academic scrutiny remains to be seen.
- Thus the following summaries do *not* represent USAID policy, nor are they constructed in language that has been manipulated for appropriateness. They reflect the implications, the language and conceptual structures of the researchers and of those who discussed the work during the conference oral sessions. Where connecting themes could be discerned, they were described; where a study or discussion may seem to depart from current accepted thinking about how to approach a particular issue, it was included in the form in which it was presented. The material here comes from the field; it is indicative of some of the questions and discussions that are being held in that context. It is phrased in the language used by the researchers. The summaries are intended only to provide an annotation to the abstracts themselves—included in the Appendix—which were written by those conducting the research.
- Finally, it should be stressed that the field of HIV/AIDS prevention is undergoing continuous evolution, as the epidemic presents new challenges that will in turn prompt new responses. This was the third in a continuing series of international meetings convened with the goal of sharing information and lessons learned—it is by no means the last. The HIV/AIDS epidemic presents the international community with very complex and dynamic health, socioeconomic and political issues. Thus there can be no single, permanent or universal truth, only a mosaic of insights and lessons learned that are shared, applied and found more or less useful and appropriate, depending on the circumstance. It is from the dynamic and energetic exchange of data and local indigenous results such as those gathered for the Oral Sessions that that mosaic must be stitched.

98

Issues Cutting Across the Prevention and Care Continuum

THE HIV/AIDS PREVENTION AND CARE CONTINUUM

CO-CHAIRS
Bulya-Rose Kizito
The AIDS Support Organization (TASO)
Kampala, Uganda

Dr. Janet Mitchell
Harlem Hospital
New York, New York

Summary

One of the most important lessons learned from the epidemic seems to apply in some measure to every society and community where HIV/AIDS is found: The more that people living with HIV/AIDS succeed—in finding quality care and in coping with the challenges presented by the disease—the better the environment in terms of prevention and care. In some areas in certain developing countries, seroprevalence is so high that a significant portion of a community may be infected, and thus virtually the entire community will be affected. Creative interventions to provide necessary social supports to those with HIV/AIDS thus can have a significant impact on the economic and social health of far more than just those with the virus. When the problems that ripple out from the population that is infected are addressed, risky behaviors will probably be reduced in this and the larger population as well, and entire cultural transformations are possible. And where actual medical care is limited by scarce resources, the quality-of-life issues become even more crucial to those with HIV/AIDS, providing them with motivation to keep living productive lives and thus strengthening the families and communities they belong to. Thus is care in its broadest sense an inextricable part of the context in which prevention interventions are mounted.

One study undertook a review of the literature in search of descriptive evidence that better care for those living with HIV/AIDS has a positive effect on preventing the spread of the virus. A number of trends were found: People with HIV are an effective point for intervention since they are carrying the virus; the better care they receive, the less they may feel driven to risky behaviors; they are more likely to reveal their serostatus if the care and support that will result is meaningful; thus the more of them publicly living with HIV/AIDS the more deterrence for others who perceive their situation; and finally, integrating care and prevention can stretch resources further. Thus, it was concluded that any overview of prevention should include the element of care, and studies should be designed to explore and further validate the above-mentioned links.

Echoing a theme that reverberated throughout the conference and which was considered explicitly in Roundtable 1, clinical care and effective HIV/AIDS prevention are indispensable to each other. Any attempt to deliver them separately undermines the opportunity to benefit from a synergy that can develop when a single continuum model is used. Compassionate care for, and acceptance of people with HIV/AIDS as integral to the prevention/care continuum serves to strengthen prevention programs.

Some discernible trends point toward possible ways the system of health care delivery can be improved and expanded to include prevention. When STD clients do seek help, it is important to establish a strong model of case management right away. This could include efforts like the "STD/Communications Interface"—facilitating encounters by training provides in communication skills; and taking advantage of pharmacies' access to most of those with STDs by promulgating other messages (such as

99

condom use) and trying to stimulate the use of other services.

In some countries, it is the traditional healers who seem to enjoy the best access to those most at risk for HIV/AIDS. They are invested with an authority in their culture that can have a powerful influence, though it can be important to coordinate their efforts into concerted action. One study revealed that they tend to have a quite accurate knowledge of HIV/AIDS, and that when asked to promote condoms they did so, even though there may have been insufficient condoms available.

To be most effective, targeted interventions must be designed around the conditions that prevail among those who do (or should) seek STD treatment. In one study in Senegal, a number of beliefs were uncovered that might help planners better tailor their programs to the ways their clients are thinking. The symptoms presented and illnesses diagnosed were often referred to by different terms by providers and patients respectively, and showed correlations by gender and other types of group; for many, the occurrence of some diseases was seen to be beneficial in that they indicated fertility or longevity; many people did not recognize the concept of asymptomatic disease (stages), others attributed STD transmission to non-sexual causes, and the basic notion of a virus was not fully comprehended by many. Such cultural perceptions cannot be lightly dismissed, since health care workers need the best possible communication with their populations, and must develop a cultural sensitivity to establish it. This in turn could lead to an environment where these local perceptions can be effectively challenged.

This and other strategies provide a type of social support, which is being more widely recognized as a crucial prime element in prevention of STDs, along with the traditional three: early treatment, access to condoms, and sex/health education. In Santa Cruz, Bolivia, the UNELDYS organization was established to provide a social support system for gay men who may suffer from stigmatization and discrimination in Bolivian society. Greater interest and participation were found when condom distribution and prevention education interventions were linked to social activities and delivered in a supportive environment. Here again the principle of responding compassionately to people's various needs can make them more receptive to prevention messages.

(See Abstracts A1–6.)

PROS AND CONS OF INTEGRATING HIV/STD SERVICES INTO OTHER HEALTH SERVICES

CO-CHAIRS
Pat Pongswatanakusira
Health Center 9
Bangkok, Thailand

James Foreit
The Population Council
Washington, D.C.

Summary

While a number of questions tend to arise around the prospect of integrating HIV/AIDS services (and prevention interventions) into existing family planning services, finite resources and increasing incidence among populations who use family planning services have encouraged more integration. Once both the providers and the users of these services actually become involved in the process, many are surprised to discover that the expanded service better meets their needs.

A key strategic element is ownership: Involving communities and staff in the design and implementation of services to ensure that new services meet the specific needs of local clients. One effective way to do this has been to "piggy-back" onto socio-cultural activities and structures that people are already involved in. One goal of a number of HIV/AIDS prevention interventions is behavior change, which in turn relies on a state of mind. Women in many cultures may benefit from consciousness raising by enhancing their self esteem and thereby gaining more power to negotiate sexual issues, such as condom use. Small group training sessions that focus on cognitive and behavioral skills building have also been successful. Heterosexual transmission is being perceived in many communities as a growing threat to families, and thus family planning services will become more meaningful to clients as they support and enhance prevention interventions. Once this is understood by both clients and providers, fears that the family planning mission might be diluted or stigmatized by the inclusion of HIV/STD issues tend to be marginalized, and the relevance of the expanded scope of services comes to be seen as a strength.

One study (assisted by AIDSCAP) looked at how best to disseminate the knowledge base that can provide a solid foundation for such programs. Standardized case management guidelines stressing the syndromic approach to STD diagnosis and treatment were included in training packages given in two-day workshops in central Nepal. Prevention models relying on provider attitudes, communication and condom demonstration skills were provided to physicians, chemists and alternative health care providers, and the Ministry of Health expects to expand the program nationwide.

A second key to the effectiveness of integration is careful appraisal of the needs and knowledge, attitudes practices and beliefs (KAPBs) of the people. When intravenous drug users are the target, and it becomes clear that needle sharing is going to continue, then perhaps the best short-term response is to provide bleach; if this population is traditionally difficult to reach with standard prevention education, then find members of their own community who have indigenous credibility and train them to get the necessary messages out. One study demonstrated that when additional clinical services are demonstrably required (in this case treating reproductive tract infections), they can be integrated effectively into family planning clinics and even people with limited resources will pay for treatment and the drugs that may accompany it. Health care workers were at first dubious, but careful planning proved to be the crucial factor, and the approach may well work for other adjuncts to the older, limited, traditional family planning model. Wherever resources are taxed in the context of a particular clinic or system, it may be constructive to reconsider

101

whether those coming for other types of services would benefit from HIV/AIDS prevention interventions, and whether the perceived liabilities are sufficient to preclude it.

(See Abstracts A7–12.)

THE PRIVATE SECTOR RESPONSE TO HIV/AIDS

CO-CHAIRS
William Schellstede FHI/AIDSCAP
Arlington, Virginia

B.J. Stiles
National Leadership Coalition on AIDS
Washington, D.C.

Summary

Exactly what is meant by "private sector" may vary from one context to another, though common to all is the need to make interventions sustainable, and to provide participants a sense of ownership and satisfaction with the project in question. But *private* could refer to NGOs in some circumstances, to social marketing organizations or to strictly commercial sector enterprises.

An example of the NGO category is the AIDS Awareness program at Seva Mandir in India. Poverty is so endemic that the quality of life is bleak and the spread of HIV/AIDS is enhanced by underlying social conditions, as much as from ignorance and lack of access to medical services/facilities. By refocusing the problem and establishing the ultimate goal—to interrupt the cycle of poverty, including a heightened awareness of HIV/AIDS prevention options—the intervention has begun to establish an altogether new social horizon. Over 1,000 para professionals are continually seeking every opportunity to elevate HIV/AIDS awareness, and have had an impact on some 400 villages.

Social marketing of condoms, often necessary where local conditions inhibit their sale, can be successful in even sophisticated markets. For example, Brazil has sophisticated media and retail sectors, a defined market potential of over 150 million condom users with adequate income, and the highest condom prices in the world. Condom use is extremely low. A social marketing organization was set up to deliver an alternative,

102

more affordable condom, and to market and distribute it according to a targeted market. The project has been a success in reaching a wider target group, and in spurring commercial retail condom sales as well.

Another social marketing success story is the advent of a diagnostic kit for HIV (1 and 2) that overcomes the problems experienced in many developing countries hampered by lesser resources and limited laboratory access. PATH in Seattle, Washington, pioneered the kit and a system of delivery and development for Africa, Asia, Latin America and the Caribbean that would be easily transferrable to local manufacturers. The technology has been certified by the WHO, and its success has solidified the commercial network developed to distribute it by exerting a competitive market pressure on competing diagnostic products and spurring the development of so-called rapid diagnostics for other conditions prevalent in these populations.

Finally, the most traditional notion of the private sector, for-profit commercial projects, have also proven viable and effective contexts for mobilizing a prevention effort. AIDSCAP's Private Sector AIDS Policy Presentation (PSAPP) activity conducted research and needs assessments in Africa to provide a clearer picture for local managers of the incurred and projected costs of HIV/AIDS to their business operations. From such financial analyses it is hoped more responsible and cogent responses will arise from the private sector, driven by (among other motives) a logical analysis of the costs and benefits of prevention. Another study in South India also undertook to specify to management the costs to the industry associated with HIV/AIDS; if the skilled workforce is highly correlated with those most at risk, then investment in workplace prevention programs can be justified and facilitated.

(See Abstracts A13–18.)

POLICY DIALOGUE: WHAT IT IS, HOW TO USE IT?

CO-CHAIRS
Jeff Levi
Office of National AIDS Policy
Washington, D.C.

Anthony Schwarzwalder
FHI/AIDSCAP
Arlington, Virginia

Summary

To be most effective, thinking and planning about HIV/AIDS must be undertaken within the context of the political reality of policy. Appropriate public policy is required to provide a context for effective interventions. Effective networking is one of the important prerequisites to both developing and sharing HIV/AIDS prevention and care policy insights. For example, in the critical area of gender relations, women are only beginning to assume their central role in these discussions. The Southeast Asian Regional Workshop convened representatives of the government, NGOs and universities from five countries and the Chinese province of Yunnan; they came together to share their thoughts and experiences on policy making, and to establish a viable network around the women and HIV/AIDS issue. Since these groups do not meet naturally, alliances were begun within and between countries that might not otherwise have developed.

Policy dialogue and development is an ongoing activity, but countries who are "behind the curve" in HIV/AIDS awareness and prevention must overcome certain threshold barriers. In the political context, AIDS awareness often follows only after the economic and social impact of the disease has been credibly demonstrated to those in power.

In the Dominican Republic, for example, senior level policy makers were targeted with an HIV/AIDS presentation, which led to development and effective dissemination of

103

supportive legislation and regulations, enhanced awareness of the epidemic and its implications, better coordination of the country's efforts and subsequent increased national and international donor support. Some lessons learned about HIV/AIDS policy reform are:

- goals must be clearly defined;
- policy decisions should be well-founded in data and analysis; and
- the issues articulated should address the concerns and perceptions of the target audiences.

Another example of a data-driven policy change is Thailand, where the Royal Thai Government (RTG) had failed to respond to the epidemic during its early years. Tourism was fueling the economy and there was a kind of institutional denial of the seriousness of the developing public health crisis. What finally broke through this cycle was better epidemiologic data on seroprevalence, the increasing visibility of people whose disease had progressed to AIDS, and pressure from NGOs. These "triggers" moved the government toward resource-intensive interventions, and formed the basic elements in any policy change.

As Russia's first major law on AIDS was being developed, the AESOP Center in Moscow began a campaign of advocacy and information dissemination that effectively opened up the public discourse beyond the closed circle of "experts" who were drafting the legislation. The mandatory testing provision for all foreigners in Russia was struck, and President Boris Yeltsin under pressure from NGOs vetoed the draft law so that more consensus could be developed. This illustrates the power of NGOs to use democratic processes to have an impact on public health policy, especially when they tap into global electronic information exchange of HIV/AIDS information.

The AIDSCAP Asia Regional Office spearheaded an effort to develop policy review programs that would effectively reach senior policy makers; to provide them with lessons learned and the relevant analogies and experiences of other countries. Indonesian policy makers, for example, used information developed by this program to assist them as they crafted the new National AIDS Strategy.

Another data presentation model that has proven effective is the AIDS Impact Model (AIM). The general goals are to raise awareness of HIV/AIDS among key government and policy decision-makers, and establish the basis for a strong national AIDS program that brings together many sectors of society. In societies where dissemination of information has been inadequate, AIM uses socioeconomic and epidemiological data to develop a computer-based simulation presentation to provide audiences with various scenarios of the epidemic and its potential progress and impact.

(See Abstracts A19–24.)

Communities and the Context of Interventions

COMMUNITY-BASED INTERVENTIONS IN HIV PREVENTION AND CARE

CO-CHAIRS
Dr. Peter Hawley
Whitman-Walker Clinic
Washington, D.C.

Shelly Smith
Peace Corps
Washington, D.C.

Summary

The studies presented here explore a number of inventive interventions aimed at prevention, but not at the care of those living with HIV/AIDS, an emphasis co-chair Peter Hawley hoped could be rebalanced in future. But the question that was central to these explorations is still an important one: How can intervention design be enhanced by, rather than inhibited by, local indigenous culture/environment. Whether it is developing local expressionist theater or targeting the general population while people are stuck in traffic—prevention efforts must be tailored around the cultural circumstances and predispositions of the audience they are reaching to have the greatest impact.

One AIDSCAP-supported initiative in Rio de Janeiro focused on poor and working-class gay men, whose high levels of knowledge about HIV/AIDS are confounded by low rates of risk reduction behavior. This experience underlies the fact that behavior change communication, risk assessment, and general education is not necessarily sufficient to alter behavior. Working in the medium of expressionist theater, a workshop set out to explore sexuality, behavior, and HIV/AIDS, and was so successful in involving people and changing attitudes that it eventually was staged as *Cabaret Prevenção* (Prevention Cabaret) in a professional theater where several thousand people saw it. The primary lesson learned is that a supportive network needs to be developed, and a context created that will affirm the value of safer sexual practices and provide the setting for a positive collective response to the epidemic, within the community the intervention is serving.

The same principle in the APOYEMONOS project in Bogotá, Colombia was extended to the general population by staging highly participatory drama to deliver HIV/AIDS messages, and drawing the audience into the experience. Following the lead of trained actors, people began to reflect and to rediscover capacities and sensibilities that had not been evident in their own thinking about sexuality and the epidemic. The success of these experiences has generated a spontaneous interest—leading to over 500 shows around the city—that perhaps could be extended further, even in rural areas. A project in North West Cameroon used professional dancer Paul Kengmo to devise an appeal based on respect for the local culture and traditions. Such interventions can provide an effective response for populations where mistrust of more western educational messages is high. Communities can be brought into the process and develop their own highly relevant strategies, which reflect beliefs and practices held by community embers and perhaps not readily appreciated or even perceived by "outsiders."

Another study suggests that targeting is most relevant in countries with low HIV prevalence. Further, it suggests that an infected person in a so-called "high risk group" is likely to infect more subsequent partners than is one from the general population. Computer modeling suggests, however, that as the prevalence approaches 5 percent nationwide, it is strategically appropriate to orient the prevention emphasis to the general population.

In Lagos, Nigeria, the traffic jam project demonstrated the possibilities in spreading the word to a non-specific population: all

105

that subjects had in common was that they were stuck in traffic—a common problem in that city where many people spend three-to-four hours a day commuting. When strategies were devised that considered the time, mood and circumstances of the commuters, significant participation and feedback developed, leading to the creation of posters, stickers and pamphlets to deliver the prevention message in a relevant form.

(See Abstracts A25–30.)

TARGETED INTERVENTIONS: COMMUNITIES RESPOND TO THE HIV EPIDEMIC

CO-CHAIRS
Mary Guinn Delaney
National Council for International Health
Washington, D. C.

Dr. Debrework Zewdie
The World Bank
Washington, D. C.

Summary

The concept of lessons learned is perhaps best applied in communities grappling with how to target and individualize their prevention efforts. Lessons may be extremely relevant though limited to a particular situation, widely applicable if adapted to the specific context—or somewhere in between. Some principles which frame the process can be asserted, however. Local and regional expertise is indispensable, often in the form of master trainers. Management and monitoring assistance from the outside can be useful, if applied throughout the entire project cycle. A balance must be struck between helping projects become cost-efficient and sustainable through external coordination and overly formalizing (and distorting) the process. Nonetheless, in the political world of donors and project rationalization, good indicators must be developed, and the consequent knowledge about a project's success clarified and publicized.

The Asia-Pacific Development Communication Center (ADCC) helped to pilot a demonstration training and education program that would train trainers and solidify communication strategies. Lessons learned were that the involved agencies should be eager to collaborate and build capacity, that the process must be balanced and flow both ways, and that trainers need to be carefully selected to be in a position to use their acquired knowledge. Another project in

106

Brazil looked at the training experience of community-based health agents working with sex workers. Each year since 1991, a new wider skill or outreach effort was incorporated onto the basic mission, ultimately taking advantage of a wide range of strategies for intervention (such as networking inside and beyond the community, adding writing and word processing skills, using herbal flower essences to reduce stress, street theater with commercial sex workers and a creative arsenal of inventive ways to disseminate the prevention message).

NGOs are always faced with the decision about how to choose the best interventions. In Nepal, a working group brought together people from major NGOs try to develop guidelines for appropriate and effective material, how to develop autonomy and create a system that would thrive on good and efficient feedback, and how to create ownership of programs. The barriers to such collaboration seem to be political, with personal competition for power and control in the group, and imbalance in the outside power and prestige of the separate groups.

The International HIV/AIDS Alliance is working to strengthen the capacity of local groups to address HIV/AIDS at the community level. The Alliance has assessed NGOs in nine countries to evaluate how they identify and establish their needs, goals and even their perceptions, and develop priorities within the context of local needs as they face their respective community situations.

AIDSCAP's Rapid Response Fund (RFF) focuses on small grants (less than $5,000) for community-based initiatives that could have an immediate impact. During one year, 102 supported activities showed significant impact, in that local NGOs built on a smaller project's success to design larger more long-term programs, and the idea of developing models to be replicated elsewhere and on a larger scale took hold.

(See Abstracts A31–36.)

IMPACT OF CULTURE, SOCIOECONOMIC STATUS AND GENDER ON HIV

Co-Chairs
Elizabeth Preble
FHI/AIDSCAP
Arlington, Virginia

Ana Vasconcelos
Casa de Passagem
Recife, Brazil

Summary

To begin to understand the HIV/AIDS epidemic, it is useful to look at how people think about sexuality and how that determines behavior; a measure has been developed for these factors: Knowledge, attitudes, practices and beliefs (KAPBs). These in turn often seem to be linked in various ways to gender and to socioeconomic status. The entire picture is a jigsaw that may provide insights on how to control and prevent the spread of HIV/AIDS.

Women in half of India's states between ages 13 and 49 who have ever been married show some predictable and some surprising patterns of sexual behavior vis-a-vis HIV/AIDS, but on average their awareness of the disease is sparse. Not surprisingly, those living in cities seem to know more about HIV/AIDS than those in rural areas; education correlates with knowledge, and knowledge correlates with radio and television habits. Thus the wealthier, more educated people know more about the disease. However, urban residents did not consistently identify more ways to prevent HIV/AIDS transmission than did those from rural areas. The question seems to be how better and more creatively to use the mass media to get the messages out to generally poorer and less educated people who normally don't hear them.

The CHAMPS project in South Africa is a care intervention designed to enhance the communities' capacity to respond to the

107

needs of those infected as well as those affected by the virus. It demonstrates the need to deliver more comprehensive support to communities than simply counseling seropositive women one-on-one using field workers, which tends to isolate them, and limit the intervention to information about transmission. Better results might follow by expanding the focus to the family and the community as a whole, delivering care to those whose disease has progressed, and providing a broader range of counseling, directed at life and social skills and parenting.

The younger women in a population who are working also reveal some specific issues that point to the role industry may have in addressing the epidemic. In Mauritius, for example, research indicated that industry-based interventions must be supported by senior administration. They can have significant impact, but they: Should involve families, could dispel myths about HIV infection, should focus on negotiating relationships in changing settings, and should provide training of peer educators.

Two studies on homosexual and bisexual men conducted in Rio de Janeiro provide a lens to look at changes in patterns between 1990 and 1994. What seems to be developing is a greater sense of "sexual subjectivity," which allows for what the researchers call a greater AIDS awareness. This is more than mere knowledge of HIV/AIDS, though the wider dissemination of such knowledge is a prerequisite for it. It has to do with a greater sense of options and power in their sexual lives, a greater efficacy that provides the foundation for behavior change.

Commercial sex workers (CSWs) experience a disheartening vicious cycle, where—in Nepal for example—they resort to this work because of economic hardship (associated with low literacy) and then camouflage their involvement to avoid stigma. Thus, in a context where better condom use could have a dramatic impact on HIV transmission, interventions to educate are difficult to implement. In Rio de Janeiro, CSWs are more accessible, and the Health in Prostitution Project has used training and peer education to reach these lower income CSWs. Improvements were noted in condom use with non-regular sex partners, but not with regular sex partners. Problems persist that seem to go deep into the attitudes of the culture. HIV needs to move beyond the health care context and be included on the agenda of women's groups who are working to wrest greater power and autonomy for women.

(See Abstracts A37–42.)

THE ROLE OF SOCIAL ENVIRONMENT IN HIV RISK BEHAVIOR

CO-CHAIRS
Dr. Michael Merson
Yale University
New Haven, Connecticut

Dr. Godfrey Woelk
University of Zimbabwe
Harare, Zimbabwe

Summary

It has become increasingly apparent that a useful entry into assessing HIV/AIDS risk is the context and social environment in which those at risk live and interpret meaning. The hope is that better understanding of behavior will reveal how to intervene in changing that behavior. For example, the social and economic context in which CSWs, truckers, refugees and laborers exist has a direct impact on their behavior and vulnerability to HIV.

Tens of thousands of Rwandans took refuge in camps in Northwestern Tanzania, where they were housed in close quarters, without work; these factors along with the general state of being displaced, could exacerbate their vulnerability to HIV infection. Rapid and effective intervention strategies that inhibit HIV/STD transmission in such contexts could be very valuable, and the collaborative project being tested include most of the components found in various approaches specially adapted and tuned to the cultural and circumstantial context.

In Thailand, many factories have a large culture of male workers to whom outreach could be directed around the workplace. Peer education was once again confirmed as an excellent framework for delivering prevention messages. After six months of such outreach, the primary gains made were in the number of workers using condoms with commercial sex workers. Changing behavior in the realm of non-commercial or regular sex partners seems to require more specialized communication that delves into the characteristics of the relationship.

In Togo, as many other places, truckers and taxi drivers seem to be at greater risk of contracting HIV. An intervention aimed at their use of condoms increased sales from 35,000 to 140,000 in a year's time. What other changes in knowledge, attitudes, beliefs and practices (KAPBs) occurred is harder to specify, and requires further quantitative analysis; but that information is critical to refine the approaches used and to lay the groundwork for implementing other effective programs nationwide.

The commercial sex industry in the Pacific and Southeast Asia is particularly vulnerable to HIV transmission. In one study, bar and brothel owners were targeted as an entree to the CSWs. Awareness training workshops, condom distribution, and other presentations seemed to work. They not only "opened doors" to CSWs, but also engaged a population that is itself at high risk for HIV/STD, in an active prevention effort.

Some women in this industry do have a high knowledge of HIV, but knew less about reproductive health in general. The use of vaginal lubricants along with education on this subject can prove effective. To the women studied in this Northern Thailand study, a more significant issue is what happens to those with HIV/AIDS when their illness forces them out of commercial sex work and back to their rural villages? Training, particularly in skills that are economically viable, is a useful way to generate supplemental income and provide them (and their dependent children) with a "profession" for their later life. Another problem endemic to the CSW industry, as highlighted in a study in the Philippines, is the number of unidentified and therefore difficult to reach "unregistered" female sex workers. This population frequently has a high incidence of STDs—in this case gonococcal and chlamydial infec-

109

tions—and within the context and nature of their work, have more partners while practicing inconsistent condom use. Thus, developing and disseminating effective interventions is critical to the prevention effort.

(See Abstracts A43–48.)

INVOLVING INDIGENOUS AND TRADITIONAL GROUPS IN HIV PREVENTION

CO-CHAIRS
Paurvi Bhatt
CARE
Atlanta, Georgia

John Rutayuga
Center for Natural and Traditional Medicine
Washington, D.C.

Summary

Experience has shown that local communities need to have a sense of "ownership" when solutions are proposed to local community problems, including HIV/AIDS. And though both the policy component and the local indigenous response must work together effectively, interventions may be perceived from a variety of angles, "top-down" from the policy view, "bottom-up" from the client's view, or from many places in between. In some communities and contexts—especially but not exclusively in developing countries and rural situations—the most significant view is the indigenous one, where the most local understanding and viewpoint is necessary to effectively implement a program. Communication is always a two-way street, and nowhere is this more evident than with HIV/AIDS prevention messages. It is not what is said, but rather what is heard and understood that establishes the reality of a message.

Magic Johnson is one prominent figure who illustrates the power of sports heroes to reach an audience with HIV/AIDS messages; in Lesotho, using the Peer Education model, CARE International has helped Division A football players learn about HIV and about how to spread prevention messages among peers and their fans. After receiving training in HIV/AIDS and education, they have been "incredibly effective" in reaching the general public.

110

Street theater is becoming an increasingly recognized context for effective prevention education. Two projects (in Haiti and Brazil) demonstrate some of the important elements and the reasons why it works. "Going where the people are" can mean not only tapping into an existing event or crowd, but also using local leaders and celebrities to stage or attract one. During Port-au-Prince's "Rara" celebration around Easter, aggressive messages not only reached a specifically targeted high-risk group, but had a significant residual effect in condoms sold thereafter. Commercial sex workers in Rio were trained by a university theater group to stage live skits in public spaces; not only did the group experience heightened awareness and involvement in the prevention issue, but generated public discussion on wider issues such as health, sexuality, living standards and violence.

The term "traditional" embraces a wide variety of customs and individuals who do not fit conveniently within modern lifestyle categories. In Senegal, two different projects illustrate the point. Within the Kolda community, two traditional women's groups, the Dimba (an itinerant ethnic group who make and sell products to enhance sexual pleasure) and the Laobe (whose members focus on fertility and health), were solicited to deliver specific HIV/AIDS awareness and behavior change messages to their respective clientele. These groups enthusiastically participated in the effort to enhance HIV/AIDS awareness and distribute condoms, and the influential role that they maintain with the Kolda residents resulted in significant behavior change.

As suggested in one study, a critical—and in some cases more problematic—piece of the Senegal health and HIV picture are the practitioners of traditional medicine, who treat the majority (perhaps up to 90%) of the sick in Senegal. Traditionally excluded from mainstream medical communications and interaction, they are in the best position to incorporate safe sex messages in their work with the people, especially the most vulnerable younger sectors. Their willingness to do so should be a message to the policy makers to utilize their special talents and access, before the seroprevalence in Senegal reaches a critical level.

(See Abstracts A49–54.)

Specific Strategies and Components of Behavior Change

HIV COUNSELING AND TESTING

CO-CHAIRS
Dr. Jeffrey Harris
Centers for Disease Control and Prevention
Atlanta, Georgia

Dr. Marie Marcell Deschamps
Cornell/Gheskio
Port-au-Prince, Haiti

Summary

The questions that surround HIV testing and counseling center on issues of cost and effectiveness, cultural appropriateness, and impact on behavior. As funds are expended on counseling and testing, such programs will be measured against the efficacy of other prevention interventions and the experience to date of counseling and testing interventions.

In a study presented during this oral session, churches, communities and individual families played a critical role in establishing a community norm which imposed a mandatory screening for HIV before marriage. It was perceived as a way to enhance protection within the community. The primary advantages to the community of testing were the opportunity to discuss risk before marriage, and the establishment of a forum in which women could negotiate safer sex (the need for this social structure in many places arises from the double standard where men entering marriage tend to be older than their partners and more likely to have engaged in premarital sex). The community also believed that testing destigmatized HIV/AIDS by bringing it into the cultural program of a community, and providing incentive for people to adopt protective behaviors.

In South Africa, problems with the testing and counseling process may alert other countries to how best to approach the issue. If counselors are not trained to look at a patient's cultural and personal context, then the encounter may focus unduly on the test outcome, and have little effect on a patient's understanding and hence prospects for behavior change. In Tanzania—a country with a mature epidemic—a large randomized trial is being conducted as part of a joint World Bank/USAID study to examine the efficacy, cost-effectiveness and impact of counseling and testing on prevention and care. Among other issues to be considered in the study is the development of a rational model to help determine appropriate levels of resources for counseling and testing versus other interventions.

A critical issue for prevention focuses on how people cognitively and imaginatively come to perceive their situation when trying to assess risk. One priest in Tanzania saw his parishioners caught in a religious/political squeeze between church dogma and aggressive condom social marketing programs. He devised an elegant and relevant metaphor (in his book *Fleet of Hope*) to try to destigmatize and facilitate their decision-making with a simple model for personal risk assessment. The HIV/AIDS epidemic is styled as a flood, with a tide of rising water, and three "boats" are offered to people—the boats of abstinence, fidelity and technology (condoms)—which they must choose and perhaps change as their circumstances and beliefs may change throughout their lives.

Another way to facilitate individuals' thinking is by appealing to the universal capacity to "see" and to visualize a situation graphically. RiskAdvisor is a computer-based interactive tool that provides an analog way to evaluate the cumulative impact of an individual's various behaviors. The outcome is a simple bar chart, which even the illiterate can comprehend in a useful way. Further, it was found that people are not only attracted to and engrossed in computers, but are actually more honest in inputting their personal

112

data on behaviors since they see the "machine" as the epitome of non-judgmental social science. The problem, of course, is the availability of computers, though AIDSCAP/Nepal has created a pen and paper version of the tool that at least maintains the visual output aspect.

(See Abstracts A55–60.)

HIV EDUCATION: WORKING WITH THE MEDIA

CO-CHAIRS
Bunmi Makinwa
FHI/AIDSCAP Africa Regional Office
Nairobi, Kenya

Martina Clark
International Community of Women Living with HIV/AIDS
New York, New York

Summary

The mass media in one form or another—newspapers, radio, television and distribution of posters and written information—has the power to reach vast numbers of the global populations. How this means of communication might be better harnessed to educate and inform people is not a single, nor a simple question. A number of the traditional lessons learned and issues that surround HIV prevention are relevant when the mass media are considered, for example:

(1) Given the power and resources behind these media, it may be more effective to focus HIV/AIDS information, education and communication (IEC) at the gatekeepers (policy and decision makers and the editorial levels of the media themselves).
(2) The private sector has not only financial but also tremendous creative resources that can be brought to crafting behavior change messages.
(3) IEC material will be more effective the more target audiences participate in its development.
(4) Different media have different reach, and should be tailored accordingly.
(5) Radio can be effective to reach large populations, both literate and non-literate.
(6) Fear-based messages empty of content still occur, despite research indicating they are not effective.
(7) Messages need to be tailored to the audience.

113

Comprehensive communication planning is the key to avoiding some of the problems that have developed: ineffective, fear-based messages; campaigns targeting too many audiences with a confusing array of messages, and a long-standing perception that mass media cannot have a real impact on risky behaviors.

A study on communication training workshops showed that media-targeted programs can produce higher quality reporting. Since few in the general media can specialize in HIV/AIDS, they must be sensitized to the field and the crucial issues, and provided with the documentation they need for support and background. This may lead to a needed consistency among press editors and radio and TV producers on editorial policies governing their coverage.

Getting feedback and community input can take various forms, and one private sector and AIDSCAP initiative in São Paulo developed an extensive battery of questions by interviewing some thousand low income female sex workers. These queries about HIV/AIDS/STD, sexuality, gynecology and drug use were collected, answered and put into a book that has found its way to thousands of other sex workers. A comprehensive multifaceted intervention was built on the book, showing how private sector leveraging and listening closely to the input of target populations can produce dramatic results. Another project in the Dominican Republic saw the development of a newsletter by and for female sex workers whose insights and relevance have led to demonstrable behavior change.

The question of what sort of message will work has been at the heart of much academic research for years, and the consensus has developed in those quarters that fear-based messages without content do not work well. Many field-based practitioners, however, disagree, and find efficacy in these sorts of IEC messages. An AIDSCAP-funded study is looking into this debate to better understand the divergences of these two sets of professionals and to explore cross-communication and how lessons learned can be shared.

(See Abstracts A61–66.)

114

HIV AND YOUTH: MEETING THE CHALLENGE

CO-CHAIRS
Mark Connolly
UNICEF
New York, New York

Jecenia de Jesus
International Community of Women Living with HIV/AIDS
New York, New York

Summary

The HIV/AIDS epidemic's patterns continually change, and one of the most troubling recent trends is the increased incidence among youth. While various theories may explain this pattern, efforts to reverse it run headlong into a number of issues and problems that are unique to dealing with young people. Some basic themes emerged across much of the discussion and most of the studies:

- Communication barriers—cultural taboos, awkwardness, discomfort and failing to adopt the right language and approaches—inhibit frank discussion of sexuality with youth, but young lives are the casualty. At the same time, the knowledge they already possess should not be underestimated. Teachers may be helped in overcoming cultural barriers to delivering information by co-presentations and strategic alliances with health professionals.
- To be effective in HIV/AIDS prevention, discussions with youth need to cover all of the difficulties and challenges they face—home life, violence, drugs, sexual and child abuse and self-esteem. Skills that should be developed are coping and learning more generally, including dealing with their own emergent sexuality.
- Information is generally more effective when it comes from peers, though parents have a role—which they too often are not fulfilling—as providers of information and as role models on sexuality. The church can help encourage parents to participate in youth education programs. Mothers and daughters are best approached, educated and counseled together.
- The most achievable norm is better HIV/AIDS education; trying to impose normative standards or to change behavior turn out to be more challenging measures to capture and to develop. And yet these present vital opportunities for reaching youth and "nipping the epidemic in the bud."

Myths and misconceptions about sexuality are commonplace, and in some countries sexual activity is initiated at a very early age. Since talking about sex and carrying condoms may bring a label of promiscuity, some of the basic strategies for prevention are made more difficult to implement. The image and ideal of virginity is found across many cultures and contexts; in one study, it was seen as an underlying factor that promoted alternatives to penetration and thus inhibited the spread of STDs. In other cultures, it promotes behaviors that actually may enhance the risk of infection with STDs or HIV.

The challenge—which is only heightened with young people—is to ground behavior change in new ways of thinking that are likely to be sustained. But the opportunities to set a pattern are correspondingly greater with those whose development is just underway, and whose patterns are more likely to be peer-driven than habitual. In cultures where HIV/AIDS presents a particular threat because of the current state of the epidemic or cultural sexual practices, the challenge and the opportunity to reach the young should perhaps receive the highest priority.

(See Abstracts A61–72.)

115

CONDOM SOCIAL MARKETING: GENERATING AND MEETING THE DEMAND FOR CONDOMS

CO-CHAIRS
Dr. Shelagh O'Rourke
USAID
Port-au-Prince, Haiti

Dr. Judith Timyan
Population Services International
Washington, D.C.

Summary

Of the many approaches that have developed during the HIV/AIDS epidemic to combat the spread of the disease, the use of condoms remains one of the most demonstrably effective. Condom Social Marketing (CSM) adresses: How best to get condoms to those who need them; and how to develop the awareness among those at risk that they should use condoms. One of the presenters insisted that it is impossible to overspend on advertising and condom promotion programs—with the proviso that they be well conceived and executed.

While the market is not strictly capitalistic—given the involvement of so many different economic systems and massive donor funding from USAID and others—condom social marketing is still primarily driven by market forces of supply and "demand," (where many programs exist to generate and spur that demand by aggressively promoting their use and benefits). In 1994, 560 million condoms were distributed by CSM programs in 43 countries.

These overall numbers are merely suggestive; a number of ways of measuring results against goals for specific areas and target audiences are being evaluated. In Haiti, even during times of extreme economic and political duress, when much of the public health service delivery was hampered, the CSM programs were surprisingly effective. NGOs there have creatively expanded the number of non-traditional outlets, and thus reached more needy clients.

It is with the public sector programs and distribution systems that so many problems continue to be seen. Much of the blame for this can be laid to factors that affect other social service government programs; failure to establish effective distribution as a goal early in the planning and policy process; inefficient bureaucracy that is not dedicated to successfully serving the client; insufficient technical training; and, because of these, little sense of ownership among workers of the goals and success of the distribution program. One recently developed forecasting model (FOCUS) has shown promising results, however, and may well provide a greater impetus for many countries to implement and improve the "forecasting need" component into their national HIV/STD programs.

Another logistics management project (supported by USAID and AIDSCAP), this one in Brazil, is developing muscular and transferrable models (including strategies, systems and practical steps) that could be used by public health systems in governments worldwide.

(See Abstracts A73–78.)

116

INTERVENTIONS RESEARCH: NEW STRATEGIES AND METHODS

CO-CHAIRS
Dr. David Wilson
University of Zimbabwe
Harare, Zimbabwe

Siri Wood
Christian Reformed World Relief Committee
Dakar, Senegal

Summary

The traditional conventions that separate research and intervention have given way to a new strategic approach to research. The increasing presence of participatory data collection and evaluation; the direct and vital importance of the information to the subjects who flesh out the studies; and the urgency of turning academic insights into workable interventions, have all spawned what is now more commonly referred to as interventions research. Many programs are being examined through this lens for their applicability and possible transference nationally and globally.

For example, the crucial importance of community involvement is reinforced in the Rakai AIDS Information Network (RAIN) system in Uganda, where involving local leaders promotes community ownership of the prevention effort, and fosters creative problem solving; the more the community is involved, the better utilized are services.

The Bangkok Behavioral Science surveys help target certain high risk behaviors and point toward specific interventions. The system can also measure whether a set of interventions have met their goal(s). Thus strategy about new interventions can be based on very specific and local data; the data also provide a useful policy tool for advocacy and fundraising. The Rapid Ethnographic Assessment Protocol (REAP) in Indonesia provides a solid epidemiological basis for designing specific prevention interventions. This project demonstrates how researchers may need to balance quantitative data collection with qualitative research, depending on the logistical barriers to the former and on the urgency to develop and disseminate effective prevention strategies.

The collective global experience has shown that when interventions occur in closed environments such as the Thai Army, significant behavior change is effected, at least in that context; but there is also evidence that results of the lessons learned persist after men returned to their home communities. After a generally short episode of increased risk behavior, the subjects manifested a decrease HIV risk thereafter. CARE's program in Vietnam similarly demonstrated residual impact from reorienting research away from "at-risk groups" to risky behaviors.

(See Abstracts A79–84.)

117

CASE MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES

CO-CHAIRS
Dr. King Holmes
University of Washington
Seattle, Washington

Colonel Mpoudi Ngole Eitel
National AIDS Control Program
Yaoundé, Cameroon

Summary

Health professionals and communities have been responding to sexually transmitted diseases (STDs) far longer than the advent of the HIV/AIDS epidemic. As greater integration is established between programs and within services, the distinction becomes less useful in some contexts than in others. There has long been anecdotal and clinical evidence about the link between how people are treated for a disease and how that disease progresses in a group or population. With an infectious situation involving sexual transmission, partner referral assumes a central significance. The crucial bottom line is that diagnosing and treating STDs reduces their transmission and also the chances of HIV infection during sexual contact.

Six studies begin to flesh out some of the details behind these generalizations. They look at how clinics may be run, some ways they—and particularly the prescription of treatments—may be improved, and how we can begin to understand the integral practice of how partners affect one another. As always, clinical insights must be translated from the bottom up, and incorporated into vertical policy initiatives that inform the entire system. This seems of particular importance for the management of STDs.

Several opportunities to improve the case management of STDs were identified and discussed. One significant issue is getting patients (and their partners) into clinics in a timely fashion, once symptoms appear; important factors in achieving this behavior are: Patients/general public perception of the clinics, patient counseling and education in general. Once at clinics, an effective system would require that certain types of service be provided; that the clinic have an efficient delivery system; that a risk assessment be conducted; that effective drugs be prescribed; that counseling and condoms be provided; and that the client become an important and effective element of the strategy to bring in her or his partner for diagnosis and treatment; this includes recognizing symptoms.

Policies concerning who can prescribe which drugs and treatments need to be revisited. Urethritis is an example, comprising (for example in Brazil) over 50% of the STD occurrences. If a majority of men self-treat for this problem, then the crucial interface with the health delivery system is the pharmacy. Though pharmacists are not formally trained in diagnosis, under such circumstances their decisions about what to prescribe become a central link in STD treatment and therefore transmission. Resisting this de facto situation seems unproductive in the short term, since pharmacists and other such providers could become a more effective component in the war on HIV/AIDS.

How clinics might improve their delivery systems requires assessment of the current situation as well as finding the most effective and efficient way to train and educate staff to improve in weak areas. But since so many of those affected do not find their way to clinics, other ways to reach and treat them must be improved. Elements of an effective treatment strategy can be constructed without the clinic-based model; ideally there should be general peer education, risk assessment by a peer health educator, STD drug treatment, and proper response to symptoms through syndromic STD case management. Outside of the clinic, issues that surround privacy, convenience of the service (location and times available), confidentiality and effective targeted treatment kits are all opportunities to improve the existing system.

118

Conference Agenda

119

Agenda

DAY ONE

August 7, 1995
Monday Morning

KEYNOTE SESSION

J. Brian Atwood
- Keynote address

Patricia Fleming
- A Pandemic Without Borders: U.S. Interests in HIV/STD Prevention Worldwide

Eustace Muhondwa
- Dynamic Epidemic, Evolving Responses: A Developing Country Perspective

Jecenia de Jesus
- Evolving Responses, New Bridges, New Partners: Insights and Concerns from a Person Living with HIV

PLENARY SESSION 1

Key Issues for the Second Decade: Part I

June Osborn
- HIV/AIDS Advocacy and Human Rights

Duff Gillespie
- HIV/STD and Reproductive Health: Challenges and Synergies in the Population, Health and Nutrition Sector

Peter Lamptey
- Comprehensive HIV/STD Prevention Programs

Peter Piot
- UNAIDS: Toward an Expanded Response to the HIV/AIDS Epidemic

Monday Afternoon and Evening

ORAL SESSIONS

- HIV and Youth: Meeting the Challenge
- Case Management of Sexually Transmitted Diseases
- Policy Dialogue: What It Is and How to Use It

120

ROUNDTABLES 1–4
meet for two working sessions around dinner break

1. Prevention and Care: Implications for Program Improvement and Sustainability

2. Behavior Change Communication: Selecting Strategies to Suit Specific Audiences and Settings

3. Community Participation and Sustainability: Increasing Participation of and Advocacy for Beneficiary Communities in HIV/AIDS Programming

4. Protecting, Respecting, and Strengthening Human Rights: Ethical Dilemmas in Clinical Practice

DAY TWO
August 8, 1995
Tuesday Morning

PLENARY SESSION II

Key Issues for the Second Decade: Part 2

Daniel Tarantola
- High-Risk Settings: Structural-Environmental Influences on HIV/STD Risk Behavior

Geeta Rao Gupta
- Sexuality and Gender Relations: Implications for HIV/STD Programs and Policies

Elizabeth Reid
- Meanings of Sustainability for HIV/STD Programs: From Financial Independence to Long-Term Behavior Change

Timothy Wirth
- The New United States HIV/AIDS Initiative

ORAL SESSIONS

- The HIV/AIDS Prevention and Care Continuum
- Condom Social Marketing: Generating and Meeting the Demand for Condoms
- Intervention Research: New Strategies and Methods

Tuesday Afternoon and Evening

ORAL SESSIONS

- Community-based Interventions in HIV Prevention & Care
- Pros and Cons of Integrating HIV/STD Services into Other Health Services
- Impact of Culture, Socioeconomic Status and Gender on HIV

ROUNDTABLES 5–8
meet for two working sessions around dinner break

5. Benchmarks, Performance Indicators and Evaluation of HIV/STD Interventions: How Do We Measure Intervention Results?

6. Pros and Cons of Merging HIV and/or STD Services into Other Health and Family Planning Services

7. HIV Counseling for Behavior Change: Available Approaches and Their Requirements and Uses

8. Building Bridges Among Communities to Introduce New HIV/STD Products

DAY THREE

August 9, 1995
Wednesday Morning

All Roundtable Groups continue working sessions

ORAL SESSIONS

- Involving Indigenous and Traditional Groups in HIV PRevention
- The Role of Social Environment in HIV Risk Behavior
- HIV Education: Working with the Media

Wednesday Afternoon

ORAL SESSIONS

- Targeted Interventions: Communities Respond to the HIV Epidemic
- HIV Counseling and Testing
- The Private Sector Response to HIV/AIDS

CLOSING/PLENARY SESSION III

Roundtable Chairs Report to Conference

- Evolving U.S. Responses to HIV/AIDS in the Developing World: A Symposium and Observations by:

Jeffrey Harris
Helene Gayle
Jacob Gayle
Eric Sawyer
Anne Keatley Solomon

Sally Shelton
- Closing remarks

Roundtable Participants

Roundtable Participants

ROUNDTABLE ONE

PREVENTION AND CARE: IMPLICATIONS FOR PROGRAM IMPROVEMENT AND SUSTAINABILITY

Author:
Fernando Zacarías
Pan American Health Organization
Washington, D.C.

Chair:
Shaun Mellors
GNP+
Amsterdam, The Netherlands

Panelists:
Janet Mitchell
Harlem Hospital
New York, New York

Elizabeth Madraa
AIDS Control Programme
Entebbe, Uganda

Respondents:
Kate Bond
Chiang Mai University
Chiang Mai, Thailand

Eddy Génécé
FHI/AIDSCAP Haiti Country Office
Port-au-Prince, Haiti

ROUNDTABLE TWO

BEHAVIOR CHANGE COMMUNICATION: SELECTING STRATEGIES TO SUIT SPECIFIC AUDIENCES AND SETTINGS

Author:
Peter Aggleton
University of London
London, United Kingdom

Chair:
Faustin Yao
Global Programme on AIDS
World Health Organization
Geneva, Switzerland

Panelists:
Danuta M. Kasprzyk
Battelle Seattle Centers
Seattle, Washington

Souleymane Barry
USAID
Abidjan, Côte d'Ivoire

Respondents:
Richard Parker
ABIA
Rio de Janeiro, Brazil

Pawana Wienrawee
FHI/AIDSCAP, Thailand Country Office
Bangkok, Thailand

125

ROUNDTABLE THREE

COMMUNITY PARTICIPATION AND SUSTAINABILITY: INCREASING PARTICIPATION OF AND ADVOCACY FOR BENEFICIARY COMMUNITIES IN HIV/AIDS PROGRAMMING

Author:
Richard Buryzinski
ICASO
Ottawa, Canada

Chair:
Purnima Mane
UNAIDS
Geneva, Switzerland

Panelists:
Vera Paiva
University of São Paulo
São Paulo, Brazil

Arturo Gonzales Cristobal
Philippines HIV/AIDS Support Program
Manila, Philippines

Respondents:
Ioanna Trilivas
International HIV/AIDS Alliance
London, United Kingdom

Warren Coetzer
NAPWA
Durban, South Africa

ROUNDTABLE FOUR

PROTECTING, RESPECTING, AND STRENGTHENING HUMAN RIGHTS: ETHICAL DILEMMAS IN CLINICAL PRACTICE

Author:
Carel IJsselmuiden
Medical University of South Africa
Johannesburg, South Africa

Chair:
Peter Weller
University of the West Indies
Kingston, Jamaica

Panelist:
Monica Gogna
Centro de Estudios de Estado Y Sociedad (CEDES)
Buenos Aires, Argentina

Respondents:
Yolanda Simon
CARE
Port of Spain, Trinidad

Julie Hamblin
Ebsworth and Ebsworth Solicitors
Sydney, Australia

David Patterson
Canadian HIV/AIDS Legal Network
Montreal, Canada

126

ROUNDTABLE FIVE

BENCHMARKS, PERFORMANCE INDICATORS, AND EVALUATION OF HIV/STD INTERVENTIONS: HOW DO WE MEASURE INTERVENTION RESULTS?

Author:
Thierry Mertens
Global Programme on AIDS
World Health Organization
Geneva, Switzerland

Chair:
Doris Storms
PVO Child Survival Support Program
Johns Hopkins University
Baltimore, Maryland

Panelists:
Susan Hassig
FHI/AIDSCAP
Arlington, Virginia

Maxine Wedderburn
Hope Enterprises
Kingston, Jamaica

Respondent:
Tim Brown
East-West Center
Honolulu, Hawaii

ROUNDTABLE SIX

PROS AND CONS OF MERGING HIV AND/OR STD SERVICES INTO OTHER HEALTH AND FAMILY PLANNING SERVICES

Author:
Bart Criel
Institute of Tropical Medicine
Antwerp, Belgium

Chair:
Marjorie Muecke
The Ford Foundation
New York, New York

Panelists:
Mamadou Diallo
Project Retro-CI
Abidjan, Côte d'Ivoire

Peter Figueroa
Ministry of Health
Kingston, Jamaica

Respondents:
Julie Becker
International Planned Parenthood Federation
New York, New York

James Shelton
USAID
Washington, D.C.

ROUNDTABLE SEVEN

HIV COUNSELING FOR BEHAVIOR CHANGE: AVAILABLE APPROACHES AND THEIR REQUIREMENTS AND USES

Author:
Olga Grinstead
Center for AIDS Prevention Studies
University of California, San Francisco
San Francisco, California

Chair:
Kevin O'Reilly
Global Programme on AIDS
World Health Organization
Geneva, Switzerland

Panelists:
Julio Désormeaux
Centres pour le Développement et la Santé
Port-au-Prince, Haiti

Sevgi Aral
Centers for Disease Control and Prevention
Atlanta, Georgia

Respondent:
Gloria Sangiwa
Muhimbili University
Dar es Salaam, Tanzania

ROUNDTABLE EIGHT

BUILDING BRIDGES AMONG COMMUNITIES TO INTRODUCE NEW HIV/AIDS PRODUCTS

Author:
Lori Heise
Pacific Institute for Women's Health
Washington, D.C.

Chair:
Zena Stein
Columbia University
New York, New York

Panelists:
Muriel Harris
Society of Women and AIDS in Africa
Freetown, Sierra Leone

Lee Claypool
CONRAD Program
Arlington, Virginia

Respondents:
Edna Viruell
Center for Women's Policy Studies
Washington, D.C.

Iris Long
ACT UP
New York, New York

128

Roster of Oral Sessions

129

Issues Cutting Across the Prevention and Care Continuum

THE HIV/AIDS PREVENTION AND CARE CONTINUUM

CO-CHAIRS:
Bulya-Rose Kizito
The AIDS Support Organization
Kampala, Uganda

Janet Mitchell
Harlem Hospital
New York, New York

Male STD health-care-seeking behavior in Bangkok, Thailand
Presenter: Gina Dallabetta, FHI/AIDSCAP
For: Patchara Benjarattanaporn
FHI/AIDSCAP Asia Regional Office
Bangkok, Thailand

Communications for sexually transmitted disease programs: An opportunity for innovation
Presenter: Annette E. Ghee
University of Washington at Seattle
Seattle, Washington

AIDS/STD prevention programs that rely on South African and Mozambican traditional healers
Presenter: Edward Green
Mozambique Ministry of Health
Maputo, Mozambique

Closing the gap: Care is a form of prevention
Presenter: Joan MacNeil
FHI/AIDSCAP
Arlington, Virginia

A targeted intervention research study for STD program design in Senegal
Presenter: C. Ibrahima Niang
Université Cheikh Anta Diop
Dakar, Senegal

The fourth pillar of HIV prevention: Linking social support to education, medical care, and condom accessibility—the case of men's outreach in Santa Cruz, Bolivia
Presenter: Timothy Wright
Programa Colaborativo de Prevencion y Control de ETS/SIDA
Santa Cruz, Bolivia

130

PROS AND CONS OF INTEGRATING HIV/STD SERVICES INTO OTHER HEALTH SERVICES

CO-CHAIRS:
Pat Pongswatanakusira
Health Center 9
Bangkok, Thailand

James Foreit
The Population Council
Washington, D.C.

Review of studies among injecting drug users in metro Cebu, Philippines
Presenter: Carmina Aquino
Program for Appropriate Technology in Health (PATH)
Makati, Metro Manila, Philippines

Integration of HIV/AIDS prevention and family planning in a community setting in Honduras: Colonia la laguna
Presenter: Ritza A. de Briseno
ASHONPLAFA (Asociacion Hondurena de Planificacion de Familia)
Tegucigalpa, Honduras

STD/HIV prevention for STD clinic attenders
Presenter: Bernadette Hadden
University of Natal
Durban, South Africa

Challenges in integrating HIV/STD prevention and family planning
Presenter: Julie Becker
International Planned Parenthood Federation
New York, New York

Integration of reproductive tract infection (RTI) services into a family planning clinic in Kenya: Cost recovery issues
Presenter: M.K. Kairu
CEDPA Regional Office
Nairobi, Kenya

Promotion of standard STD case management guidelines in Nepal
Presenter: Doris Mugrditchian
FHI/AIDSCAP Asia Regional Office
Bangkok, Thailand

131

THE PRIVATE SECTOR RESPONSE TO HIV/AIDS

CO-CHAIRS:
William Schellstede
FHI/AIDSCAP
Arlington, Virginia

B.J. Stiles
National Leadership Coalition on AIDS
Washington, D.C.

Condom social marketing experience in Brazil
Presenter: Carlos Ferreros
DKT do Brasil
São Paulo, Brazil

AIDS prevention and sustainable development
Presenter: G.C. Lodha
Seva Mandir
Udaipur, India

Technology transfer of HIV diagnostic kit production into the developing world and the establishment of a south-south network of diagnostics manufacturers
Presenter: Melinda Moree
Program for Appropriate Technology in Health
Seattle, Washington

Mobilizing the business sector to respond to the HIV/AIDS crisis in Africa: Findings and experiences of the private sector AIDS policy presentation (PSAPP) activity
Presenter: Andrew Nyamete
For: Matthew Roberts
FHI/AIDSCAP
Arlington, Virginia

Advocacy tool for private sector initiatives to develop workplace policy and programs to control AIDS
Presenter: Saraswathi Sankaran
Deepam Educational Society for Health
Madras, India

Promoting a sense of ownership as a critical aspect of capacity building
Presenter: Pawana Wienrawee
FHI/AIDSCAP Thailand Country Office
Bangkok, Thailand

132

POLICY DIALOGUE: WHAT IT IS AND HOW TO USE IT

CO-CHAIRS:
Jeff Levi
Office of National AIDS Policy
Washington, D.C.

Anthony Schwarzwalder
FHI/AIDSCAP
Arlington, Virginia

Building alliances across borders: Women networking on HIV/AIDS prevention in Southeast Asia
Presenter: E. Maxine Ankrah
FHI/AIDSCAP
For: Singhanetra Renard Anchalee
Chiang Mai University
Chiang Mai, Thailand

AIDS policy program in the Dominican Republic: Keeping AIDS in the agenda
Presenter: Martha Butler de Lister
FHI/AIDSCAP Dominican Republic Country Office
Santo Domingo, Dominican Republic

Spidnet: a tool forRussian AIDS policy
Presenter: Kevin Gardner
AESOP Center
Moscow, Russia

The impact of policy study programs: The case of Indonesia
Presenter: Suriadi Gunawan
Ministry of Health
Jakarta, Indonesia

From denial to response: Factors influencing the evolution of HIV/AIDS prevention policies of the royal Thai government (RTG)
Presenter: Neil Brenden
FHI/AIDSCAP Asia Regional Office
For: Y. Porapakkham
ASEAN Institute for Health Development (AIHD)
Bangkok, Thailand

Raising awareness about HIV/AIDS in Kenya: An application of the AIDS impact model (AIM)
Presenter: John Stover
The Futures Group International, Inc.
Glastonbury, Connecticut

133

Communities and the Context of Interventions

COMMUNITY-BASED INTERVENTIONS IN HIV PREVENTION AND CARE

CO-CHAIRS:
Peter Hawley
Whitman-Walker Clinic
Washington, D.C

Shelly Smith
Peace Corps
Washington, D.C

Cabaret prevenção: Expressionist theatre and HIV/AIDS prevention for men who have sex with men in Brazil
Presenter: Vagner de Almeida
ABIA
Rio de Janeiro, Brazil

Behavioral interventions for reduction of HIV/STD transmission among female sex workers and male clients in Bali, Indonesia
Presenter: Kathleen Ford
University of Michigan
Ann Arbor, Michigan

Targeting interventions for the prevention of HIV infection in developing countries: When to begin targeting non-core groups
Presenter: Julie Denison
For: Munkolenkole Kamenga
FHI/AIDSCAP
Arlington, Virginia

Community-based AIDS education and prevention in nine Menoua villages of western Cameroon
Presenters: Cynthia E. Mariel and Pierre-Marie Metangmo
For: Paul Kengmo
Baobab International
Washington, D.C

An innovative initiative for targeting commuters in traffic jams in Lagos, Nigeria, through the AIDSCAP rapid respond fund
Presenter: Juliana Umozurike
FHI/AIDSCAP Nigeria Country Office
Lagos, Nigeria

Alternative communication: A preventive strategy
Presenter: Manuel Velandia
APOYEMONOS (Fundacion Colombiana de Apoyo en Sida Hepatitis y Enfermedades de Transmision Sexual)
Bogotá, Colombia

134

TARGETED INTERVENTIONS: COMMUNITIES RESPOND TO THE HIV EPIDEMIC

CO-CHAIRS:
Mary Guinn Delaney
National Council for International Health
Washington, D.C.

Debrework Zewdie
The World Bank
Washington, D.C.

Developing a center of excellence in HIV/AIDS training
Presenter: Neil Brenden
For: Chalintorn Burian
FHI/AIDSCAP, Asia Regional Office
Bangkok, Thailand

Rapid response funds: Supporting community-based initiatives in HIV prevention
Presenter: Wendy Githens
FHI/AIDSCAP
Arlington, Virginia

Enhancing NGO capacities in HIV/AIDS materials development: Experiences from Nepal's NGO IE&C coordination committee
Presenter: Navin Pyakuryal
Save the Children U.S.
Kathmandu, Nepal

Maintaining enthusiasm to sustain HIV peer education in Zimbabwe: Experiences to be shared
Presenter: Thabani Sibanda
University of Zimbabwe
Harare, Zimbabwe

Evolving training needs of community-based health agents in a long-term commercial sex workers' AIDS prevention project
Presenter: Celia Szterenfeld
Institute of Religious Studies
Rio de Janeiro, Brazil

Local NGO perceptions of HIV/AIDS needs and priorities
Presenter: Ioanna Trilivas
International HIV/AIDS Alliance
London, United Kingdom

135

IMPACT OF CULTURE, SOCIOECONOMIC STATUS, AND GENDER ON HIV

CO-CHAIRS:
Elizabeth Preble
FHI/AIDSCAP
Arlington, Virginia

Ana Vasconcelos
Casa de Passagem
Recife, Brazil

Knowledge of AIDS in India
Presenter: Deborah Balk
East-West Center
Honolulu, Hawaii

Sexual behavior and condom use by sex workers in Nepal
Presenter: Benu Karki
National Centre for AIDS and STD Control (NCASC)
Kathmandu, Nepal

Sexual behavior and behavior change among men who have sex with men in Brazil, 1989–1994
Presenter: Richard Parker
For: Murilo Mota
ABIA
Rio de Janeiro, Brazil

Community HIV/AIDS pilot project (CHAMPS) phase 1
Presenter: Sbongile Manyathi
NACCW
Johannesburg, South Africa

Sexual decision making and AIDS risk among young unmarried working women in Mauritius
Presenter: Jean Schensul
Institute for Community Research
Hartford, Connecticut

Monitoring of condom use by female sex workers in Rio de Janeiro and implications for participatory education in AIDS prevention
Presenter: Celia Szterenfeld
For: Christopher Peterson
Institute of Religious Studies (ISER)
Rio de Janeiro, Brazil

136

THE ROLE OF SOCIAL ENVIRONMENT IN HIV RISK BEHAVIOR

CO-CHAIRS:
Michael Merson
Yale University
New Haven, Connecticut

Godfrey Woelk
University of Zimbabwe
Harare, Zimbabwe

AIDS prevention in a society in crisis: The case of Rwanda refugees in Tanzania
Presenter: Judy A. Benjamin
CARE International/Tanzania
Dar es Salaam, Tanzania

Men involved in the commercial sex industry and HIV/AIDS prevention in Puerto Plata, Sosua, and Montellano
Presenter: Milanes De Castro
Comité de Vigilancia y Control del SIDA
Santo Domingo, The Dominican Republic

Lessons learned from HIV risk reduction interventions in rural brothels in northern Thailand
Presenter: Kate Bond
For: David Celentano
Johns Hopkins University
Baltimore, Maryland

Togolese transporters against AIDS: Impact of an education intervention (april 1992 to september 1994)
Presenter: Marcelle Chevallier
CARE International/Togo
Lomé, Togo

Comparison of STD prevalence and the behavioral correlates of STD among registered and unregistered female sex workers (FSW) in Manila and Cebu City, Philippines
Presenter: Annette Ghee
University of Washington
For: Teodora Wi
FHI/AIDSCAP, Philippines Country Office
Manila, Philippines

Behavioral effects of HIV outreach communication and peer education to male laborers in factories in Bangkok, Thailand
Presenter: Pawana Wienrawee
FHI/AIDSCAP Asia Regional Office
For: S. Wongsawat
ASEAN Institute for Health Development
Phuttamonton, Thailand

137

INVOLVING INDIGENOUS AND TRADITIONAL GROUPS IN HIV PREVENTION

CO-CHAIRS:
Paurvi Bhatt
CARE
Atlanta, Georgia

John Rutayuga
Center for Natural and Traditional Medicine
Washington, D.C.

Lesotho footballers against AIDS: An innovative approach to AIDS education
Presenter: J.S. Anderson
CARE International/Lesotho
Maseru, Lesotho

Haiti condom social marketing program, "rara" celebration: Integrating cultural activities with condom promotion and sales
Presenter: Bertrovna Grimard
Population Services International/Haiti
Port-au-Prince, Haiti

The role of traditional medical practitioners in preventing the spread of HIV in Senegal
Presenter: Kaiya Montaocean
Center for Natural and Traditional Medicines
Washington, D.C.

Integration of traditional women's associations in HIV prevention in Kolda, Senegal
Presenter: Helene Benga
For: Cheikh I. Niang
Université Cheikh Anta Diop
Dakar, Senegal

A community-based approach to behavior change: HIV/AIDS and STD education among Devadaasi women and their community, experiences from rural Karnataka, India
Presenter: Sudha Sivaram
Plan International
Warwick, Rhode Island

The use of street theater in commercial sex workers AIDS prevention and citizenship education
Presenter: Celia Szterenfeld
Institute of Religious Studies
Rio de Janeiro, Brazil

138

Specific Strategies and Components of Behavior Change

HIV COUNSELING AND TESTING

CO-CHAIRS:
Jeffrey Harris
Centers for Disease Control and Prevention
Atlanta, Georgia

Marie Marcell Deschamps
Cornell/Gheskio
Port-au-Prince, Haiti

Premarital screening for human immunodeficiency virus infection: Issues to consider
Presenter: Munkolenkole Kamenga
FHI/AIDSCAP
Arlington, Virginia

High-risk behavior and AIDS testing among married respondents in Uganda
Presenter: Karungari Kiragu
Johns Hopkins University
Baltimore, Maryland

Responding to the HIV epidemic in a rural district health service in northern Kazulu, South Africa
Presenter: Nicol Coetzee
Columbia University
For: David McCoy
Hlabisa Hospital
Hlabisa, South Africa

Does the "fleet of hope" hold water? An evaluation of a controversial campaign to provide a personal assessment of risk
Presenter: Penina Ochola
FHI/AIDSCAP Tanzania Country Office
For: Tim Manchester
Population Services International
Dar es Salaam, Tanzania

A study of the impact of HIV counseling and testing on behavior change in Tanzania: Justification and methods
Presenter: Gloria Sangiwa
Muhimbili University
Dar es Salaam, Tanzania

Risk advisor: A computer-based, interactive tool for risk assessment and risk reduction counseling
Presenter: Scott Wittet
Program for Appropriate Technology in Health
Seattle, Washington

139

HIV EDUCATION: WORKING WITH THE MEDIA

CO-CHAIRS:
Bunmi Makinwa
FHI/AIDSCAP, Africa Regional Office
Nairobi, Kenya

Martina Clark
International Community of Women Living with HIV/AIDS
New York, New York

The role of the media in the developing world in HIV/AIDS prevention: Ongoing assessment
Presenter: Martin Foreman
Panos Institute
Washington, D.C.

Effectiveness of mass media campaigns as catalyst for behavior change communication
Presenter: Juliana Umozurike
For: M.L. Garba
FHI/AIDSCAP Nigeria Country Office
Jigawa, Nigeria

AIDS, sexuality, sexually transmitted diseases...everything you always wanted to know and had the courage to ask: A book for commercial sex workers (CSW)
Presenter: Veronica Hughes
Private Sector Physician
São Paulo, Brazil

Fear-based and content-free information, education and communication (IEC) messages: The academic perspective versus the field reality
Presenter: Hally Mahler
FHI/AIDSCAP
Arlington, Virginia

Empowerment against AIDS in the sex industry
Presenter: M. Moreno
Centro de Orientación Investigación Integrál (COIN)
Santo Domingo, The Dominican Republic

How innovative communication can create awareness, mobilize public opinion, and leverage resources for an AIDS prevention campaign
Presenter: Gloria Ortega
For: Manuel Velandia
APOYEMONOS
Bogotá, Colombia

140

HIV AND YOUTH: MEETING THE CHALLENGE

CO-CHAIRS:
Mark Connolly
UNICEF
New York, New York

Jecenia de Jesus
International Community of
Women Living with HIV/AIDS
New York, New York

Assessment of knowledge, attitudes, and practices on sexuality and HIV/AIDS among Kenyan church-going youth
Presenter: Ndunge Kiiti
Cornell University
For: Petrida Ijumba
MAP International
Nairobi, Kenya

Perspectives on AIDS education in primary schools: evaluation of the HIV/AIDS education orientation for primary school teachers in Malawi
Presenter: Ruth Kornfield
John Snow Inc. - STAFH
Washington, D.C.

Youth peer education: An HIV intervention strategy in Rakai district, Uganda
Presenter: Eddie Mireego
Rakai AIDS Information Network
Kalisizo, Uganda

Knowledge, attitudes, beliefs, and behaviors regarding the sexual activities of girls in traditional authority Kalolo, Lilongwe district, Malawi
Presenter: Marjorie Ngaunje
Society for Women and AIDS in Africa-
Malawi Branch
Lilongwe, Malawi

Attitudes towards virginity and its effects on sexual behavior in a sample of Sri Lankan youth
Presenter: P.U. Ratnayake
Faculty of Medicine, Department of
Psychiatry
Mahaiyana, Kandy, Sri Lanka

Mothers and daughters: How the relationship affects HIV risk of low-income adolescent females in Recife, Brazil
Presenter:Ana Vasconcelos
Casa de Passagem
Recife, Brazil

CONDOM SOCIAL MARKETING: GENERATING AND MEETING THE DEMAND FOR CONDOMS

CO-CHAIRS:
Shelagh O'Rourke
USAID
Port-au-Prince, Haiti

Judith Timyan
Population Services International
Washington, D.C

Haiti condom social marketing program: Safety net-private sector condom distribution versus free condom distribution in time of crisis
Presenter: Michele Cato
Population Services International/Haiti
Port-au-Prince, Haiti

NGO condom social marketing in Haiti: A motivating model for condom promotion and distribution
Presenter: Eddy Génécé
FHI/AIDSCAP Haiti Country Office
Port-au-Prince, Haiti

Against all odds: Toward a new definition of social marketing and the Tanzania experience
Presenter: Tim Manchester
Population Services International
Dar es Salaam, Tanzania

Assessment of the distribution network of condoms in Honduras
Presenter: Ramon Jeremoas Soto
Ministry of Health (STD/AIDS Division)
Tegucigalpa, Honduras

National AIDS control policy planning for condom requirements forecasting
Presenter: Glenn Wasek
John Snow Inc.
Boston, Massachusetts

Brazil logistics management of essential commodities for AIDS prevention
Presenter: Pete Paterson
FHI/AIDSCAP/ John Snow Inc.
For: Glenn Wasek
John Snow Inc.
Boston, Massachusetts

142

INTERVENTION RESEARCH: NEW STRATEGIES AND METHODS

CO-CHAIRS:
David Wilson
University of Zimbabwe
Harare, Zimbabwe

Susan Wood
Christian Reformed World Relief Committee
Dakar, Senegal

Integrating HIV/AIDS prevention into the royal Thai army reduces HIV and STD risks among young Thai conscripts
Presenter: David D. Celentano
Johns Hopkins University School of Hygiene and Public Health
Baltimore, Maryland

Participatory evaluation methods for community-based AIDS programs: Lessons from Uganda
Presenter: Anne Coghlan
Cornell University
Kalisizo, Uganda

Sample design and selection for social research: The experience of conducting quantitative KAPB surveys on AIDS in eastern Caribbean countries
Presenter: C. Gayle
Caribbean Epidemiology Center (CAREC)
Trinidad, West Indies

Care Vietnam's action research approach on HIV/AIDS: The results and ramifications for future policy and programming
Presenter: Paula Kelly
CARE International Vietnam
Hanoi, Vietnam

The Bangkok behavioral surveillance survey (BSS): Methodology and use in HIV prevention programming
Presenter: Jan Hogle
FHI/AIDSCAP
For: Steven Mills
FHI/AIDSCAP Asia Regional Office
Bangkok, Thailand

Strategic planning for AIDS prevention in five Indonesian cities
Presenter: Wayne Wiebel
University of Illinois at Chicago School of Public Health
Chicago, Illinois

143

CASE MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES

CO-CHAIRS:
King Holmes
University of Washington
Seattle, Washington

Colonel Mpoudi Ngole Eitel
National AIDS Control Programme
Yaounde, Cameroon

Partner referral as a component of integrated STD services in two Rwandan towns
Presenter: Richard Steen
FHI/AIDSCAP Africa Regional Office
For: Sosthene Bucyana
USAID/Kigali
Kigali, Rwanda

Comparison of data on quality of provider performance on STD case management: direct observations, provider interviews, and simulated patients
Presenter: Gina Dallabetta
FHI/AIDSCAP
Arlington, Virginia

Study of urethritis management in pharmacies in São Paulo, Brazil
Presenter: Maria Eugênia Lemos Fernandes
FHI/AIDSCAP Brazil Country Office
São Paulo, Brazil

Tutorial training for syndromic STD case management in a Kingston, Jamaica, STD clinic
Presenter: Tina Hylton-Kong
Ministry of Health
Kingston, Jamaica

STD services for women in truck stops in Tanzania: An evaluation of acceptable approach
Presenter: Klinton Nyamuryekung'e
AMREF
For: Conrad Mbuya
African Medical and Research Foundation (AMREF)
Dar es Salaam, Tanzania

The MStop experience in Cameroon: Conclusions
Presenter: Jean Paul Tchupo
Population Services International (PSI)
Douala, Cameroon

144

Conference Participants

145

Conference Participants

Mounkaila Abdou
Student
Tulaue University
Box 3, 1501 Canal Street
New Orleans LA 70112
Tel: 504-529-1456

Sarah Abernethy-Oo
Project Officer Health
UNICEF-Dhaka, Bangladesh
P.O. Box 5747
New York NY 10163
Tel: 880-2-869180
Fax: 880-2-863678

Tilly-Gyado Abiola
Plan International
Chobham House
Christchurch Way: Woking Surrey
GU21 IJG
London
U.K
Tel: 01483733-237

Greg Adams
Senior Health Advisor
USAID RDO/Caribbean Bridgetown
US Embassy Bridgetown
PO Box 302
FPO AA 34055
Tel: 809-436-4950
Fax: 809-429-4438

Samuel Adeniyi-Jones
Researcher
National Institute of Health
Bld. 10 13 N 240
N.I.H
Bethesda MD 20892
Tel: 301-402-1754
Fax: 301-402-0575

Peter Aggleton
Health & Education Research Unit
Institute of Education
University of London
55-59 Gordon Square
London WC1H ONT
United Kingdom

Navneet S. Ahluwalia
Intern Investment Program
PPC/SA
2140 L St. NW
The Winston House
#704
Washington DC 20037
Tel: 202-496-0726

Paul Kodjo Akoda
Medical Officer
Enfance Et Famille
BP. 8560 Be
Lome
Togo
Tel: 228 21 77 23
Fax: 228 22 49 56

Chinua Akukwe
Project Coordinator
DC Office of Maternal/Child Health
613 G Street, NW
Room 638
Washington DC 20001
Tel: 202-727-0393
Fax: 202-727-0622

A. Raouf Al-Suwaid
Senior Consultant, Dermatology &
STD/AIDS Programme
Ministry of Health, Oman
c/o Dr. Yasmin Ahmed Jaffer
38 Fernald Drive
No. 21
Cambridge MA 02138
Tel: 617-661-9338

Yeshimebet Alemayehu
Health Officer CARE Ethiopia
CARE Habro Project
P.O. Box 17
Kampala
Uganda
Tel: 301-270-6569

Neen B. Alrutz
TAACS/Kenya
USAID
USAID Unit 64102
APO, AE 09831-4102
Tel: 254-2-751613
Fax: 254-2-749590

Elena M. Alvarado
National Director
Latinas: Partners for Health Network
1000 16th St. NW
Suite 603
Washington DC 20036
Tel: 202-452-8750
Fax: 202-452-0086

El Hadj Amadou Sy
ENDA-SANTE
B.P. 3370
Dakar
Senegal
Tel: 221-22-96-95
Fax: 221-22-26-95

Avni Amin
Student
Johns Hopkins University, School of
Public Health
c/o Dr. Margaret Bentley, Dept. Inter.
Division Human Nutrition
615 N. Wolfe Street
Baltimore MD 21218
Tel: 410-614-4064

Vathani Amirthanayagam
Health, Population & Nutrition Officer
USAID
1801 N. Kent Street
Room 120
Arlington VA 22209
Tel: 703-875-4714
Fax: 703-875-4686

Joseph Amon
Associate Evaluation Officer
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Kwame Ampomah
Assoc. Director/Africa
Advocates for Youth
1025 Vermont Avenue
Washington DC 20005
Tel: 202-347-5700

Eric Amnndson
Staff Assistant
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Jennifer Anderson
AIDS Programme Manager
CARE Lesotho
P.O. Box 682
Maseru 100
Lesotho
Tel: 266 314398
Fax: 266 310195

Sigrid Anderson
Chief, 7PSD
USAID/Washington
G/PHN, POP, FPSD
Room 809. SA-18
Washington DC 20523-1819
Tel: 703-875-4607
Fax: 703-875-4413

Maxine Ankrah
Senior Advisor
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Juana E. Antigoni, M.D.
President
Asociacion Isis
Casilla Postal 12-185
Lima
Peru
Tel: 051-14790849
Fax: 051-14724797

Carmina Noela A. Aquino
Project Consultant
PATH Philippines
4/F Thomas Jefferson Cultural Center
395 Gil Puyat Avenue
Makati City 1254
Philippines
Tel: 632-895-3201
Fax: 632-899-5561

Sevgi Aral
Associate Director for Science
Division of STD/HIV Prevention
Centers for Disease Control & Prevention
1600 Clifton Road, NE, M/S E-02
Atlanta GA 30333
Tel: 404-639-8259
Fax: 404-639-8608

Ruben Arand
Health Education Coordinator
Ar. Human Development Coordinator
300 Spring Street Building, Suite 800
Little Rock AR 72201
Tel: 501-374-1103

Rita Arauz
Executive Director
Foundation Nimehuatzin
Apartado A-262
Managua
Nicaragua
Tel: 505-2-780028
Fax: 505-2-786534

Howard Armistead
Executive Director
Project for Aspirin Research and Education (PARE)
P.O. Box 691068
West Hollywood CA 90069
Tel: 310-659-6965
Fax: 310-205-0809

Emil Jones Asamoah-Odei
Appointed National Coordinator - HIV/AIDS Surveillance
Ministry of Health - Ghana
c/o R. Abramson, Program Officer, PIET
2000 M. Street NW, Suite 650
Washington DC 20036
Tel: 202-429-0810
Fax: 202-429-8764

Odan Ascosta
ETD/Sup
Midwest Farmworker Employment and Training
1009 So. Robert Street
W. St. Paul MN
Tel: 612-450-9615
Fax: 612-450-9713

Nasrin Astani
Medical Doctor
KKKS - Batam (Communication and Social Services Division)
R.E. Martadinata Street
Sekupang - P. Batam 29422
Indonesia
Tel: 778-322-347
Fax: 778-322-201

James Astleford
Executive Director
Adventist Development and Relief Agency (ADRA)/Phillipines
P.O. Box 8015
1700 Paranaque
Metro Manila
Phillipines
Tel: 632-832-5457
Fax: 632-832-5455

Honorable Brian Atwood
Administrator
USAID
21st and C Street
Washington DC 20523

Judith Auerbach
Behavioral & Social Science Coordinating Chair
Office of AIDS Research, National Institutes of Health
Bldg 31, Room 4C06
9000 Rockville Pike
Bethesda MD 20892
Tel: 301-496-0357
Fax: 301-496-4842

Ritza Aviles de Briseno
Coordinator. HIV/STD Prevention
Asociacion Hondurenade Planificacion de Familia
c/o International Planned Parenthood Fed
902 Broadway
New York NY 10010
Tel: 212-995-8800
Fax: 212-995-8853

Felix N. Awantang
HPN Officer
USAID/Lagos
Department of State
Washington DC 20521-8300
Tel: 23412614412
Fax: 23412614698

Josephine R. Awicli
Research Scientist
African Committee NYC
5061 1st Street, NW, #203
Washington DC 20011
Tel: 202-723-1120

Ileana M. Baca
Project Manager - AIDS/STD Prevention Project
USAID/Bolivia
Unit 3914
APO AA 34032
Tel: 591-2-786583
Fax: 591-2-872325

Timoteo J. Badoy, Jr.
Project Coordinator-HIV Surveillance
Field Epidemiology Program, Department of Health
Sta. Cruz
Manilla
Phillippines
Tel: 7312930
Fax: 7417048

Martha Cecilia Baez
PHM
Metrosatud (Minestein Salud Publica)
CRa 51D #60 -36
Medellin
Colombia
Tel: 5119532
Fax: 5115143

Tristan Bahr
Managing Director
Bahr Mapping and Printing
P/B A34
Maseru 100
Lesotho
Tel: 266-310537
Fax: 266-310195

147

Brendan Bain
University of the West Indies
Department of Soc. & Preventative Med.
Mona Campus
Kingston 7
Jamaica
Tel: 809-977-2645
Fax: 809-977-2129

Paulina Bain
Director
Medical and Educational Services Ltd.
P.O. Box 673
Kingston 6
Jamaica
Tel: 927-2262

Deborah Balk
Fellow
East-West Center
Program on Population
1777 East-West Road
Honolulu HI 96848
Tel: 808-944-7462
Fax: 808-944-7490

Peter Ballard
Reporter
The Blue Sheet
5550 Friendship Boulevard, Suite 7
Chevy Chase MD 20815
Tel: 301-657-9830
Fax: 301-656-3094

Godfrey Baltazar
Epidemiologist
Kenya National AIDS Control
P.O. Box 58150
Nairobi
Kenya
Tel: 729527
Fax: 729504

Milinda Balthrop
Project Associate Africa Region
CEDPA
1717 Massachusetts Avenue NW
St. 200
Washington DC 20036
Tel: 202-667-1142

Arabinda Banik
Database and Information Coordinator
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Christeen Barbour
Secretary/Administrative Assistant
Family Health International
2224 Chapel Hill - Nelson Highway
Durham NC 27705
Tel: 919-544-7040
Fax: 919-544-0207

Lewellys F. Barker
Acting Assoc. Director/Vaccine Prevention and Research Prog.
AIDS/NIAID/National Institutes of Health
Solar Building, Room 2A07
6003 Executive Boulevard
Rockville MD 20892
Tel: 301-402-0846
Fax: 301-402-3684

Victor A. Barnes
Dep. Division Chief, HIV/AIDS Global Bureau
USAID
G/PHN/HN/HIV-AIDS
Suite 1200 SA-18
Washington DC 20523
Tel: 703-875-4636
Fax: 703-875-4686

Elizabeth Barnes
Documentation Management Coordinator
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Mark A. Barone
Medical Advisor
AVSC International
79 Madison Avenue
New York NY 10016
Tel: 212-561-8081
Fax: 212-779-9439

Jeffery R. Barrus
Program Manager
Population Services Int'l
1120 19th St. NW
Suite 600
Washington DC 20036
Tel: 202-785-0072

Souleymane Barry
Supervisory HPN Officer
Regional Economic Development Services Office/West Africa
c/o American Embassy
5 rue Jesse Owens, 01 B.P. 1712
Abidjan 01
Cote d'Ivoire

Kristin Bashore
Program Assistant
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Carol Baume
Senior Research and Evaluation Officer
Academy For Education Development
1255 23rd Street, NW
4th floor - 4230
Washington DC 20037
Tel: 202-884-8980
Fax: 202-884-7988

Julie Becker
Associate, HIV/STD Prevention Program
International Planned Parenthood Federation, WHR
902 Broadway
10th Floor
New York NY 10010
Tel: 212-995-8800
Fax: 212-995-8853

Michael Beer
President
Bisexual Resource Center
1719 Harvard Street
Washington DC 20009

Frieda Behets
Research Instructor
University of North Carolina at Chapel Hill
Division of Infectious Diseases
CB#7030
Chapel Hill NC 27599-7030
Tel: 919-966-6325
Fax: 919-966-5775

Thomas G. Belloff
HIV Coordinator
Mid-State Health Advisory Corp.
LAB IV
Rider University
2083 Lawrenceville Road
Lawrenceville NJ 08648
Tel: 609-896-8484
Fax: 609-896-3133

Helen Benga
Universite Cheikh Anta Diop
Dakar
Senegal

148

Benhida
General Secretary
Association Marocaine des Jeunes Contre le SIDA
1 bis Rue Abon El Kasui
Ezzabrani B.P. 1811
Tel: 295326/25
Fax: 295327

Judy A. Benjamin
Project Manager, Rwandan Refugee AIDS Project
CARE International
P.O. Box 150
Ngara
Tanzania
Fax: 255 06622507

Dawn Bennett
Assistant Project Manager
OPAC Clghs
PO Box 30686
Bethesda MD 20824-0686
Tel: 301-654-6190
Fax: 301-907-9655

Michelle Bennett
Project Assoicate
American Assn for World health
1129 20th Street, NW
Suite 400
Washington DC 20036
Tel: 202-466-5883
Fax: 202-466-5896

Ruth Berger
Private
2627 Hillegass
Berkeley CA
Tel: 510-843-1885
Fax: 510-848-5421

Solanges Marie Bernard
Project Manager
CARE Haiti
92 Rue Gregoire
Petion Ville
Haiti
Tel: 509-57-5358

Daniel Bernier
Travailleur Social
Center Haitienae Service Social
209 Fontamara 41
Route de Carrefour
Port-au-Prince
Haiti
Tel: 340509
Fax: 340490

Patrick Bertrand
Sidalerte Internationale (France)
c/o A. Broderick
950 Cabrillo Street, #14
San Francisco CA 94118
Tel: 33-78606565
Fax: 33-78606767

Mary B. Bess
Senior Program Officer
National Council of Negro Women Inc.
1001 G Street, NW
Suite 800
Washington DC 20001
Tel: 202-628-0015

Shewit Bezabeh
1021 Arlington Boulevard
#1022
Arlington VA 22209
Tel: 703-527-3488

Paurvi Bhatt
Senior Program Officer
CARE
151 Ellis Street, NE
Atlanta GA 30303
Tel: 404-681-2552
Fax: 404-577-1205

Mimi Binns
Associate Program Officer, LA/C
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

William Bland
Director of National Programs
National Task Force on AIDS Prevention
973 Market Street
Suite 500
San Francisco CA 94117
Tel: 415-356-8131
Fax: 415-356-8138

Naomi Blumberg
Population Fellow
USAID, Office of Population
G/PHN/POP/CLM SA 18
Room 806
Washington DC 20523
Tel: 703-875-4563
Fax: 703-875-4413

Kate Bond
Center for Public Health Research
Chaing Mai University
P.O. Box 80
Chaing Mai 5002

Paul Boneberg
Program Director
Global AIDS Action Network - GAAN
1931 13th Street, NW
Washington DC 20009
Tel: 202-483-6622
Fax: 202-483-1135

Paungthip Boonperm
(Thailand)
1737 Crestline Court
Atlanta GA 30345
Tel: 404-634-1089

Sandra Boring
Program Assistant
National Council on International Health
1701 K Street, NW, Suite 600
Washington DC 20006
Tel: 202-833-5905
Fax: 202-833-0075

Mary Ann Borman
Dircetor, Midwest Farmworker HIV/STD/TB Consortium
UMOS Inc. Special Projects
929 West Mitchell Street
Milwaukee WI 53204
Tel: 414-671-5700
Fax: 414-671-4838

Kirsten Bose
Program Officer
JHU/Center for Communication Programs
111 Market Place, Suite 310
Baltimore MD 21202-4012
Tel: 410-659-6303
Fax: 410-659-6299

Sujata Bose
8500 Carlynn Drive
Bethesda MD 20817
Tel: 301-320-3422
Fax: 301-320-3922

Dr. Paul Bouey
Johns Hopkins University
3495 Manor Lane
Ellicot City MD 21042
Tel: 410-418-5463

Arnold Ross Boulter
Swiss Red Cross Delegate-Nepal
Swiss Red Cross
99A Milton Street
Brixham - Deuon
TQ5 OAR
England
Tel: 441803852017
Fax: 441803852017

149

Clare Boulter
Swiss Red Cross Delegate
Swiss Red Cross
c/o Eye Hospital
P.O. Box 32
Nepalgunj
Nepal
Tel: 977-81-20255
Fax: 977-81-20589

Stephanie Bracey
Program Assistant
Americans for a Sound HIV/AIDS Policy
102 Elden Street
Suite 11
Herndon VA 22070
Tel: 703-471-7350
Fax: 703-471-8409

Oly Bracho
Financial Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Bill Brady
STD Advisor
Mother Care/JSI
1616 North Fort Meyer Drive, 11th Fl.
Arlington VA 22209
Tel: 703-528-7474
Fax: 703-528-7480

Neil R. Brenden
Asia Regional Director
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Muireann Brennan
Technical Specialist
PVO Child Survival Support Program
103 E. Mount Royal Avenue
Room 2C
Baltimore MD 21202
Tel: 410-659-4100
Fax: 410-659-4107

Tricia Bright
Research Assistant
USAID/Jorge Scientific Corporation
USAID Support Office
1601 N. Kent Street
Suite 1016
Arlington VA 22209
Tel: 703-814-7790
Fax: 703-841-0327

Andrew Broderick
Director
AIDS - Sidalerte International
950 Cabrillo Street
#14
San Francisco CA 94118

Jamie Browder
Logistics Advisor
John Snow, Inc.
1616 N. Fort Meyer Drive, 11th Floor
Arlington VA 22209
Tel: 703-528-7474
Fax: 703-528-7480

Tim Brown
Fellow
East-West Center, Program on Population
1777 East-West Road
Honolulu HI 96848
Tel: 808-944-7476
Fax: 808-944-7490

Jane Brown
Deputy Director
CEDPA
1717 Massachusetts Avenue, NW
Washington DC 20036
Tel: 202-667-1142

Marion Brown
Project Assistant
National Council of Negro Women
24 E. Wayne
#411
Siver Spring MD 20901
Tel: 301-489-1473

Michael Buja
Conference Registration Coordinator
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

John R. Burdick
FSO
USAID G/PHN/FPS
1325 18th Street, NW, #504
Washington DC 20036
Tel: 703-875-5334
Fax: 702-875-4675

Marianne Burkhart
Senior Program Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Richard Buryzinski
ICASO Central Secretariat
100 Sparks Street
Ottawa, Ontario KIP 5B7
Canada

Martha Butler de Lister
Resident Advisor/Dominican Republic
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Jeanine Buzy
American Association for the Advancement of Science Fellow
USAID HIV-AIDS Division
G/PHN/HN/HIV-AIDS
Suite 1200 SA-18
Washington DC 20523

Lovette Byfield
Communication Specialist
Ministry of Health, Jamaica
30 - 34 Half Way Tree Road
Kingston 5
Jamaica
Tel: 926-1819
Fax: 926-5674

David Calder
Health Officer
USAID
CDIE\POA
USAID
Washington DC 20523-1802
Tel: 703-975-4763
Fax: 703-875-4866

Ricardo Calderon
Regional Director, LAC Region
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington Va 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Christine L. Campbell
Executive Director
Bahamas Family Planning Association
P.O. Box N9071
Nassau
Bahamas
Tel: 809-323-6338
Fax: 809-325-4886

150

Carl Campbell
Senior Public Health Advisor
Centers for Disease Control and Prevention
4770 Buford Highway MS K01
Atlanta GA 30341-3724
Tel: 404-488-1102
Fax: 404-488-1003

Agnes M. Carlos
Population Program Officer III
City Population Office
08 Datu Silongan Street
Butan City, Agusan Norte 8600
Philippines
Tel: 44-90-13

Patricia Carter
HIV Prevention Program Coordinator
NOBCO - National Organization of Black County Officials
440 First Street NW, Suite 500
Washington DC 20001
Tel: 202-347-6953
Fax: 202-393-6596

Kathleen Cash
Project Director
Chiang Mai University
644 Grand Street
Morgantown, WV 25605
Tel: 304-291-1048
Fax: 304-291-1048

Mercedes Castillo
Consultant
USAID Honduras/HRD
Unit 2927
APO AA 34022
Tel: 504-36-5966
Fax: 504-36-7776

Willard Cates
Corporate Director, Medical Affairs
Family Health International
P.O. Box 19350
Research Triangle Park NC 27709
Tel: 919-544-7040
Fax: 919-544-7261

Michele R. Cato
Country Representative/Haiti
Population Services International
B.P. 2041
272, Rue du Magasin de l'Etat
Port-au-Prince
Haiti
Tel: 509-22-3271
Fax: 509-22-3205

Pat Caviness
Public Relations Consultant
PO Box 60704
Washington DC 20039

David D. Celentano
Professor
The Johns Hopkins University
624 N. Broadway
Baltimore MD 21205
Tel: 410-955-2312
Fax: 410-955-7241

Omar Centurion
Latino HIV/AIDS Programs Coordinator
Whitman-Walker Clinic
1407 S Street, NW
Washington DC 20010
Tel: 202-939-7871
Fax: 202-797-3504

Vilay Chaleunrath
Executive Director
Indochinese Community Center
1628 16th Street, NW
Washington DC 20009
Tel: 202-462-4330
Fax: 202-462-2774

Jennifer K. Chambers
Public Policy
National Women & HIV/AIDS Project
710 Eye Street, SE
Washington DC 20003
Tel: 202-547-1155
Fax: 202-547-5080

Clotilde Charlot
WID Specialist
Inter-American Development Bank (IDB)
4601 N. Park Avenue, Apt. 604
Chevy Chase MD 20815
Tel: 202-623-3843
Fax: 202-623-1483

Marcelle Chevallier
Health Sector Coordinator
CARE International Togo
151 Ellis Street
Atlanta GA 30303
Tel: 228-263610
Fax: 228-264084

Eunyong Chung
Nutrition Advisor
USAID
G/PHN/HN, Room 1200, SA-18
Washington DC 20523
Tel: 703-875-4074
Fax: 703-875-4686

Rev. Richard Cizile
Congressional Relations
National Assn of Evangelicals
1023 15th Street, NW
Washington DC 20005
Tel: 202-789-1011
Fax: 202-842-0392

Peter Clancy
Director
Population Services International
1120 19th Street, NW
Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Martina Clark
548-B Clayton Street
San Francisco CA 94117

John Paul Clark
USAID/AFR/SD
1111 N 19th Street
S-300
Arlington VA 22209
Tel: 703-235-9100
Fax: 703-235-4466

Lee Claypool
Research Coordinator
CONRAD
1611 North Kent Street, #806
Arlington VA 22209

Christine Claypoole
Assistance Program Manager
Population Services International
1120 19th Street, NW
Washington DC 20036
Tel: 202-785-0072

Marcio Clemente
Product Manager
DKT Do Brasil
Av. Brig. Faria Lima 1106
Cs 1110 CEP:01452-000
Sao Paulo SP
Brazil
Tel: 55-118155095
Fax: 55-112114237

Thomas J. Coates
Director
Center for AIDS Prevention Studies
74 New Montgomary
Suite #600
San Francisco CA 94105
Tel: 415-597-9157
Fax: 415-597-9213

151

Ellen Coates
Child Survival Coordinator
World Vision Relief & Development
220 Eve Street NE, Suite 270
Washington DC 20002
Tel: 202-547-3743
Fax: 202-547-4834

Nicol Coetzee
Fogarty Epidemiology Training Program Fellow
Columbia University School of Public Health
Division of Epidemiology
600 West 168th Street
New York NY 10032
Tel: 212-305-9414
Fax: 212-305-9413

Warren Coetzer
No. 51
67 Victoria Embankment
Durban 4001
South Africa

Christa Coggins
Staff Associate
The Population Council
One Dag Hammarskjold Plaza
New York NY 10017
Tel: 212-339-0617
Fax: 212-755-6052

Anne Coghlan
Evaluation Specialist
Cornell University
HSS, MVR N132
Ithaca NY
Tel: 607-255-2521
Fax: 607-255-4071

Myron S. Cohen
Professor of Medicine, Microbiology and Immunology
The University of North Carolina at Chapel Hill
Division of Infectious Diseases
CB# 7030, 547 Burnett-Womack Buliding
Chapel Hill NC 27599-7030
Tel: 919-966-2536
Fax: 919-966-6714

Barney Cohen
Program Officer
National Academy of Sciences
2101 Consitution Ave., NW
Washington DC 20418
Tel: 202-334-3167
Fax: 202-334-3768

Lynda Cole
Director, Field Operations
Family Health International
P.O. Box 19350
Research Triangle Park NC 27709
Tel: 919-544-7040
Fax: 919-544-7261

Rebecca Coleman
Program Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington Va 22201
Tel: 703-516-9779
Fax: 703-516-9781

Mark Connolly
Health Promotion Unit
UNICEF
UNICEF (H-10F), 3 U.N. Plaza
New York NY 10017
Tel: 212-326-7470
Fax: 212-326-7336

George W. Contreras
Columbia University School of Public Health
255 West 98th Street
#1B
New York NY 10025
Tel: 212-740-6316

Worth Cooley-Prost
Research Consultant
621 North Kensington Street
Arlington VA 22205
Tel: 703-522-3818
Fax: 703-528-7036

Alan Corbin
Senior Vice President Research and Development
Family Health International
P.O. Box 19350
Research Triangle Park NC 27709
Tel: 919-544-7040
Fax: 919-544-7261

Francois Crabbe
Research Assistant, STD/HIV Research & Intervention Unit
Institute of Tropical Medicine
Nationalestraat 155
B-2000 Antwerp
Belgium
Tel: 323-2476534
Fax: 323-2476532

Bart Criel
World Health Organization
Prince Leopold Institute of Tropical Medicine
Nationalestraat 155
B-2000 Antwerpen
Belgium

Arturo G. Cristobal, Jr.
Program Manager
Philippines HIV/AIDS NGO Support Program (PHANSUP)
Suite 401, Heart Building
7461 Bagtikan Street
San Antonio Village, Makati City 1203
Phillipines
Tel: 61858996357
Fax: 61858996357

Ljiljana Crnkovic
International Baccalaureate Coordinator
XV. Gimnazisa
4100 Zagreb
Jordanovac 8
Croatia
Tel: 385-1-214255
Fax: 385-1-221564

Donya Currie
Assistant Editor
The Nations Health
1015 15th Street, NW
Suite 300
Washington DC 20005
Tel: 202-789-5632
Fax: 202-789-5661

Caroline Curtis
Program Manager
Pragma
116 East Broad Street
Falls Church VA 22046
Tel: 703-237-9303
Fax: 703-237-9326

Peggy D'Adamo
Librarian
Johns Hopkins School of Public Health
Center for Communication Programs
111 Market Place, Suite 310
Baltimore MD 21202
Tel: 410-659-6256
Fax: 410-659-6266

Margaret Dadian
Senior Writer/Editor
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

152

Hanna Dagnachew
Population Intern/Michigan Fellows Program
USAID Family Planning Service Division
SA-18, Room 809
Washington DC 20523-1819
Tel: 703-875-4413
Fax: 703-875-4416

Gina Dallabetta
Associate Director, STD Unit
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Julie R. Dargis
Program Manager
World Learning
1015 15th Street, NW
Suite 750
Washington DC 20005
Tel: 202-408-5420
Fax: 202-408-5397

Sharmi Das
Program Director
Indochinese Community Center
1628 16th Street, NW
Washington DC 20009
Tel: 202-462-4330
Fax: 202-462-2774

Lisa Daughtry
Assistant to the Director of the Washington Office
Christian Children's Fund
1717 Massachusetts Avenue, NW
Suite 601
Washington DC 20036
Tel: 202-462-2161
Fax: 202-462-0601

Gem Daus
Consultant/Trainer
Gem Educational Systems
6319 N. 31st Street
Arlington VA 22207
Tel: 703-532-7065

Mercia Davids
Program Specialist - Health
USAID/Zimbabwe
Department of State
Washington DC 20521-2189
Tel: 263-4-720757
Fax: 263-4-722418

Harold Davis
Medical Epidemiologist
USAID/AFR
111 North 19th Street, Room 500
Rosslyn VA 22209
Tel: 703-235-5434
Fax: 703-235-4466

Sarah Davis
Research Analyst, Family Health International Fellow
USAID, FHI
Jorge Scientific Corporation
1601 N. Kent Street
Arlington VA 22209
Tel: 703-841-7790
Fax: 703-841-0327

Beverly Davis
Administrative Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Michael W. Deegan
President
DATCO
1524 Victoria Farms
Vienna VA 22182
Tel: 703-759-6445
Fax: 703-759-1521

Michele De Grauwe
Interpreter
Linx
5410 Connecticut Avenue, NW
Washington DC 20015
Tel: 202-686-0467

Lisa Swenarski de Herrera
Press Officer
CARE
151 Ellis Street
Atlanta GA 30303
Tel: 404-681-2552
Fax: 404 577 5761

Jecenia de Jesus
International Community of Women Living with HIV/AIDS
215 Bennett Avenue, No. 3B
New York NY 10040

Amstelina Deker-Sessay
Staff Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Mary Guinn Delaney
AIDS Program Manager
National Council for International Health (NCIH)
1701 K Street, NW, Suite 600
Washington DC 20006
Tel: 202-833-5905
Fax: 202-833-0075

Joelle Delaplace
Interpreter
Linx
5127 Tilden Street, NW
Washington DC 20016
Tel: 202-966-2421

Paul DeLay
Senior Technical Advisor on STD/HIV
USAID HIV-AIDS Division
G/PHN/HN/HIV-AIDS
Suite 1200 SA-18
Washington DC 20523

Ruben F. del Prado
National AIDS Program of Suriname
4205 NW, 36th Avenue
Miami FL 33142-4217
Tel: 597-49-8238
Fax: 597-49-4871

Ruth De Moraes Prata Gaspar
Program Assistant
FHI/AIDSCAP, Brazil
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 5511-8131677
Fax: 5511-8155204

Julien Denakpo
Program Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Julie Denison
Research Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Arnoux Descardes
General Coordinator
Volontariat pour le Developpement d'Haiti (VDH)
No. 4 lere Ruelle Riviere
Port-au-Prince
Haiti
Tel: 453109

153

Jody DeVoll
Health Management Consultant
7204 Central Avenue
Takoma Park MD 20912
Tel: 301-270-0436
Fax: 301-270-0321

Barbara de Zalduondo
Senior Technical Advisor for
Behavioral Research
USAID HIV-AIDS Division
G/PHN/HN/HIV-AIDS
Suite 1200 SA-18
Washington DC 20523

Mamadou Diallo
Project Retro - CJ
BP 1712
Abidjan
Cote d'Ivoire

Jose R. Diaz
Community Planning Organizer
National Taskforce on AIDS Prevention
973 Market Street
Suite 500
San Francisco CA 94105
Tel: 415-356-8100
Fax: 415-356-8138

Julio Dicent-Taillepierre
Director AIDS Services
Alianza Dominicana
715 W. 179th Street
New York NY 10033
Tel: 212-795-4226
Fax: 212-795-4285

Michelle Didier
MIS Analyst
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Sheila Dinotshe Tlou
Senior Lecturer, Director of Nursing
University of Botswana
Private Bag 0022
Gabarone
Botswana
Tel: 267-351-151
Fax: 267-356-591

Maria-Isabel Dizon
Program Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Joyce S.H. Djaelani
PATH, Indonesia
GD Tifa, 11th Floor, Suite 1102
Kuningan Barat #26
Jakarta
Indonesia
Tel: 6221-5200737
Fax: 6221-5200621

Sambe Duale
Research Manager
Sara Project, Tulane SPH TM
Sara Project - AED
1255 23rd Street NW, Suite 400
Washington DC 20037
Tel: 202-884-8809
Fax: 202-884-8701

Sister Ann Duggan
AIDS Response Coordinator
Catholic Relief Services
209 W. Fayette Street
Baltimore MD 21201-3443
Tel: 410-652-2220
Fax: 410-685-1635

Keely Dunham
Program Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Stella Susan Duodu
Nursing Officer - Public Health
(AIDS Control Programme)
Ministry of Health - Ghana
c/o R. Abramson, Program Officer,
PIET
2000 M Street NW, Suite 650
Washington DC 20036
Tel: 202-429-0810
Fax: 202-429-8764

Duplay
Prevention Working Group
ACT-UP Paris
45 Rue Sedaine
Paris 75011
France
Tel: 331-49294475
Fax: 331-48061674

Veronica Dyah Dwyanti
Communication and Social Services
Division
Bunga Raya
45 Baldi Persero
Batam Island
Indonesia
Tel: 322347

Duncan Earle
Contry Representative
DKT-PSI Ethiopia
1120 19th Street, NW, #610
Washington DC 20036
Tel: 251-1-519300
Fax: 251-1-519966

Lawrence R. Eicher
Health Development Officer
USAID
G/PHN/HN/HIV-AIDS
Room 1209 SA-18
320 21st Street, NW
Washington DC 20523-1817
Tel: 703-875-4740
Fax: 703-875-1817

Mpoudi Ngole Eitel
Chief of Cameroon N.A.C.P.
Ministry of Health/N.A.C.P. Cameroon
P.O. Box 155
Yaounde
Cameroon
Tel: 237-226-719

Charlotte Ellertson
Staff Associate
The Population Council
One Dag Hammarskjold Plaza
New York NY 10017
Tel: 212-339-0607
Fax: 212-755-6052

Lyn Elliott
HIV/AIDS Technical Advisor
Save the Children Fund, U.K.
17 Grove Lane
London SE4 PR0
England
Tel: 441717035400
Fax: 441717937630

Isabel Ellis
Analyst, Africa Projects
Office of International Health
Parklawn Building
Room 18-85
Rockville MD 20857
Tel: 443-4010
Fax: 443-4549

Katharine Esty
Ibis Consulting Group
125 Cambridge Park Drive
Cambridge MA 02140

154

William E. Fanelli
AIDS Training Coordinator
Department of the Army
HQDA(DAPE-CPC
Pentagon, Room 2C662
Washington DC 20310-0300
Tel: 703-697-4429
Fax: 703-695-8411

Marivic Farrales
George Washington University
4124 N. 11th Street
Arlington VA 22201
Tel: 703-527-4439

Pamela Faura
Executive Director
Project Life
1534 Tremont Street
Roxbury MA 02120
Tel: 617-442-3620
Fax: 617-442-1746

Douglas A. Feldman
President
D.A. Feldman & Associates, Inc.
3001 South Ocean Drive
Suite 12X
Hollywood FL 33019
Tel: 305-927-0304
Fax: 305-927-0304

Michael Feldstein
USAID
Office of the Administrator
Room 5894, Department of State
Washington DC 20523
Tel: 202-647-8617
Fax: 202-647-1770

Nina Ferencic
Country Support
UNAIDS
c/o WHO
20 Ave Appia
Geneva
Switzerland
Tel: 4122-7914812
Fax: 4122-7914880

Patricia Ferguson-Smith
Project Associate
CEDPA
1717 Massachusetts Avenue, NW
Suite 200
Washington DC 20036
Tel: 202-667-1142

Maria Eugenia Fernandes
Resident Advisor, Brazil
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 55-118131677
Fax: 55-118155204

Tomas Fernandez
City Health Officer
Cebu City Health Department
Lahug Street
Cebu City
Philippines
Tel: 023-96396

Francisca Ferreira
Centro de Orientacion e Investigacion Ingegral (COIN)
Calle 18 Sur, #60
Ensanche Luperon
Santo Domingo
Dominican Rep.
Tel: 809-681-1515
Fax: 809-681-4827

Carlos Ferreros
Country Director
DKT do Brasil
Av. Brig. Faria Lima 1106
CS 110 CEP: 0145200
Sao Paulo SP 01452-000
Brazil
Tel: 5511-8155095
Fax: 5511-2114237

Mary Lyn Field
Senior Program Officer (UNICEF Technical Support), STDs
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Dallas Fields
Communications Coordinator
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Peter Figueroa
Principal Medical Officer, Epidemiology
Ministry of Health, Jamaica
30-34 Half Way Tree Road
Kingston 5
Jamaica
Fax: 441414364230

Jim Fisher-Thompson
Writer/editor
USIA
301 4th Street, SW
Washington DC 20547
Tel: 202-619-4076
Fax: 202-619-4079

Tekola Fisseha
Health Education Supervisor
Durham County Health Department
414 East Main Street
Durham NC 27701
Tel: 919-560-7761
Fax: 919-560-7772

Donna Flanagan
Associate Director, Behavior Change Communication Unit
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Fleutelot
Prevention Working Group
ACT UP PARIS
45 Rue Sedaine
75011
Paris
France
Tel: 331-49294475
Fax: 331-48061674

Holly Fluty
USAID G/PHN/HR/HIV-AIDS
SA-18 Room 1200
Washington DC 20523

Tessa Forbes
Research Assistant
PCS/Johns Hopkins University
111 Market Place, Suite 310
Baltimore MD 21202-4102
Tel: 410-659-6300
Fax: 410-659-6266

Kathleen Ford
Research Scientist
University of Michigan School of Public Health
Univeristy of Michigan
Ann Arbor MI 48109-2029
Tel: 313-763-5974
Fax: 313-936-8199

155

Miniabiyi Ford
Student
Howard University
5055 Seminary Road
#1114
Alexandria VA 22311
Tel: 703-820-2029
Fax: 703-820-7241

James R. Foreit
Senior Associate
The Population Council
4201 Connecticut Avenue, NW
Suite 408
Washington DC 20008
Tel: 202-237-6455
Fax: 202-237-6458

Martin Foreman
Program Officer, AIDS in the Americas
Panos Institute
1717 Massachusetts Avenue NW
Suite 301
Washington DC 20036
Tel: 202-483-0044
Fax: 202-483-3059

Kelly Forrest
AIDSLink Editor / AIDS Program Assistant
National Council for International Health (NCIH)
1701 K Street, NW, Suite 600
Washington DC 20006
Tel: 202-833-5905
Fax: 202-833-0075

Steven Forsythe
Health Economics Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Henry Francis
Assistant Professor
Johns Hopkins University
Johns Hopkins Hospital, Ross 1159
720 Rutland Avenue
Baltimore MD
Tel: 410-614-0929
Fax: 410-955-7889

Nina Frankel
2710 Scott Street
San Francisco CA 94123
Tel: 415-931-0172
Fax: 415-931-2730

Matthew S. Frey
Program Advisor
Save the Children
P.O. Box 2218
Kathmandu
Nepal
Tel: 977-1-412598
Fax: 977-1-410375

Pat Funderburk Ware
Director of Educational Services
Americans for a Sound AIDS/HIV Policy
102 Elden Street
Suite 11
Herndon VA 22070
Tel: 703-471-7350
Fax: 703-471-8409

Evelyn Grace B. Gacad
Program Manager
National AIDS/STD Prevention & Control Program
3/F Building 12, Dept. of Health
Sta. Cruz
Manila
Philippines
Tel: 632-711-6693
Fax: 632-711-6693

Paul A. Gaist
Senior Program Analyst
Office of AIDS Research
National Institutes of Health
Room 4C-06, Bldg. 31
Bethesda MD 20892
Tel: 301-496-0357
Fax: 301-496-843

Raman Gangakhedkar
Senior Research officer
National AIDS Research Institute - India
c/o M. Shepherd
Johns Hopkins University
720 Rutland Avenue, Ross 1159
Baltimore MD 21205

Maria Vileni Garcia
Sociologist
Casa de Passagem
1717 Massachusetts Avenue, NW
Suite 302
Washington DC 20036
Tel: 202-797-0007
Fax: 202-797-0020

Ricardo Garcia
Medical Doctor
Ministry of Health of Colombia
Cra 70 # 32-71
Piso 11
Bogota
Colombia
Tel: 284-2021
Fax: 336-0178

Kevin J. Gardner
Co-Founder and Chairman
AESOP Center
P.O. Box 27
Moscow 121552
Russia
Tel: 70951418315
Fax: 70951418315

Rachel Garfield
Intern
White House AIDS Policy Office
750 17th Street
Suite 600
Washington DC 20503
Tel: 202-632-1090
Fax: 202-632-1096

Carol Gayle
Programme Management Officer
Caribbean Epidemiology Center (CAREC)
16-18 Jamaica Boulevard
Federation Park
Port of Spain
Trinidad
West Indies
Tel: 809-622-2153
Fax: 809-622-2792

Jacob A. Gayle
Chief, HIV/AIDS Division
USAID/W:G/PHN/HN
G/PHN/HN/HIV-AIDS
SA - 18, Suite 1200
Washington DC 20523-1817
Tel: 703-875-4494
Fax: 703-875-4686

Helene Gayle
Acting Director, National Ctr. for HIV, STD & TB Prevention
Centers for Disease Control and Prevention
1600 Clifton Road
NE MS E07
Atlanta GA 30333
Tel: 404-639-8000
Fax: 404-639-8600

156

Eddy Genece
Resident Advisor - Haiti
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Karen L. Geney
Technical Assistance Coordinator
National Pediatric and Family HIV Resource Center
Suite 422
910 17th Street NW
Washington DC 20006
Tel: 202-785-3509
Fax: 202785-3545

Sarah George
AIDS Prevention Coordinator
USAID/Dominican Republic
Unit #5541
APO AA 34041-5541
Tel: 809-221-1100
Fax: 809-221-6565

Rebecca George
Program Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Phibeon Tonderai Gerald Muchando
I. E.C./N.G.O. Officer
c/o AIDSCAP
P.O. Box CY 1417 Causeway
Harare
Zimbabwe

Phyllis Gestrin
Resident Technical Advisor
AID/AFR
1111 N. 19th Street
Room 300
Arlington VA 22209
Tel: 703-235-4446
Fax: 703-235-4466

Annette Ghee
Program Manager
Center for AIDS and STD
University of Washington
1001 Broadway, Suite 215
Seattle WA 98122
Tel: 206-720-4211
Fax: 206-720-4209

Duff Gillespie
Deputy Assistant Administrator
Center for Population, Health and Nutrition
USAID
Washington DC 20523-1817

Wendy Githens
Senior Program Officer, PVO/NGO Grants
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

David M. Gittelman
Public Health Advisor
Centers for Disease Control & Prevention
153 Ridley Lane
Decatur GA 30030
Tel: 404-488-1104
Fax: 404-488-1003

Carolina Godinez
Program Officer
Program for Appropriate Technology in Health (PATH)
1990 M Street NW, Suite 700
Washington DC 20036
Tel: 202-822-0033
Fax: 202-457-1466

Christian Draven Godwin
HIV Coordinator/Counselor
Student Health Service
UNC-Chapel Hill
CB#7470
Chapel Hill NC 27599
Tel: 919-966-6658
Fax: 919-966-3461

Shirley Goering
Educator
World Vision
1603 Wrightson Drive
McLean VA 22101
Tel: 703-848-0727
Fax: 703-848-0727

Elizabeth Gold
Consultant
RRI Box 211G
Roseland VA 22967
Tel: 804-277-8777
Fax: 804-277-8817

Ann S. Goldman
Research Consultant
PAHO AIDS/STD Program
525 23rd Street, NW
Washington DC 20037
Tel: 202-861-6661
Fax: 202-861-6088

Dr. Bayardo Gomez
Director
Comite de Vigilancia y Control del SIDA (COVICOSIDA)
EPS# P-6555, P.O. Box 02-5261
Miami FL 33102-5261
Tel: 809-586-8987
Fax: 809-320-7614

Nestor Gonzalez
GNPT Amigos de la Vida Foundation
Esquina Padre Sierra, piso 2
Carelitas 3322
Caracas
Venezuela
Tel: 582-817-213
Fax: 582-817-213

Gail Goodridge
Associate Director, Office of Country Programs
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Patrick Gourley
HIV Case Manager
Provident Hospital of Cook County
500 East 51st Street
Chicago IL 60615
Tel: 312-572-2728
Fax: 312-572-1813

Mark Grabowski
Chief Medical Officer for International Research
NIH/DIADS
2762 Ft. Scott Dr.
Arlington VA
Tel: 301-496-6177

Edward C. Green
Consultant
2807 38 Street NW
Washington DC
Tel: 202-338-3221
Fax: 202-338-9267

159

Cynthia Z. Green
HIV Program Director
The Washington Free Clinic
PO Box 43202
Washington DC 20011
Tel: 202-667-1106
Fax: 202-328-2652

Samantha Grey
Program Manager
Population Services International
1120 19th Street
Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Gary G. Grieve
HIV/AIDS Projects Coordinator
Case Manager
NAF Multicultural Human Development Corp.
2509 Dakota Avenue
South Sioux City NE 68776
Tel: 402-494-6576
Fax: 402-494-2784

Bertrovna Bourdeau Grimard
Marketing Director
Population Services International - Haiti
272 Rue du Magasin de l'Etat, BP 2041
Port-au-Prince
Haiti
Tel: 509-22-3271
Fax: 509-22-3205

Robert Gringle
Communications Associate
IPAS
P.O. Box 100
Carrboro NC 27510
Tel: 919-967-7052
Fax: 919-929-0258

Olga A. Grinstead
Research Psychologist
University of California at San Francisco
Center for AIDS Prevention Studies
74 New Montgomery Street, Suite 600
San Francisco CA 94105
Tel: 415-5979168
Fax: 415-5979213

Sven Groennings
Consultant
Civil-Military Alliance to Combat HIV and AIDS
1104 Roberta Court
McLean VA 22101
Tel: 703-356-6030
Fax: 703-356-6030

Theresa Gruber-Tapsoba
Program Manager
PSI - Cameroon,Guinea
1120 19th Street, NW, Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Ernesto Guerrero
Director
PROCETS
EPS# P-6555, P.O. Box 02-5261
Miami FL 33102-5261
Tel: 809-681-3394
Fax: 809-681-4827

Suriadi Gunawan
Director, Institute for Health Research
Ministry of Health, Republic of Indonesia
Litbangkes
Jl. Percetakan Negara No. 29
Jakarta
Indonesia
Tel: 62-214244375

Geeta Rao Gupta
Vice President
International Center for Research on Women
1717 Massachusetts Avenue, NW
Suite 302
Washington DC 20036
Tel: 202-797-0007
Fax: 202-797-0020

Anita Haddawat
Intern Investment Program
PPC/SA
2140 L Street, NW
Apt. #704
Washington DC 20037
Tel: 202-496-0726

Carol Haddaway
Program/ADM Coordinator
JHU/PCS
111 Market Place
Suite 310
Baltimore MD 21202-4024
Tel: 410-695-6244
Fax: 410-695-6266

Bernadette Hadden
Project Director
DVC Research Office
University of Natal
King George V Avenue
Durban - 4001
South Africa
Tel: 27-31-260
Fax: 27-312602384

Lan Hader
Vice President
Association Narocaine de Jeune Cmtre le Fido
Abis Aben Kashim Ezzahraou
BP 1811
Casablanca
Tel: 295326
Fax: 295327

Robert H. Haladay
Health Population Office
USAID/Washington
AFR/SP Dept of State, Room 2847
21st and Virgina Avenue
Washington DC 20523
Tel: 202-647-8767
Fax: 202=647-2993

David Hale
Program Analyst
Centers for Disease Control and Prevention HIV/AIDS Prev.
1600 Clifton Road NE, D 21
Atlanta GA 30333
Tel: 404-639-8317
Fax: 404-639-0910

David Hall
CEO
Black Press International
1338 K Street, SE
Washington DC 20008

Scott Halstead
Director, Infectious Diseases
US Navy
NMRDC
Bethesda MD 20852
Tel: 301-295-0883
Fax: 301-295-4033

Tjanja Hambartini
Communication and Social Services Division
R.E. Martadinata Street
Sekupang
P. Batam 29422
Indonesia
Tel: 0778-322347

Julie Hamblin
Partner
Ebsworth & Ebsworth, Australia
135 King Street
Sydney N.S.W.
Australia
Tel: 61 2 2342366
Fax: 61 2 2353606

158

Abby Harnson
Research Associate
Mother Care/JSI
1616 North Fort Meyer Drive
11th Fl.
Arlington VA 22209
Tel: 703-528-7474
Fax: 703-528-7480

Jeffrey Harris
Managed Care Coordinator
Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta GA 30333
Tel: 404-639-4500
Fax: 404-639-4413

Muriel Harris
Society for Women and AIDS in Africa
30-A Wallace Johnson Street
P.O. Box 603
Freetown
Sierra Leone

Tekena Obu Harry
Assistant Director (Medical Research)
University of Maiduguri Teaching Hospital
P.M.B. 1414
Maiduguri, Borno State
Nigeria
Tel: 076-232-501
Fax: 234-76232702

Meredith Hart
Research Specialist
Aspen System Corporation
1600 Research Boulevard
MS1E
Rockville MD 20850
Tel: 301-2515386
Fax: 301-738-6616

Susan Hassig
Senior Advisor
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Peter Hawley
Medical Director
Whitman-Walker Clinic
1701 14th Street NW
Washington DC 20009
Tel: 202-745-6159
Fax: 202-745-6159

Janet M. Hayman
Resident Advisor, Kenya
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Karen A. Heckert
Senior Program Officer
JHU/CCP
111 Market Place
Baltimore MD 21202-4012
Tel: 410-659-6123
Fax: 410-659-6266

Lori Heise
Project Director
Pacific Institute for Women's Health
1730 Rhode Island Avenue NW
Suite 172
Washington DC 20036
Tel: 703-516-9779
Fax: 703-516-9781

Michal Herbsman
Programs Coordinator
Jerusalem AIDS Project
P.O.B. 7956
Jerusalem 91077
Israel
Tel: 9722-612266
Fax: 9722-412204

Carrie Hessler-Radelet
Health/AIDS Advisor
USAID
USAID/HIRD
Jakarta
Indonesia
Tel: 62-21-360360
Fax: 62-213806694

Rod Hoff
Chief Efficacy Trails
NIH DIADS/NIAID
6003 Executive Boulevard
Solor Building
Rockville MD
Tel: 301-496-6177
Fax: 301-402-3865

Irving Hoffman
Research Instructor
University of North Carolina at Chapel Hill
Division of Infectious Diseases
CB # 7030
Chapel Hill NC 27599-7030
Tel: 919-966-6325
Fax: 919-966-5775

Jeffrey A. Hoffman
Senior Vice President, Executive Director
Center for Drug Treatment and Research, Koba Associates
1156 15th Street NW, Suite 200
Washington DC 20005
Tel: 202-328-5733
Fax: 202-659-3027

Jan Hogle
Evaluation Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Panla E. Hollerbach
Senior Associate
Sociomedical Resource Associates, Inc
10143 Oakwood Chase Court
Oakton VA 22124-2727
Tel: 703-255-0229

Christine A. Hollis
Director of Education and Training
Planned Parenthood League of Massachusetts
9 Bishop Allen Drive
Cambridge MA 02139
Tel: 617-492-0518
Fax: 617-661-9212

Vivian Hon
Research Specialist
The World Bank
1818 H Street, NW
Room 511-048
Washington DC 20433
Tel: 202-473-3429
Fax: 202-522-3234

Carol Hooks
Program Officer
Program for Appropriate Technology in Health (PATH)
1990 M Street NW, Suite 700
Washington DC 20036
Tel: 202-822-0033
Fax: 202-457-1466

Porsha Howell
Vice Chairman
National Aid Program
Box 132
Providenciales
Turks Islands
Tel: 809-964-4313
Fax: 809-946-4532

159

Lois Hue
Project Director HIV/STD
Jamaica Red Cross
Central Village
St. Catherine
Jamaica
Tel: 984-7863

Gail D. Hughes
Fogarty Fellow
Columbia University, Fogarty Fellowship Training Program
c/o Zena Stein
School of Public Health and Epidemiology
630 W. 168th Street
New York, NY 10032
Tel: 212-305-4414
Fax: 212-305-9413

Philip R. Hughes
Private Sector Officer
Population Services International/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Beri Hull
Community Education and T.A. Coordinator
National Association of People With AIDS
1413 K. Street, NW, 7th Floor
Washington DC 20005
Tel: 202-898-0414
Fax: 202-898-0435

Anjum Husain
Intern
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Tina Hylton-Kong
Medical Doctor
Ministry of Health
EPI Unit
30-34 Half Way Tree Road
Kingston 5
Jamaica
Tel: 926-1819
Fax: 926-5674

Ndoye Ibra
Manager
National AIDS Control Programme
BP 3435
Dakar
Senegal

Vicki Iden
Accountant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Andriei Illias
USIA Writer
USIA
301 4th Street, NW
Washington DC 20547
Tel: 202-619-4129
Fax: 202-619-4077

Rudolph E. Jackson, M.D.
Director, Zambia HIV/AIDS Prevention Project
Morehouse School of Medicine
720 Westview Drive, SW
Atlanta GA 30310-1495
Tel: 404-752-1706
Fax: 404-752-1060

F.N.O. Adagogo Jaja
National Coordinator/Project Director
AIDS Must Go Group, Nigeria
Block 10, Flat 19
Games Village Off Bode Thomas Street
Suru-Lere Lagos
Nigeria
Tel: 861039

Richard A. Jenkins
Senior Scientist
Henry M. Jackson Foundation
1 Taft Court
Suite 250
Rockville MD 20850
Tel: 301-294-1880
Fax: 301-294-1896

L. Jenkins-Waelk
Fogarty Fellow
University of Zimbabwe
5 Stoachan Street
Hielbennce, Waterfalls
Harare
Zimbabwe
Tel: 263-4-731691

Valerie Jiminez
Board Member
Housing Works - New York
549 Broadway, Suite 700
New York NY 10022

Henrietta Johnson
Project Coordinator
HRS / Palm Beach County Public Health Unit
38754 State Road 80
Belle Glade FL 33430
Tel: 407-996-1600
Fax: 407-992-8363

Charlotte Johnson-Welch
Public Health Specialist
International Center for Research on Women
1717 Massachusetts Avenue, NW
Suite 302
Washington DC 20036
Tel: 202-797-0007
Fax: 202-797-0020

Alan G. Johnston
Senior Population Specialist
Center for International Development (CID)
Research Triangle Institute
P.O. Box 12194
Research Triangle Park NC 27709
Tel: 919-541-7394
Fax: 919-541-6621

Ntsiki Jolingana
Coordinator - Welkom Goldfields Mining Intervention
National Progressive Primary Health Care Network (NPPHCN)
#8 Alma Court, Corner Twist & Hammond
Reitspark
Welkom 9459
South Africa
Tel: 057-396-1699
Fax: 057-352-2050

W.D. Joseph
Director
Adventist Development and Relief Agency/Sri Lanka
37 Purana Road
Wattegedera, Maharagama
Sri Lanka
Tel: 9471-22372
Fax: 9471-852049

160

Claudes Kamenga
Research Officer, Behavioral Research Unit
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Benu B. Karki
Director
National Center for AIDS and STD Control (NCASC)
Teku
Kathmandu
Nepal

Danuta M. Kasprzyk
Health and Population
4000 N.E. 41st Street, P.O. Box 5395
Seattle WA 98015-9901

Carole Kauffman
Manager, Policy and Planning
American Red Cross, Health and Safety Services
811 Gatehouse Road
Falls Church VA
Tel: 703-206-7637
Fax: 703-206-7765

Elvie Zulka Kautzia Rahmawati
Medical Doctor
Kudalaut, Villa Windsor No. 7
Bukit Senyum
Batam
Indonesia
Tel: 0778-421267

Kevin Kavanaugh
HIV Trainer
U.S. Department of Agriculture
1843 Ontario Place, NW
Washington DC 20009
Tel: 202-483-9230

Maura Keaney
Information Programs Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Joseph Kelaghan
Program Officer
National Institute Child Health & Human Development
9000 Rockville Pike
Bethesda MD 20892
Tel: 301-496-4924
Fax: 301-496-0962

Paula Kelly
Coordinator of HIV/AIDS Programs
CARE International - Vietnam
130A Thuy Khue
Hanoi
Vietnam
Tel: 84-8-650232
Fax: 84-8-650232

Robert Kelly
Technical Assistant
Rakai Project/Columbia University
Box 1691
Wasaka
Uganda
Tel: 256-48121140
Fax: 256-48121140

Michael R. Kent
Behavioral Scientist/Project Administrator
John Snow, Inc.
210 Lincoln Street, 6th Floor
Boston MA 02111
Tel: 617-482-9485
Fax: 617-482-0617

Thomas M. Kerkering
Professor of Medicine
Medical College of Virginia
PO Box 980049
Medical College of Virginia
Richmond VA 23298
Tel: 804-828-9711
Fax: 804-828-0570

Kathy Kerr
HIV Prevention Coordinator
Durham County Health Department
414 East Main Street
Durham NC 27701
Tel: 919-560-7793
Fax: 919-560-7772

George S. Kerr III
Administrative Services Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Ndunge Kiiti
Director, Communications
MAP International - Africa
514 Wyckoff Street, Apt. B
Ithaca NY 14850
Tel: 607-257-8008

Theodore M. King
President/Chief Operating Officer
Family Health International
2224 E. Chapel Hill Nelson Highway
Durham NC 27713
Tel: 919-544-7040
Fax: 919-544-7261

Karungari Kiragn
Research and Evaluation
Johns Hopkins University PCS/PIP
111 Market Place, Suite 310
Baltimore MD 21202
Tel: 410-659-6236
Fax: 410-659-6266

Rose Bulya Kizito
Librarian
The AIDS Support Organization
P.O. Box 10443
Kampala
Uganda
Tel: 25641-271752
Fax: 25641-251982

Winslow Klaskala
Assistant Professor
University of Miami School of Medicine
P.O. Box 6522
Miami FL 33152
Tel: 305-243-4072
Fax: 305-548-4687

Kent Klindera
HIV Education Program Associate
Advocates for Youth
1025 Vermont Avenue, Suite 200
Washington DC 20009
Tel: 202-347-5700
Fax: 202-347-2263

Ashley Kline
Government Affairs
AIDS Action Council
1875 Connecticut Avenue, NW
Suite 700
Washington DC 20008
Tel: 202-986-1300
Fax: 202-986-1345

Jennifer W. Knox
Program Assistant
Johns Hopkins University - Center for Communication Programs
School of Hygiene and Public Health
111 Market Place, Suite 310
Baltimore MD 21202-4024
Tel: 410-659-6300
Fax: 410-659-6266

161

Nouhoum Koita
AIDS/STD Project Coordinator
PLAN International
c/o Karla Steele
155 Plan Way
Warwick RI 02886
Tel: 401-7385600
Fax: 401-7385608

Kathi Kotellos
Associate Evaluation Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Katherine Kreis
USAID
1601 N. Kent Street
Arlington VA 22209
Tel: 703-875-4721

Liz Kresse
Staff Associate
U.S. Conference of Mayors
1620 Eye Street NW
Washington DC 20006
Tel: 202-861-6757
Fax: 202-887-0652

Daria Kruprova
Communications Assistant
PACT
1901 Pennsylvania Avenue, NW
Suite 501
Washington DC 20006
Tel: 202-466-5666
Fax: 202-466-5669

Alexis Kuate-Boupda
Resident Advisor, Cameroon
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

S.K. Kuthiala
Associate Professor
University of North Florida
2461 Bernice Drive
Jacksonville FL 32257
Tel: 904-262-4512
Fax: 904-739-0498

Chitra Kuthiala, Capt. MC, USN
Head, Allergy/Clinical Immunology Division
Naval Hospital (Code 0301)
Naval Air Station
Jacksonville FL 32214-5000
Tel: 904-777-7787
Fax: 904-777-7483

Mr. LaHuffman
Peace Corps Fellow
Peace Corps
PO Box 42209
Washington DC 20015
Tel: 202-606-3205

Deirdre LaPin
Senior Technical Advisor
USAID
3732 Veazey Street, NW
Washington DC 20016
Tel: 703-975-5339

Jon A. Lacey
AIDS Education Project
Michigan State University
415 West Fee Hall
East Lansing MI 48824
Tel: 517-335-9324
Fax: 517-432-2662

Judith M. Lamar
16341 Oak Springs Drive
Ramona CA 92064
Tel: 619-789-5256

Peter Lamptey
Senior Vice-President, AIDS Programs
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Nancy Lamson
Senior Associate
Family Health International
P.O. Box 13950
Research Triangle Park NC 27709
Tel: 919-544-7040
Fax: 919-544-7261

Cate Lane
Program Associate
Advocates for Youth
1025 Vermont Avenue, Suite 200
Washington DC 20005
Tel: 202-347-5700
Fax: 202-347-2263

Evelyne Laurin
Project Manager - BHSS
USAID AFR/EA Rm. 2733A
USAID - Department of State
Washington DC 20523
Tel: 202-647-9069
Fax: 202-647-9805

Michael J. Lavelline
Director, Finance & Administration
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Joan Lawrence
Development/Community Health Services
Milwaukee Indian Health Board, Inc.
930 North 27th Street
Milwaukee WI 53208
Tel: 414-931-8111
Fax: 414-931-0443

Agathe Lawson
IEC Technical Advisor, Senegal
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Shui-shan Lee
Consultant
AIDS Unit, Department of Health, Hong Kong
5/F Yaumatei JCC
145 Battery Street
Yaumatei, Kowloon
Hong Kong
Tel: 852-27804390
Fax: 852-27809580

Efrew Tovar Leoa
Deputy Director
Midwest Farmworker Employment Training
PO Box 1231
St. Cloud MN 56302
Tel: 612-253-7010
Fax: 612-255-1215

Alexandra Levitt
Science Officer
US Department of State
2201 C Street, NW
OES/STH Room 5806
Washington DC 20520
Tel: 202-647-4542
Fax: 202-736-7336

162

Denise Lionetti
Project Director
Health Technical Services
1601 N. Kent Street, Room 1104
Arlington VA 22209
Tel: 703-516-9166

Donna Lizewski
Program Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

G. C. Lodha
Secretary/Director, Health, Education & Primary Health Care
Seva Mandir Udaipur
Fatehpura
Udaipur (Rai) 313001
India
Tel: (294)560047
Fax: (294)560047

Wesley Lona, Jr.
HIV/AIDS Prevention Educator
Harvest America Corporation
14th and Metropolitan
Kansas City KS 66103-1084
Tel: 913-342-2121
Fax: 913-342-2861

Iris Long
ACT UP - New York
84-09 35th Avenue
Jackson Heights NY 11372

Moria Lopes
Executive Director
NOBCO - National Organization of Black County Officials
440 First Street NW, Suite 500
Washington DC 20001
Tel: 202-347-6953
Fax: 202-393-6596

Frank Lostumbo
President
NCIH
1701 K Street, NW
Washington DC 20006
Tel: 202-833-5902
Fax: 202-833-0075

Lisbeth Loughran
Program Officer
PACT
1901 Pennsylvania Avenue, NW
Washington DC 20006
Tel: 202-466-5666
Fax: 202-466-5669

Nancy Lowenthal
Research Assistant
PSI
1120 19th Street, NW
Suite 600
Washington DC
Tel: 202-785-0072
Fax: 202-785-0120

Bradford Lucas
Program Manager
PSI
1120 19th Street, NW
Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-1020

Sylvestre Ludzen
13 Rue DeBussy
BP 1390
Port-au-Prince
Haiti

Mary Luke
Vice President, Field Programs
CEDPA
1717 Massachusetts Avenue, NW
Washington DC 20036
Tel: 202-667-1142
Fax: 202-332-4496

Sonja Lunn
Health Educator
AIDS Secretariat, Bahamas
P.O. Box N215
Nassau
Bahamas
Tel: 809-325-5120

William Lyerly
Tropical and Infectious Diseases Coordinator
USAID/AFR/SD
Department of State
Room 2744 NS
Washington DC 20523
Tel: 202-647-6542
Fax: 202-647-2993

Catherine Lyttle
Communication Specialist
Ministry of Health - Jamaica
30 - 34 Half Way Tree Road
Kingston 5
Jamaica
Tel: 926-1819
Fax: 926-5674

Terence MacCaughan
Director for Programmes/AIDS Project Director
PLAN International, Mali
B.P. 1598
Bamako
Mali
Tel: 223-230583
Fax: 223-228143

Keys MacManus
Senior Technical Advisor
USAID/W
210 Duke Street
Alexandria VA 22314
Tel: 703-875-4665

Joan MacNeil
Research Officer, Behavioral Research Unit
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Timothy Mackay
Country Director
Project Concern International
P.O. Box 99/JKPJ
Jakarta 10210
Indonesia
Tel: 62-215707904
Fax: 62-215707904

Jillian M. Mackin
Membership and Marketing Coordinator
National Association of People With AIDS
1413 K. Street, NW, 7th Floor
Washington DC 20005
Tel: 202-898-0414
Fax: 202-898-0435

Elizabeth Madraa
Programme Manager STD/AIDS
Ministry of Health, Uganda
P.O. Box 8
Entebbe
Uganda
Tel: 20297
Fax: 256-42-20608

Hally Mahler
Program Assistant, BCC Unit
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

163

Reid Maki
Manager
Association of Farmworker Opportunity Programs
1611 N. Kent Street, Suite 910
Arlington VA 22314
Tel: 703-528-4141
Fax: 703-528-4145

Bunmi Makinwa
Communication Officer, Africa Regional Office
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Janet Malikongwa
AIDS at the Workplace Programme Coordinator
Community Health Services Division
Private Bag 00269
Gabarone
Botswana
Tel: 267-374-351
Fax: 267-374-354

Carol Malope
South African Black Social Workers Association
P.O. Box 8441
Johannesburg 2000
South Africa
Tel: 11-333-5010
Fax: 11-333-3578

Gregory Maltz
Staff Writter
IMNG
12230 Wilkins Avenue
Rockville MD 20852
Tel: 301-816-8784
Fax: 301-816-8738

Corazon R. Manaloto
Public Health Advisor
USAID/Philippines
17th Floor, Ramon Magsaysay Center
1680 Roxas Boulevard
Manila
Philippines
Tel: 632-522-4411
Fax: 632-521-5241

Timothy Manchester
Director, PSI Tanzania
Population Services International
1120 19th Street, NW, Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Purnima Mane
World Health Organization
20, Avenue Appia
CH-11211
Geneva
Switzerland
Tel: 4122-7912111
Fax: 4122-7914179

Joanne E. Mantell
Research Consultant/Psychosocial & Qualitative Care
HIV Center for Clinical & Behavioral Studies
Columbia University
722 West 168th Street
New York NY 10032
Tel: 212-982-1030
Fax: 212-473-3927

Sibongile Manyathi
Project Manager, Champs Project
National Association of Child Care Workers (NACCW)
Box 28323
Malvern, Durban 4055
South Africa
Tel: 031-463-1099
Fax: 031-44-1106

Gloria Maqutu
Field Worker - Project Champs
NACCW
c/o Ms. Sibongile Manyathi
Box 28323
Malvern, Durban 4055
South Africa
Tel: 031-463-1099
Fax: 031-44-1106

Cynthia Mariel
Project HOPE/Malawi
7129 Sycamore Avenue
Takoma Park MD 20912
Tel: 301-270-1582

Mary L. Markowicz
LA/C Evaluation Program Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Suzanne Marks
Johns Hopkins University
72 Thayer Avenue
Silver Spring MD 20910
Tel: 301-585-8125

Miguel Martinez
Medico
Metro Salud
Miniserio Salud Publica
Cra 84 #50A-20
Medillin
Colombia
Tel: 5119432

Maricarmen Martinez de Estrada
Project Manager Assistant
USAID / El Salvador
AM Embassy - AID Unit No. 3110
APO AA 34023
Tel: 503-298-1666
Fax: 503-298-0885

Narcisse Maryse
Health Technical Director
Save the Children
13 Rue de DeBussy
Port-au-Prince
Haiti
Tel: 454606
Fax: 45003?

Myrta Mathews
Associate
Prospect Associates
1801 Rockville Pike, Suite 500
Rockville MD 20852
Tel: 301-468-6555
Fax: 301-770-5164

Irene Mathias
Scholarship Program Consultant
XI International Conference on AIDS
11th Floor-1090 W. Pender
Vancouver BC V6E2N7
Canada
Tel: 604-6683225
Fax: 604-6683242

Olivia Mauerstein-Bail
Senior Program coordinator
United Nations Development Project
1 UN Plaza
Room FF 1288
New York NY 10017
Tel: 212-906-6349
Fax: 212-906-6350

Alison H. Mayas
Vice President
Mayatech Corperation
1300 Spring Street
Silver Spring MD 20910
Tel: 301-587-1600
Fax: 301-587-1686

164

Joan C. Mayer
MCH-FP Consultant
6104 Wooten Drive
Falls Church VA 22044
Tel: 703-532-1732

Tom Mboya Okeyo
Epidemiologist/Project Coordinator
Kenya National AIDS & STD Control Program
P.O. Box 19632
Nairobi
Kenya
Tel: 2542-729527
Fax: 2542-729504

David McAlary
Science Correspondent
Voice of America
330 Independence Avenue, SW
Washington DC 20547
Tel: 202-619-0713
Fax: 202-619-2400

Elizabeth J. McCabe
Program Assistant
Population Services International
1120 19th Street, NW
Washington DC 20007
Tel: 202-785-0072
Fax: 202-785-0120

Theresa McCann
Consultant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Mary Kay McGeown
Program Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Vivian McLaurin
Acting Project Coordinator
Family Health International
2224 Chapel Hill - Nelson Highway
Durham NC 27705
Tel: 919-544-7040
Fax: 919-544-0207

Tim McLellan
Assistant Program Manager
Population Services International
1120 19th Street, NW
Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Rosie McMahan
Assistant Director
CASPAR Alcohol & Drug Education Program
226 Highland Avenue
Somerville MA 02143
Tel: 617-623-2080
Fax: 617-623-7665

Shaun Mellors
Global Network of People Living With HIV/AIDS (South Africa)
P.O. Box 1126
1001 G.S.
Amsterdam
The Netherlands

Teal Mendez
HIV Prevention Education Coordinator
UMOS Inc. Special Projects
929 West Mitchell Street
Milwaukee WI 53204
Tel: 414-671-5700
Fax: 414-671-4833

Gabriel E. Mendy
Medical Director, Early Intervention Services
Office of Public Health - Louisiana
P.O. Box 750339
New Orleans LA 70175-0339
Tel: 504-568-8367
Fax: 504-899-0905

Michael H. Merson
Dean of Public Health
Yale University
Department of Epidemiology/Public Health
60 College Street, P.O. Box 208034
New Haven CT 06520-8034
Tel: 203-785-2867
Fax: 203-785-6103

Thierry Mertens
World Health Organization
Global Programme on AIDS
30 Avenue Appia CH 1211
Geneva 27
Switzerland

Lisa Messersmith
Senior Technical Advisor on Women and AIDS
USAID HIV-AIDS Division
G/PHN/HN/HIV-AIDS
Suite 1200 SA-18
Washington DC 20523

Pierre-Marie Metangmo
President
L'Association Camerounaise Pour La Sante et le Developpement
c/o David Haynes
8430 Freyman Drive
Chevy Chase MD 20815-3848
Tel: 301-585-6958

Marilyn Metcalf-Whittaker
Acting Director, Clinical Applications
Family Health International
2224 Chapel Hill - Nelson Highway
Durham NC 27705
Tel: 919-544-7040
Fax: 919-544-0207

Genie Miebach
Finance Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Miram Milanes de Castro
Project Coordinator
Comite de Vigilancia y Control del SIDA (COVICOSIDA)
EPS# P-6555, P.O. Box 02-5261
Miami FL 33102-5261
Tel: 809-586-8987
Fax: 809-320-7614

Marcia W. Miller
HIV/AIDS Instructor Trainer
American Red Cross
100 Elmsmere Road
Mt. Vernon NY 10552
Tel: 914-668-5206

Clarence Mini
Resident Advisor - South Africa
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

165

Liz Miranda
Acquisition Specialist
Aspen Systems Corp.
1600 Research Boulevard
Mailstop IE
Rockville MD 20850
Tel: 301-251-5589
Fax: 301-738-6616

Sheila Mitchell
Director, Program Management Division
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Janet L. Mitchell
Chief of Perinatology
Harlem Hospital Center
Department of OB/GYN, Room 4139
506 Lenox Avenue
New York NY 10037-1802
Tel: 212-939-4333
Fax: 212-939-4097

Steven Mobley
Social Marketing Consultant
Stelos International Marketing and Sales Company
P.O. Box 441001
Ft. Washington MD 20744
Tel: 301-248-3652
Fax: 301-248-4136

Khadijat L. Mojidi
Deputy Director, Africa Programs
CEDPA
1717 Massachusetts Avenue, NW
Washington DC 20036
Tel: 202-667-1142
Fax: 202-332-4476

Kaiya Montaocean
Co-Director
Center for National and Traditional Medicines
1601 Connecticut Avenue NW
Suite 201C
Washington DC 20009

Richard Monteith
TAACS Advisor
USAID/Nicaragua
AMEMB Managua USAID
Unit 2712 Box 9
APO AA 34021
Tel: 505-2-670502
Fax: 505-2-783828

Leslye Moore
Program Officer, Asia & Latin America/Caribbean
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Tim Moore
Durham County Health Department
3402 Freeman Road
Durham NC
Tel: 560-7768

Kathy Moore
201 West 86th Street
New York NY 10010

K. Mona Moore
1712 16th Street
#604
Washington DC 20036
Tel: 202-387-7136

Roscoe M. Moore, Jr.
Associate Director, Development Support and African Affairs
Dept. of Health and Human Services
5600 Fishers Lane, Room 18-87
Parklawn Building
Rockville MD 20853
Tel: 301-443-9942
Fax: 301-443-6288

Patricia Morales
HIV Technical Assistance/Traning Specialist
UMOS Inc. Special Projects
929 West Mitchell street
Milwaukee WI 53204
Tel: 414-671-5700
Fax: 414-671-4833

Melinda Moree
Consultant
Program for Appropriate Technology in Health (PATH)
4 Nickerson Street
Seattle WA 98109

Lic. Luis Moreno
Project Coordinator
Centro de Orientacion y Informacion Integral (COIN)
EPS# P-6555, P.O. Box 02-5261
Miami FL 33102-5261
Tel: 809-681-1515
Fax: 809-549-4521

Karen Morita
Technical Advisor/PHN Coordinator for US-Japan Common Agenda
USAID
Office of Health and Nutrition
G/PHN/HN/HIV-AID, SA-18
Rm. 1204
Washington DC 20523-1817
Tel: 703-875-4645
Fax: 703-875-4686

Claudia Morrissey
Reproductive Health Advisor
USAID
Office of Health and Nutrition
G/PHN/HN/NMH SA-18
Suite #1200
Washington DC 20523-1817
Tel: 703-875-7281
Fax: 703-875-4686

Aryc W. Mosher
Health Education Specialist
Telamon Corporation
6250 W. Michigan Avenue
Suite C
Lansing MI 48917
Tel: 517-323-7002
Fax: 517-323-9840

Biotumelo Motshidisi
AIDS at the Workplace Programme Coordinator
Ministry of Health, Community Health Services Division
Private Bag 00269
Gabarone
Botswana
Tel: 267-374-351
Fax: 267-374-354

Marjorie Muecke
Program Officer for AIDS
The Ford Foundation Reproductive Health & Population Prog.
320 East 43rd Street
New York NY 10017

Joshua Mugerwa
Engineer
National Food Processors Association
4831 86th Street NW, #2H
Washington DC 20808
Tel: 202-637-8053

Eustace Muhondwa
University of Dar-es-Salaam
Dar-es-Salaam
Tanzania

166

Priscilla Mujuru
AIDS Project Manager
Nat'l Employment Council for the Transport Operating Indust.
Box 2100
Harare
Zimbabwe
Tel: 794063
Fax: 263-4-735025

Matthew Murguia
Acting Deputy Director, Division of Policy and Data
Office of Minority Health
5515 Security Lane, Suite 1000
Rockville MD 20852
Tel: 301-443-9923
Fax: 301-443-8280

Jessica Muro
Project Officer
American Association for World Health
1129 20th Street, NW
Suite 400
Washington DC 20036
Tel: 202-466-5883
Fax: 202-466-5896

Deborah Murray
Program Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Warren Naamara
Resident Advisor, Zimbabwe
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Nancy Nauhbar
JHU
3333 North Charles Street
#900
Baltimore MD 21218
Tel: 410-243-7199

Amy Naylor
Health Educator
American Social Health Association
5001 Kerley Road
Durham NC
Tel: 919-493-0530

Thembile Ndlovu
Fieldworker - Project Champs
NACCW
c/o Ms. Sibongile Manyathi
Box 28323
Malvern, Durban
South Africa
Tel: 031-463-1099
Fax: 031-44-1106

Charles E. Nearn
Membership & Marketing Associate
National Association of People With AIDS (NAPWA)
1413 K Street NW
Washington DC 20005
Tel: 202-898-0414
Fax: 202-898-0435

Joe R. Neel
National Public Radio - Science Unit
635 Massachusetts Avenue, NW
Washington DC 20007
Tel: 202-414-2778
Fax: 202-414-3229

Lucile F. Newman
Professor
Brown University
Box G-A4
Providence RI 02912
Tel: 401-863-1637
Fax: 401-863-3173

Irene Ngaiza
Information Programs
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Abigail Nhova
Army AIDS Coordinatior
Zimbabwe National Army
18 Barnour Road
Cranborng Park
Harare
Zimbabwe
Tel: 736326
Fax: 732710

Cheikh L. Niang
Project Director
Institut des Sciences de l'Enviornment, Faculte des Sciences
Universite Cheikh Anta Diop
Dakar
Senegal
Tel: 221-24-60-25
Fax: 221-14-24-37

Gloria Nichtawitz
Project Coordinator
USAID/Peru
Larrabure y Unanue 110
Lima 1
Peru
Tel: 5114-333200
Fax: 5114-337034

Phillip Nieburg
Centers for Disease Control and Prevention
Mailstop E-50
CDC
Altanta GA 30333
Tel: 404=639-6100

Alfred Nimocks
Confernce Coordinator
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Isabella Njagi
Project Manager
Family Life Promotion and Services
P.O. Box 19698
Nairobi
Kenya
Tel: 254-2-339087
Fax: 254-2-339087

Alphonse Nkusi
c/o AIDSCAP/Rwanda
Blvd de la Revolution, B.P. 3149
Building Banque, Rwandaise de Developpment (BRD), Kigali
Rwanda
Tel: 250-76193
Fax: 250-74038

Regina H. Norman
Project Specialist, Health Education Division
National Assn. for Equal Opportunity in Higher Education
400 12th Street NE, Room 206
Black Higher Education Center
Washington DC 20002
Tel: 202-543-9111
Fax: 202-543-9113

Karen J. Nurick
Health/Population Officer
USAID
G/PHN/FPS SA18, Rm. 714
1601 N. Kent Street
Arlington VA 22209
Tel: 703-875-5337
Fax: 703-875-4675

167

Andrew Nyamete
Policy Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Klinton Nyamuryekunge
AIDS Programme Associate
African Medical and Research Foundation (AMREF)
P.O. Box 2773
Dar-es-Salaam
Tanzania
Tel: 27817/46785
Fax: 255-51-46440

Mary O'Grady
Associate Director, Information Programs
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

David O'Keefe
Research Analyst
Population Services International
1120 19th Street, NW
Suite 610
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Anne-Marie O'Leary
Health Technical Services
1601 North Kent Street
Suite 1104
Arlington VA 22209
Tel: 703-516-9166

Cheryl O'Neil
Communication Officer
Caribbean Epidemiology Center (CAREC)
16-18 Jamaica Boulevard
Federation Park
Port of Spain
Trinidad
West Indies
Tel: 809-622-2153
Fax: 809-622-2792

Kevin O'Reilly
World Health Organization, Global Programme on AIDS
20 Avenue Appia, CH 1221
Geneva 27
Switzerland

Shelagh O'Rourke
STD/HIV Advisor
USAID Haiti
Department of State
Washington DC 20523
Tel: 509-29-3041
Fax: 509-23-9603

Penina Ochola
Resident Advisor, Tanzania
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Jean Joseph Ohery
Educateur Communautaire
Centre Haitien de Service Social (CHASS)
209 Fontamara 41
Route de Carrefour
Port-au-Prince
Haiti
Tel: 340509
Fax: 340490

Judith Olei
Lead Facilitator
Health technical Services Project
Suite 1104
1601 North Kent Street
Arlington VA 22209
Tel: 703-516-9166
Fax: 703-516-9188

Eba A. Ongele
Researcher
Howard University
12301 Kings Valley Court
Mitchellville MD 20721
Tel: 301-249-3115
Fax: 301-249-3153

Pamela Onyango
Program Officer, Africa Regional Office
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 254-2713913
Fax: 254-2726130

David Oot
USAID
Room 1200, SA-18
Washington DC 20523-1817

Cynthia Opaku-Boahen
Staff Assistant
AIDSCAP/FHI
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Larry Origlio
Financial Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Beth Orlick
Advocates for Youth
2500 Clarendon Boulevard
Suite 101
Arlington VA 22201
Tel: 703-522-4596

Gloria I. Ortega
Journalist
Fundacion Apoyemonos, Colombia
Carrera 15 No. 59-57, OFC 503
Bogota
Colombia
Tel: 571-3101010
Fax: 571-2559814

June E. Osborn
Professor of Epidemiology
School of Public Health
University of Michigan
109 South Observatory Street
Ann Arbor MI 48109

Jane Anyasa Otado
Researcher
Howard University
5061 First Street, NW
#203
Washington DC 20011
Tel: 202-723-1120

Junko Otani
AIDS Specialist
The World Bank, ASTHR, AIDS in Asia Unit
1818 H. Street NW
Washington DC 20433
Tel: 202-458-0159
Fax: 202-522-1662

168

Vera Paiva
University of Sao Paolo
c/o Center for AIDS Prevention Studies
University of California, San Francisco
74 New Montgomery, Suite 502
San Francisco CA 94105
Tel: 415-597-9171
Fax: 415-597-9171

Donna Rae Palmer
Global AIDS Action Network
626 14th Street
San Francisco CA 94114
Tel: 415-522-0939
Fax: 415-522-0939

Richard G. Parker
Center for AIDS Prevention Studies
74 New Montgomery Street
Suite 502
San Francisco CA 94105
Tel: 415-597-9371
Fax: 415-597-9125

Marvelin Parsons
Staff Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Shelby Pasarell
Advocates for Youth
1025 Vermont Avenue
Suite 200
Washington DC 20006
Tel: 202-347-5700

Pete Paterson
Logistics Systems Analyst
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

David Patterson
Canadian HIV/AIDS Legal Network
4007 De Mentana
Montreal, Quebec H2L 3R9
Canada
Tel: 514-526-1796
Fax: 514-526-5543

Sandy Paul
Graphics Coordinator
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Bonnie Pedersen
Public Health Advisor
USAID Office of Population
SA-18, Room 809
Washington DC 20523-1819
Tel: 703-874-4772
Fax: 703-875-4413

Kerry Pelzman
2905 University Terrace, NW
Washington DC 20016
Tel: 202-537-0911

Moises Perez
Executive Director
Alianza Dominicana
715 W. 179th Street
New York NY 10033
Tel: 212-795-4226
Fax: 212-795-4285

Patricia K. Peterson
HIV/AIDS Project Coordinator
Proteus, Inc.
P.O. Box 10385
Des Moines IA 50306
Tel: 515-244-5694
Fax: 515-244-4166

Carolyn Peterson
Medical Writer/Clinical Monitor
Family Health International
2224 Chapel Hill - Nelson Highway
Durham NC 27705
Tel: 919-544-7040
Fax: 919-544-0207

Neena Philip
APICHA
476-1/2 State Street
Brooklyn NY 11217
Tel: 718-802-0782

Peter Piot
Director
UNAIDS
c/o World Health Organization/GPA
20 Avenue Appia, Ch 1221
Geneva 27
Switzerland

Suzanne Plopper
Consultant
511 Hubble Street
Davis CA 95616
Tel: 916-753-7673
Fax: 916-753-7454

Miles Pomper
Reporter
Legistaltive News Service
777 North Capitol Street
Washington DC 20002
Tel: 202-898-3023
Fax: 202-508-4654

Pat Pongswatanakulsiri
Director of Health Center 9
Department of Health, Bangkok Metropolitan Administration
Health Center 9
64 Thanon Prachatipatat, Baan Panthom
Bangkok 10200
Thailand
Tel: 662-281-7861
Fax: 662-282-8494

Neal Porter
Assistant Program Manager
PSI
1120 19th Street, NW
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

May Post
Public Health Advisor
SARA/Tulane SPH & TM
Sara Project - AED
1255 23rd Street NW, Suite 400
Washington DC 20037
Tel: 202-884-8815
Fax: 202-884-8701

Dr. Glenn L. Post
Chief, Human Resource and Democracy Division
Office of Sustainable Development, Bureau for Africa - USAID
AFR/SO/HRD, Room 2744
USAID
Washington DC 20523
Tel: 202-647-6026
Fax: 202-647-2993

Vanessa Potkin
Intern
Whitehouse Office of National AIDS Policy
19 First Avenue
Apt 2
New York NY 10003
Tel: 212-677-6572

169

Mary Beth Powers
Reproductive Health Specialist
Save the Children
54 Wilton Road
Westport CT 06880
Tel: 203-221-4000
Fax: 203-221-3799

Veronique Praz
Country Representative - PSI/Burundi
Population Services International
1120 19th Street, NW
Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Elizabeth Preble
Director, Technical Support Division
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Willa Pressman
Regional Coordinator
USAID
6/PHN/FPS, SA-18
Room No. 702
Washington DC 20523-1819
Tel: 703-516-1982
Fax: 703-875-4675

Elizardo Puello
Coordinator General
Coordinadora de Animacion Socio-Cultural (CASCO)
Calle Arzobispo Merino #208
APTO 306
Santo Domingo
Dominican Rep.
Tel: 809-685-1221
Fax: 809-682-9927

Dissi Pulcherie
AIDSCAP - Dakar
B.P. 95
Dakar
Senegal
Tel: 221-21-16-90
Fax: 221-22-47-50

Navin Pyakural
Program Officer
Save the Children/U.S.
Post Office Box 2218
Kathmandu
Nepal
Tel: 977-1-412447
Fax: 977-1410-375

Janet Rabe
Accountant
AIDSCAP/FHI
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Jeanne Radday
MPH Student
George Washington University
1701 N. Adams Street
Arlington VA 22201
Tel: 703-525-9492

Allan Ragi
c/o AIDSCAP/Kenya
The Chancery, 2nd Floor
P.O. Box 38835, Valley Road
Nairobi
Kenya
Tel: 254-2-713911
Fax: 254-2-726130

Gerry Rainingbird
National Resource Specialist
Northwest Portland Area Indian Health Board
520 SW Harrison, Suite 335
Portland OR 97201
Tel: 503-228-4185
Fax: 503-228-8182

Elizabeth Ralston
Reproductive Health Coordinator
USAID
1601 N. Kent Street
Suite 1016
Arlington VA 22209
Tel: 703-841-7797
Fax: 703-841-0327

Diana Randall
Conference Exhibition Coordinator
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Priyani U. Ratnayake
Senior Lecturer/Consultant Psychiatrist
Department of Psychiatry, Faculty of Medicine
University of Peradeniya
Peradeniya
Sri Lanka
Tel: 94-8-32368
Fax: 94-8-32572

Edward Rattner
Research Associate
George Mason University
9308 Coronado Terrace
Fairfax VA 22031
Tel: 703-385-8453
Fax: 703-993-1521

Bill Rau
Associate Director, Policy
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Sumali Ray-Ross
Program Specialist, Asia Region
CEDPA
1717 Massachusettes Avenue
Washington DC
Tel: 202-667-1142

Linda Reck
Science Policy Analyst
Fogarty International Center, National Institutes of Health
Building 31, Room B2C08
31 Center Drive, MSC 2220
Bethesda MD 20892-2220
Tel: 301-496-1491
Fax: 301-594-1211

Karen Reddon
Acting Coordinator for Speakers Bureau
Whitman-Walker Clinic
1407 S Street, NW
Washington DC 20009
Tel: 202-939-7879

Elizabeth Reid
Director, HIV and Development Program, BPPS
United Nations Development Programme
One United Nations Plaza
Room FF-986
New York NY 10017
Tel: 212-906-6976
Fax: 212-906-6336

Michael Rekart
Conference Co-Chair
XI International Conference on AIDS
11th Floor-1090 W Pender Street
Vancouver BC V6E 2N7
Canada
Tel: 604-6883225
Fax: 604-66832421

170

Michelle Renaud
Director of Research and Evaluation
United States Conference of Mayors
1620 Eye Street NW
Washington DC 20006
Tel: 202-861-6751
Fax: 202-887-0652

Carol Rice
Health Advisor
USAID - Asia Near/East Bureau
ANE/SEA/SPA
SA 2 Room 102
Washington DC 20523-0219
Tel: 202-663-2196
Fax: 202-663-2643

Zynia L. Rionda
Population Advisor
USAID - ANE Bureau
ANE/SEA/SPA, Rm 102
SA-2, USAID Washington
Washington DC 20523
Tel: 202-663-2630
Fax: 202-663-2843

E. Edward Rizzo
Consultant in Development Administration
2600 Triadelphia Lake Road
Brookeville MD 20833
Tel: 301-924-4280

Lilliana Rocha
Project Coordinator
Institute for Integral Development (IDDI)
Calle Arzobispo Merino #208
APTO 306
Santo Domingo
Dominican Rep.
Tel: 809-685-1221
Fax: 809-682-9927

Jon Rodeback
Information Programs Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Pablo Rodrigues
Interpreter
Linx
3803 Benton Street, NW
Washington DC 20007
Tel: 202-961-1694

Leon Roets
Project Manager - Targeted Intervention Research
Welkom Mining Project - Vista University
P.O. Box 1881
Welkom 9460
South Africa
Tel: 057-3964112
Fax: 057-81325

Allan Ronald
Professor
University of Manitoba
Room A1105
St. Boniface General Hospital
409 Tache Avenue
Winnipeg, Manitoba
Canada
Tel: 204-237-2927
Fax: 204-233-7125

S.T. Roobant
Institute of Hygiene and Epidemiology
14 L. Wytsmanstrect
Brussels 1050
Belgium
Tel: 322-642-5029
Fax: 322-642-5410

Lic. Santo Rosario
Executive Director
Centro de Orientacion e Investigacion Integral (COIN)
EPS# P-6555, P.O. Box 02-5261
Miami FL 33102-5261
Tel: 809-681-1515
Fax: 809-549-4521

Wendy Roseberry
STD/HIV Strategy Coordinator
The World Bank
1818 H Street, NW
Washington DC 20433
Tel: 202-473-4287
Fax: 202-477-2900

David Rosen
HIV Case Manager
AIDS Resource Center
54 Main Street
Woodbridge NJ 07095
Tel: 908-855-0010
Fax: 908-634-4785

Zeda F. Rosenberg
Senior Scientist
NIAID/NIH
Solar Building, Rm 2A-05
6003 Rockville Pike
Bethesda MD 20892
Tel: 301-496-6177
Fax: 301-402-3684

Alex Ross
Senior Technical Advisor
USAID/AFR/SD
1111 North 19th Street
Suite 300
Arlington VA 22209
Tel: 703-235-4453
Fax: 703-235-4466

Denise Rouse
AIDSCAP Project Manager and COTR
USAID HIV-AIDS Division
G/PHN/HN/HIV-AIDS
Suite 1200 SA-18
Washington DC 20523

Adrienne H Rozzell
Project Director
Orphans United in Christ
8528 Stonewall Road
Manassas VA 22110
Tel: 703-257-0841
Fax: 703-257-0841

Julian A. Russell
Project Coordinator
Orphans United in Christ
8528 Stonewall Road
Manassas VA 22110
Tel: 703-257-0841
Fax: 703-257-0841

John B.K. Rutayuga
Co-Director
Center for Natural & Traditional Medicines
1601 Connecticut Avenue, NW
#201C
Washington DC 20009
Tel: 202-234-9632
Fax: 202-332-2132

Shane Ryland
Epidemiologist
DHS
11785 Beltsville Drive, Suite 300
Calverton MD 20705
Tel: 301-572-0394
Fax: 301-572-0993

Karen Sai
Associate Writer/Editor
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

171

Tobi Saidel
Evaluation Officer/Epidemiologist
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Natasha Sakolsky
Health Educator
Pediatric AIDS Program of Children's Hospital
Children's Hospital
914 Richard Street
New Orleans LA 70130
Tel: 504-524-4611
Fax: 504-523-2084

Cynthia Salter
Writer/Researcher
Johns Hopkins School of Public Health
Center for Communication Programs
111 Market Place, Suite 310
Baltimore MD 21202
Tel: 410-659-6124
Fax: 410-659-6266

Carlyn Saltman
Program Officer, Africa Division
PCS/CCP/Johns Hopkins University
111 Market Place, Suite 310
Baltimore MD 21202-4013
Tel: 410-659-6129
Fax: 410-659-6266

Jorge Sanchez
National Director, AIDS Control Program
CASITA/Peruvian MOH
1001 Broadway
Suite 215
Seattle WA 98122
Tel: 206-720-4211
Fax: 206-720-4209

Cherylann Sanderson Jones
Coordinator of N.A.P.
Ministry of Health
South Base
Grans Turk
Turks and Caicos
Brit. W. Indies
Tel: 809-946-1675
Fax: 809-946-1675

Gloria Marilyn Sangiwa
Counseling and Testing Efficacy Study
Muhimbili University College of Health Sciences
P.O. Box 65218
Dar-es-Salaam
Tanzania

Saraswathi Sankaran
Executive Director
DEEPAM Educational Society for Health
42, Srinivasapuram, East Coast Road
Thiruvanmiyur
Madras 600 041
India

Noriko Sasaki
3040 Idaho Avenue, NW
Washington DC 20016
Tel: 202-364-3187

Lynn Belland Sauls
International Program Officer
World Vision
220 I Street NE
Washington DC 20002
Tel: 202-547-3743
Fax: 202-574-4834

Eric Sawyer
Co-founder
ACT-UP/Housing Works
543 Manhatten Avenue
New York NY 10027
Tel: 212-864-5672
Fax: 212-316-0020

William Schellstede
Executive Vice-President, FHI
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201-3062

Inon Schenker
Executive Director
Jerusalem AIDS Project
P.O. Box 7956
Jerusalem 91077
Israel
Tel: 972-2-412226
Fax: 972-2-422204

Jean J. Schensul
Executive Director
Institute of Community Research
2 Hartford Square West, Suite 100
Hartford CT 06106-5128
Tel: 203-278-2044
Fax: 203-278-2141

Stephen L. Schensul
Associate Professor & Director CICHS
Center for International Community Health Studies - MC6330
University of Connecticut Health Center
Farmington CT 06030-6330
Tel: 203-679-1570
Fax: 203-679-1581

Helen Schietinger
USAID
1623 Kennedy Place
Washington DC 20011
Tel: 202-722-4333
Fax: 202-722-1294

Joan Schubert
Deputy Director, Population Unit
CARE
151 Ellis Street NE
Atlanta GA 30303
Tel: 404-681-2552
Fax: 404-577-1205

Jane Schueller
Staff Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Tony Schwartzwalder
Deputy Project Director, AIDSCAP
FHI/AIDSCAP
2101 Wilson Boulevard
Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Anne Scott
HIV/AIDS Coordinator
USAID - Asia/Near East Bureau
Office of Strategic Planning, USAID
Room 102, SA-2
Washington DC 20523-0219
Tel: 202-663-2628
Fax: 202-663-2643

Seaborn Scott
Occupational Safety and Health Manager
Defence Logistics Agency/DCMDN
495 Summer Street
Boston MA 02210-2184
Tel: 617-753-4051
Fax: 617-753-3175

Debra Sehume
AIDS Educator
Township AIDS Project
P.O. Box 4168
Johannesburg 2000
South Africa
Tel: 9821016
Fax: 9825621

172

Eduardo Aguilu Semidey
Director of Institutional Services
Latino Health Institute
95 Berkeley Street
Boston MA 02116
Tel: 617-350-6900
Fax: 617-350-6901

Donald L. Sepulvado
Acting Director, Division of Policy and Data
Office of Minority Health/Public Health Service
5515 Security Lane, Suite 1000
Rockville MD 20852
Tel: 301-443-9923
Fax: 301-443-8280

Eleonore Seumo
CARE in Cameroon
c/o Paurvi Bhatt, CARE
151 Ellis Street
Atlanta GA 30303
Tel: 404-681-2552
Fax: 404-577-1205

Juana Shal
Research Intern
Advocates for Youth
1025 Vermont Avenue
Suite 200
Washington DC 20005
Tel: 202-347-5700

B. M. Sharma
Secretary
Ctr. for Labor Education & Social Research, Delhi
D-32 Tara Apartments
New Delhi 110019
India
Tel: 011-643-9330
Fax: 9111644-2361

Kathleen Shears
Senior Writer/Editor
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Michele Shedlin
President
Sociomedical Resource Association
181 Post Road W.
Westport CT 06880
Tel: 203-454-0505
Fax: 203-222-0266

Sally Shelton
Assistant Administrator
USAID Bureau of Global Programs, Field Support & Research
320 21st Street NW, Room 4942
Washington DC 20523

James Shelton
Senior Technical Advisor
Office of Population, USAID
G/HPN/POP
Washington DC 20523
Tel: 703-875-4505

Amy R. Sheon
Health Specialist
NIAID
6003 Executive Boulevard
Rockville MD 20892
Tel: 301-496-6177
Fax: 301-402-3684

Mary Shepherd
Biostatistician
The Johns Hopkins University
720 Rutland Avenue
Ross 1159
Baltimore MD 21205
Tel: 410-592-3382
Fax: 410-955-7889

H.R. Shepherd
Chairman
Albert Sabin Vaccine Foundation
P.O. Box 848
New Canaan CT 06840
Tel: 203-972-7907
Fax: 203-966-4763

Tigest Shiferaw
Staff Assistant
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Thabani Sibanda
Research Fellow
University of Zimbabwe
Psychology Department
P.O. Box MP 167, Mt. Pleasant
Harare
Zimbabwe

Galia Siegel
Associate Policy Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Godfrey Sikipa
Regional Director for Africa
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Yolonda Simon
Programme Director, Caribbean Representative
Global Network of People Living with HIV/AIDS (GNP+)
101 Oxford Street
Port of Spain
Trinidad
Tel: 809-622-0176
Fax: 809-622-0176

Paul Sisco
Producer
USIA-TV
601 D Street, NW
Washington DC 20002
Tel: 202-501-6479
Fax: 202-501-6070

James B. Sitrick, Jr.
TAACS
USAID, LAC Bureau
LAC/RSD/PHN, Rm. 2249 NS
Washington DC 20523 0025
Tel: 202-647-8605
Fax: 202-736-4867

Sudha Sivaram
Project Coordinator
PLAN International
c/o Karla Steele
155 Plan Way
Warwick RI 02886
Tel: 401-738-5600
Fax: 401-738-5608

Fay Slattery
Consultant
PAHO, Regional Program on AIDS/STDs
525 23rd Street, NW
Washington DC 20037
Tel: 202-861-4354
Fax: 202-233-5971

Zeljko Slemensek
National Coordinator on AIDS
Ministry of Health, Croatia
Baruna Trenka 6
Zagreb 41000
Croatia
Tel: 985-1-451555

173

Tracy Smarrella
Associate Program Officer, STD Unit
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Jaynell R. Smith
Program Operations Assistant
USAID/G/PHN/HN/HIV-AIDS
Rm. 1200: SA-18
Washington DC 20523-1817
Tel: 703-875-4494
Fax: 703-875-4686

Anita Smith
Vice-President
Americans of a Sound AIDS/HIV Policy
102 Elden Street, Suite 11
Herndon VA 22070
Tel: 703-471-7350
Fax: 703-471-8409

W. Shepherd Smith
President
Americans for a Sound AIDS/HIV Policy
102 Elden Street
Suite 11
Herndon VA 22070
Tel: 703-471-7350
Fax: 703-471-8409

Bruce Smith
Professor
McGill University
95 Eastor Avenue
Montreal, Quebec
Canada
Tel: 514-481-6714
Fax: 514-481-6716

Shelley Smith
Health Sector Specialist
Peace Corps
OTAPS, Health Sector
1990 K Street, NW
Washington DC 20526
Tel: 202-606-3765
Fax: 202-606-3024

Rachel Smith
Intern
Office of National AIDS Policy
White House
85 Easton Avenue
Apt 4C
New Brunswick NJ 08901
Tel: 908-545-9638
Fax: 202-632-1096

Lahoma Smith Romocki
Senior Associate/Liaison
Office of National AIDS Policy
750 17th Street NW, Suite 600
Washington DC 20503
Tel: 202-632-1090
Fax: 202-632-1096

Mladen Smoljanovic
Specialist of Epidemiology
Institute of Public Health
Dinka Simunovica 11/IX
58000 Split
Croatia
Tel: 385-21512486
Fax: 385-21525195

Cecilia Snyder
Program Associate
AIDS in the Americas
Panos Institute
1717 Massachusetts Avenue NW
Suite 301
Washington DC 20036
Tel: 202-483-0044
Fax: 202-483-3059

Sri Soedarsono
Social Worker
KKKS - Batam
c/o Jl. R.E. Martadinata
Sekupang - P. Batam
Indonesia
Tel: 0778 322347
Fax: 0778 322201

Suwedha Ningsih Soedjana
Communication and Social Services Division
R.E. Martadinata Street
Sekupang
P. Batam 29422
Indonesia

Christine Solomon
Technical Writer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062

Daniel Solomon
Special Assistant
US Department of Labor
Room S-2235
200 Constitution Avenue, NW
Washington DC 20210
Tel: 202-219-7867
Fax: 202-219-5980

Elizabeth Sommerfelt
Macro International
11785 Beltsville Drive
Suite 300
Calverton MD 20705
Tel: 301-572-0875
Fax: 301-572-0999

Sujatha Sosale
University of Minnesota
School of Journalism
TC Campus
PO Box 13023
Minneapolis MN 55414
Tel: 612-625-4297

Ramon Jeremias Soto
MD MHS
STD/AIDS Division, Ministry of Health
Division ETS/SIDA
Calle el Telegrafo, Minesterio de Salud
Tegucigalpa
Honduras

Barbara J. Spaid
Chief, Health & Nutrition Division
USAID/Indonesia
USAID/HIRD/HN
Box 4/Unit 8235
APO AP 96520-8135
Fax: 62 213806694

Marie St. Cyr
Executive Director
Iris House
2271 2nd Avenue
New York NY 10035
Tel: 212-423-9049
Fax: 212-423-9193

Karen A. Stanecki
Chief Health Studies Branch
U.S Bureau of the Census
International Programs Center
Population Division
Washington DC 20233-8860
Tel: 301-457-1406
Fax: 301-457-3033

Kelli Stauning
Reporter - African Division
Voice of America
330 Independence Avenue, SW
Washington DC 20547
Tel: 202-619-0183
Fax: 202-619-1664

Richard Steen
STD Officer
FHI/AIDSCAP, Nairobi
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Maria C. Stephens
Economist
U.S. Treasury Department
4831 86th Street NW #217
Washington DC 20808
Tel: 202-622-1856
Fax: 202-622-0974

Gabriel Sternik
Biologist
Hospital Nac. Le. Pediatria J.P. Garraham
Lab de Biolope Celulary Retrovirus
Combate de Los Pozos 1881 - 1245
Buenos Aires
Argentina
Tel: 54-1-5081998
Fax: 54-1941-8532

Krista Stewart
Evaluation Advisor
USAID/G/PHN/POP/PHE
SA 18 Room 711, USAID
Washington DC 20523-1819
Tel: 703-875-4664
Fax: 703-875-4693

Kate Stewart
Rreproductive Health Specialist
DHS/Macro
11785 Beltsville Drive
Calverton MD 20705
Tel: 301-572-0383
Fax: 301-572-0999

Wayne Stinson
Senior Scientist
University Research Corporation
7200 Wisconsin Avenue
Bethesda MD 20814
Tel: 301-941-8415
Fax: 301-941-8427

Doris Storms
Director
PVO Child Survival Suport Program
Johns Hopkins University
103 East Mt. Royal Avenue, Room 2C
Baltimore MD 21202

Isabel Stout
Program Officer, LA/C
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

John Stover
The Futures Group International
80 Glastonbury Boulevard
Glastonbury CT 06033
Fax: 203-657-3918

John Strand
Deputy Director
AIDS Communication Support Project
AED
1255 23rd Street
Washington DC
Tel: 202-884-8902
Fax: 202-884-8713

Robert Sturm
Peer Support Services Coordinator
Test Positive Aware Network
1258 W. Belmont
Chicago IL 60657
Tel: 312-404-8726
Fax: 312-472-7505

Leigh Sue
Health Policy Analyst
1860 California Street, NW
Washington DC
Tel: 202-234-7455
Fax: 202-234-7455

Robyn Sussel
Manager Information Services
XI International Conference on AIDS
11th Floor-1090 W. Pender
Vancouver BC V6E 2N7
Canada
Tel: 604-6683225
Fax: 604-6683242

Harry G. Susser
Publications Assistant
Johns Hopkins School of Public Health
Center for Communication Programs
111 Market Place, Suite 310
Baltimore MD 21202
Tel: 410-659-6312
Fax: 410-659-6266

Linda Sussman
Doctoral Candidate
Johns Hopkins University
School of Public Health
3815 Williams Lane
Chevy Chase MD 20815
Tel: 301-951-9619

B.K. Suvedi
Senior Medical Officer
National Center for AIDS and STD Control
PO Box 2323, 9PO
Kathamandu
Nepal
Tel: 226-653
Fax: 230-406

George A. Swales
Health Education Coordinator
JHU, School of Public Health
111 Market Street
Suite 840
Baltimore MD 21201-6709
Tel: 410-223-1694
Fax: 410-223-1695

Michael Sweat
Associate Director
Behavioral Research Unit
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Nancy Sweeney
Project Coordinator
USAID/Mexico
P.O. Box 3087
Laredo TX 78044
Tel: 525-211-0042
Fax: 525-207-7558

John L. Syphax
Howard University Hospital
907 M Street, NW
Washington DC 20001
Tel: 202-289-4653

Zsuzsa Szabo-Schubertne
Psychologist
St. Laszlo Hospital
Budapest PF. 29. 1450
Hungary
Tel: 36-1215-0219
Fax: 36-1215-2883

175

Celia Szterenfeld
General Coordinator
Institute of Religious Studies
Ladeira da Gloria 98
Rio de Janeiro, RJ 22211-120
Brazil
Tel: 55212655747
Fax: 55212054796

Stephen Tabet
Senior Fellow
University of Washington Center for AIDS and STDs
101 Broadway, Suite 215
Seattle WA 98122
Tel: 206-720-4379
Fax: 206-720-4209

Daniel Tarantola
Harvard School of Public Health
Bagnoud Ctr. for Health and Human Rights
8 Storey Steet
Cambridge MA 02138

Joan Tarasench
Program Officer
JHU/PCS
111 Market Place
Suite 310
Baltimore MD 21202-4012
Tel: 410-659-6397
Fax: 410-659-6266

Nicola Taylor
Project Analyst
Caribbean Epidemiology Centre (CAREC)
16-18 Jamaica Boulevard, Federation Park
Port of Spain
Trinidad
West Indies
Tel: 809-622-2153
Fax: 809-622-2792

Stephanie Taylor
Graduate Research Assistant
Columbia University
600 W 168th Street
7th Floor
New York NY 10032
Tel: 212-305-1920
Fax: 212-305-6832

Jean Paul Tchupo
Population Services International
PSI/Cameroon
B.P. 4989
Douala
Cameroon
Fax: 237 21 41 33

Prisca Tembo
HIV/AIDS Coordinator for Workplace
Ministry of Health Botswana
P/Bag 0038
Caborone
Botswana
Tel: 274-351

Mulunesh Tennagashew
Resident Advisor, Ethiopia
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Angeline Tennah
Kenya Country Office
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Stanley S. Terrell
Technical Advisor in AIDS and Child Survival (TAACS)
USAID / Honduras
USAID Honduras / HRD
Unit 2927
APO AA 34022
Tel: 504-36-9320
Fax: 504-36-7776

Daniele Testelin
Senior Programme Manager
Canadian International Development Agency
500 Laurier West #2607
Ottawa, Ontario K1R 5E1
Canada
Tel: 819-994-3941
Fax: 613-237-9575

Kitty Thuermer
Director of Information
Population Services Information
1120 19th Street, NW
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Pimsuda Tiandum
Associate Peace Corps Director/Health
Peace Corps/Thailand
c/o Shelley Smith, Peace Corps, OTAPS
1990 K Street, NW
Washington DC 20526
Tel: 202-606-3765
Fax: 202-606-3024

Judith Timyan
Vice President
Population Services International
1120 19th Street, NW
Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

A.P. Tiwari
Regional Secretary
Center for Labour Education and Social Research (CLEAR)
D-32, Tara Apartments
Kalkaji
New Delhi - 110 019
India
Tel: 643-9330
Fax: 644-2361

Martin Tjituka
World Education Inc.
Private Bag 13376
Windhoek
Namibia
Tel: 26461 239461
Fax: 26461 240319

Brian Tjugum
Program Officer
AED
CDC/ACSP
1255 23rd Street, NW #400
Washington DC 20037
Tel: 202-884-8719
Fax: 202-884-8713

Judith Torimiro
Biomedical Scientist
National AIDS Control Program, Cameroon
6010 Edsall Road, #303
Alexandria VA 22304
Tel: 703-461-6864

David Torr
MD MPH
424-425 115th Street E.
Saskatoon, Saskatchewan S7N 2ES
Canada
Tel: 306-736-3186
Fax: 306-934-3186

Ioanna Trilivas
International HIV/AIDS Alliance
Barratt House
341 Oxford Street
London W1R 3BH
United Kingdom

176

Melody A. Trott
Senior Technical Advisor
USAID Office of Health and Nutrition, Child Survival Div.
G/PHN/HN, SA-18, Room 1260
Washington DC 20523-1817
Tel: 703-875-4525
Fax: 703-875-4686

Joyce Tsheko
S.R.N.
Ministry of Health Botswana
P/Bag 0038
Gaborone
Botswana
Tel: 352-000

Kanoko Tsuda
Program Officer
Japan Int'l Cooperation Agency
900 19th Street, NW
Suite 350
Washington DC 20006
Tel: 202-457-0412
Fax: 202-457-0415

Elizabeth Tuco
Membership Manager
Nat'l Council for International Health
1701 K Street, NW
Suite 600
Washington DC 20006
Tel: 202-833-5900
Fax: 202-833-0075

Kaye Turner
University of Waikato
School of Law, Private Bag 3105
Hamilton
New Zealand
Tel: 647-838-4167
Fax: 647-838-4171

Mary Uatlin
Program Manager
LASITA
1001 Broadway
Suite 210
Seattle WA
Tel: 206-720-4211
Fax: 206-720-4209

Juliana C. Umozurike
Program Officer, Nigeria
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Garance Upham
President
Sidalerte Internationale (France)
c/o A. Broderick
950 Cabrillo Street, #14
San Francisco CA 94118
Tel: 33-78606565
Fax: 33-78606767

Maricela Ureno
HIV/STD Prevention Program
International Planned Parenthood Federation/WHR
902 Broadway, 10th Floor
New York NY 10010
Tel: 212-995-8800
Fax: 212-955-8853

Ingrid Van Loon
Human Resources Specialist
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Basil Vareldzis
Senior Technical Advisor for TB/HIV
USAID
G/PHN/HN/HIV-AIDS
SA-18 Suite 1200
Washington DC 20523-1817
Tel: 703-875-4628
Fax: 703-875-4686

Alicia Vargas
Program Specialist
National Assn. for Equal Opportunity in Higher Education
400 12th Street NE
Washington DC 20002
Tel: 202-543-9111
Fax: 202-543-9113

Ana Vasconcelos
Project Director
Casa de Passagem
Rua Arnobio Marques
432 - Santo Amaro
50.100.130 Recife
Brazil
Tel: 55-812221471
Fax: 55-812223849

Manuel Antonio Velandia-Mora
Sociologist, Philosopher, Researcher
Fundacion Apoyemonos, Colombia
Carrera 15 No. 59-57 OFC. 503
Bogota
Colombia
Tel: 571-3101010
Fax: 571-2559814

Carmen Venturini
Interpreter
Linx
4601 N. Park Avenue, #11
Chevy Chase MD 20815
Tel: 301-656-3810

Oscar Vigano
BCC Officer
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Edna Viruell
Center for Women's Policy Studies
200 P Street NW, #508
Washington DC 20036

Liliana Vivanco
Librarian
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Almeida Wagner
Theater Workshop Coordinator
ABIA
Rua Sete de Setembro,
48-120a. CEP. 20050-000
Rio de Janeiro RJ
Brazil
Tel: 55-212241654
Fax: 55-212243414

David Walker
Program Manager
PSI
1120 19th Street, NW, Suite 600
Washington DC 20036
Tel: 202-785-0072
Fax: 202-785-0120

Glenn Wasek
Vice-President, John Snow Inc.
c/o FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Peter Way
Senior Research Analyst
U.S. Bureau of the Census
International Program Center
WP II Room 312
Washington DC 20233
Tel: 301-457-1406
Fax: 301-457-3034

177

Dana Weckesser
Senior Document Abstractor/Indexer
Johns Hopkins Center for Communication Programs
2702 St. Paul Street
Baltimore MD 21218
Tel: 410-366-8008
Fax: 410-366-8008

Maxine Wedderburn
Director
Hope Enterprises
86 East Street
Kingston
Jamaica

Laura Wedeen
Consultant
c/o SCF/US
P.O. Box 2218
Kathmandu
Nepal
Tel: 9771-410087
Fax: 9771-410375

Sharon Weir
Epidemiologist
Family Health International
P.O. Box 19350
Research Triangle Park NC 27709
Tel: 919-544-7040
Fax: 919-544-7261

Ellen Weiss
Public Health Specialist
International Center for Research on Women
1717 Massachusetts Avenue, NW
Suite 302
Washington DC 20036
Tel: 202-797-0007
Fax: 202-797-0020

Lisa A. Weiss
Consultant
1501 Emerson Street, NW
Washington DC 20011
Tel: 202-829-3192

Peter Weller
Clinical Psychologist
Epidemiology Unit - Ministry of Health
c/o AIDSCAP Resident Advisor - Jamaica
EPI Unit, 30-34 Half Way Tree Road
Kingston 5
Jamaica
Tel: 809-926-3411
Fax: 809-926-5674

Florence A. Wellington
Programme Coordinator
National HIV/STD Control Programme (Western Region)
Western Area Health Administration
Cornidall Regional Hospital, Montego Bay
St. James
Jamaica
Tel: 809-952-1124
Fax: 809-952-2963

David Wendt
Director of Economic and Social Development
CSIS
1800 K Street, NW
Washington DC 20006
Tel: 202-775-3241
Fax: 202-775-3199

Bruce G. Weniger
Medical Epidimiologist
Centers for Disease Control and Prevention
Division of HIV/AIDS (E-50)
Atlanta GA 30333
Tel: 404-639-6113
Fax: 404-639-6118

Daniel Whelan
Project Associate
International Center for Research on Women
1717 Massachusetts Avenue, NW
Suite 302
Washington DC 20036
Tel: 202-797-0007
Fax: 202-797-0020

Wayne Wiebel
Director
Community Outreach Intervention Projects
School of Public Health - West
2121 W. Taylor Street
Chicago Il 60612-1450
Tel: 312-996-5523
Fax: 312-996-1450

Pawana Wienrawee
Resident Advisor, Thailand
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201-3062
Tel: 703-516-9779
Fax: 703-516-9781

Steven Wiersma
Senior Technical Advisor
USAID/Zambia
USAID Lusaka
Washington DC 20521-2310
Tel: 260-1-254303
Fax: 260-125-4532

Judith K. Williams
Director
HIV/AIDS Counseling Program
National Institutes of Health
Building 10, Room 1C144
9000 Rockville Pike
Bethesda MD 20892
Tel: 301-496-8331
Fax: 301-402-1573

Brian O. Williams
Co-Director, AMHPS AIDS Research Consortium
Morehouse School of Medicine
720 Westview Drive, SW
Atlanta GA 30310-1495
Tel: 404-752-1706
Fax: 404-752-1060

Dorlus Wiluer
Trainer
Volontariat pour le Developpement d'Haiti (VDH)
No. 4 lere Ruelle Riviere
Port-au-Prince
Haiti
Tel: 453109

Tim Wirth
Undersecretary of State for Global Affairs
U.S. Department of State
2201 C Street, NW, Room 7250
Washington DC 20520

Richard Wittenberg
President
American Association for World Health
1129 20th Street, NW
Suite 400
Washington DC 200036
Tel: 202-466-5883
Fax: 202-466-5896

Scott Wittet
Program Officer for Communication, Training and New Media
PATH
4 Nickerson Street
Seattle WA 98109
Tel: 206-28553500
Fax: 206-2856619

178

Godfrey Woelk
Project Director
University of Zimbabwe - Dept. of Comm. Medicine
P.O Box A 178
Avondale
Harare
Zimbabwe
Tel: 26-34-791631
Fax: 26-34795-019

Siri Wood
Project Coordinator
CRWRC
B.P. 5323
Dakar Farm
Senegal
Tel: 221-25-70-08
Fax: 221-25-70-08

Brenda Woods-Francis
Vice-President HIV/AIDS Programs
Mayatech Corporation
1300 Spring Street
5th Floor
Silver Spring MD 21217
Tel: 301-587-1600
Fax: 301-587-1686

Timothy Wright
National Outreach Coordinator 3/93-3/95
Proyecto Contra SIDA - USAID/ Bolivia 511-0608
2923 Calle Frontera
San Clemente CA 92673
Tel: 714-492-6493
Fax: 714-498-7731

David Wright
2923 Calle Frontera
San Clemente CA 92673
Tel: 714-492-6493
Fax: 714-498-7731

Richard Wright
Professor
Department of Criminology
Univeristy of Missouri
St. Louis MO 63121
Tel: 314-516-5034

Faustin Yao
Acting Chief, Prevention Unit
World Health Organization
Global Programme on AIDS
20 Avenue Appia, CH 1221
Geneva 27
Switzerland
Tel: 4122-7914501
Fax: 4122-7914187

Nancy Yinger
Senior Demographer
International Center for Research on Women
1717 Massachusetts Avenue, NW
Suite 302
Washington DC 20036
Tel: 202-797-0007
Fax: 202-797-0020

Fernando Zacarias
Program Coordinator
AIDS/STD Program, Pan American Health Organization
525 23rd Street, NW
Washington DC 20037

Dennis L. Zaenger
Traning/Research Associate
Quality Assurance Project
University Research Corporation/CHS
7200 Wisconsin Avenue, Suite 600
Bethesda MD 20814-4820
Tel: 301-941-8442
Fax: 301-941-8427

Samuel Zanya Bugri
Head, Disease Control Unit of the Ministry of Health Hdqtrs.
Ministry of Health - Ghana
c/o R. Abramson, Program Officer, PIET
2000 M. Street NW, Suite 650
Washington DC 20036
Tel: 202-429-0810
Fax: 202-429-8764

Paul S. Zeitz
Child Survival Technical Advisor
USAID/G
G/PHN/HN, SA-18, 1200
Washington DC 20523-1817
Tel: 703-875-4551
Fax: 703-875-4686

Julia Zenge
Community Health Services Manager
Milwaukee Indian Health Board Inc.
930 N. 27th Street
Milwaukee WI 53208
Tel: 414-931-8111
Fax: 414-931-0443

Debrework Zewdie
The World Bank
1818 H Street, NW
Washington DC 20433
Tel: 202-473-9414

Joana Zuaiter
FHI/AIDSCAP
2101 Wilson Boulevard, Suite 700
Arlington VA 22201
Tel: 703-516-9779
Fax: 703-516-9781

Acronyms/ Abbreviations

180

Acronyms

ACLU	American Civil Liberties Union (USA)
AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
AIDSCOM	AIDS Public Health Communication Project (former USAID-supported project implemented by the Academy for Educational Development)
AIDSTECH	AIDS Technical Support Project (Former USAID project of FHI)
AMREF	African Medical and Research Foundation
ANE	Asia Near East Bureau (USAID)
AVP	Anti-Violence Project
AWI	AIDSCAP Women's Initiative
AZT	Zidovudine (azidothymidine)
BCC	behavior change communication
BRP	Behavioral Research Program
BRU	Behavioral Research Unit
BSS	behavioral sentinel surveillance
CAPS	Center for AIDS Prevention Studies, University of California at San Francisco
CBD	community-based distribution
C&T	counseling and testing
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CPLM	Condom Programming and Logistics Management
CSM	condom social marketing
CSW	commercial sex worker
DIMS	Documentation and Information Management Services
DR	Dominican Republic
ECMIS	Essential Commoditive Management Information System
EEC	European Economic Community
ELISA	enzyme-linked immunosorbent assay
FHI	Family Health International
FP	Family Planning
FPLM	Family Planning Logistics Management
FPPS	Family Planning Private Sector
FSW	female sex worker
FY	fiscal year
GP	general practitioner
GTZ	German Technical Assistance Cooperation
HCP	health care providers
HHS	U.S. Department of Health and Human Services
HIV	human immunodeficiency virus
HIVNET	international network of HIV intervention research sites funded by NIH
HOPWA	Housing Opportunities for People with AIDS (USA)

181

IA	implementing agency
IEC	information, education and communication
ITM	Institute of Tropical Medicine
IUVDT	International Union of Venereal Disease and Treponematoses
IV	intravenous
iwgAIDS	Inter-Agency Working Group on AIDS
JSI	John Snow International
KAPB	knowledge, attitudes, beliefs and practices
LA/C	Latin America/Caribbean Region
LLD	long-distance lorry drivers
LOA	Letter of Agreement
MCH	maternal and child health
MIS	management information system
MOH	Ministry of Health
MPSC	multiple partner sexual contact
MSW	male sex worker
MTE	midterm evaluation
MWM	men who have sex with men
NGO	nongovernmental organization
NIAID	National Institute of Allergy and Infectious Diseases (USA)
NIH	National Institutes of Health (USA)
OA&R	Ogilvy, Adams & Rinehart
OCP	Office of Country Programs
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PAVE	Preparation for AIDS Vaccine Evaluations
PHE	peer health educator
PHSC	Protection of Human Subjects Committee (FHI)
PI	prevention indicators
PIF	process indicator form
PROCETS	Program for the Control of AIDS and Sexually Transmitted Disease
PSAPP	Private Sector AIDS Policy Presentation
PSI	Population Services International
PSU	Project Support Unit
PVO	private voluntary organization
PWA	person with AIDS
RA	resident advisor
RATE	Regional AIDS Training and Education Program
RTI	reporductive tract infections

182

SHRP TSG	Sexual and Reproductive Health Promotion Technical Support Group
SMU	Social Marketing Unit
SOMARC	Social Marketing for Change (TFG)
STD	sexually transmitted disease
STI	sexually transmitted infection
TA	technical assistance
TAG	Technical Advisory Group
TB	tuberculosis
TFG	The Futures Group
TIR	targeted intervention research
TSG	Technical Support Group
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPROFOR	United Nations Peacekeeping Forces
USAID	United States Agency for International Development
VHS	Voluntary Health Services
VTC	voluntary testing and counseling
WHO	World Health Organization
WHO/GPA	World Health Organization/Global Programme on AIDS
WID	Women in Development (USAID)
WMP	women with multiple partners

183

Appendix

184

Abstracts

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Title: Male STD Health Care Seeking Behavior in Bangkok, Thailand

Benjarattanaporn, Patchara*; Mugrditchian, D.*; Mills, S.*; Bennett, T.*; Mandel, J.**. *AIDSCAP/FHI, Bangkok, Thailand. **University of California, San Francisco.

Objective: To study the socio-demographic characteristics, previous STD treatment seeking behavior and STD/AIDS related perceptions and practices of men seeking STD treatment at government STD clinics, private clinics and drugstores in Bangkok, Thailand.

Methods: Between May and August 1994, a total of 213 men with STDs at 3 government STD clinics, 6 private clinics, and 13 drugstores in 8 districts in Bangkok were surveyed using structured interviews.

Results: Fifteen percent (15%) of male STD patients interviewed at the government STD clinics had previously sought treatment for the current episode of STD at either a private clinic or a drugstore. A similar proportion of men with an STD interviewed at drugstores had previously sought treatment for the current episode of STD at either a private clinic or a government STD clinic. In contrast, only 2% of men interviewed at private clinics had previously sought treatment for the current episode from a drug store or a government STD clinic. Characteristics of men seeking STD treatment at different points of first encounter will be compared. Past STD treatment seeking behaviors were compared to the current episode. Data regarding health education gained during consultation were assessed. Two fifths (41%) of all men with STDs believe that they are not likely to get HIV infection and only 23 % planned to be tested for HIV in the next 3 months. Regarding high-risk behavior, 17% reported that they continued to have sex without a condom while symptomatic for current STD. Furthermore, 37% reported a non-commercial sex partner as the source of their current STD episode.

Conclusions: The point of first encounter for STD treatment in Bangkok includes government STD clinics, private clinics and drugstores. Treatment at the point of first encounter is not always effective and therefore increases the opportunity for further spread of infection. Many STD patients do not perceive themselves at risk for HIV infection suggesting that patient education needs to be strengthened. These findings also draw attention to the role of non-commercial sex in the spread of STD/HIV in Bangkok.

Topic No. 4 Select one from Key List

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Communications for Sexually Transmitted Disease Programs: An Opportunity for Innovation

Ghee AE*, Dubow J**, Flanagan D***, Dallabetta GA***. * Center for AIDS and STD, University of Washington, USA. ** World Bank, USA, *** FHI/AIDSCAP, USA.

Objectives: The need for communication approaches and tools tailored to the needs of STD programs has been identified in many settings. A framework is proposed to serve as the basis for interdisciplinary collaboration between STD program managers, clinical and behavior researchers, and communicators.

Results: The steps taken in both the STD and the behavior change communications technical areas as a typical AIDSCAP project develops are summarized. Key concepts from STD case management, STD clinical epidemiology, behavior research, and communications are then interrelated to build a basis for formative research. The behavior change targets for STD programs are summarized and included in a consumer-based model for communications program development. Specific types of communications materials identified as high priority in the context of the STD program strategy include: modules for STD health worker training courses to build interpersonal communications skills; memory-jogging tools for STD health care workers to support the transition to syndromic management of STD cases; low-literate materials that support interpersonal communication between health care workers and STD patients; clinic waiting area and take-away materials; low-literate materials for community-based outreach workers who contact high risk behavior populations.

Conclusions: Opportunities for the formation of an interdisciplinary approach to communications for STD programs should be encouraged and supported. The needs of STD program managers in the communications area are pressing and may include a range of activities and materials that should be prioritized within the overall STD program strategy.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 7 94 95 66 ____ ____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

AIDS/STD Prevention Programs that Rely on South African and Mozambican Traditional Healers.

Green, Edward;* Zokwe, B.;* Dupree, J.;* Marrato, J.**
*formerly AIDSCAP/FHI; **Mozambican Ministry of Health

Objectives: The objectives of both programs, one funded by AIDSCAP in South Africa, the other initially funded by AIDSCOM and the European Union in Mozambique, are to reduce the spread of HIV not only through promotion of responsible sexual behavior and condom usage but also by means of treatment and prevention of standard STDs. The hypothesis is that this can be better accomplished by working collaboratively rather than competitively with traditional healers, in part because healers see and attempt to treat many or most STD cases in the region.

Methods: Both programs follow the same approach: ethnomedical research, development of a research-based, culture-specific educational strategy, collaborative (or "training") workshop for healers, and evaluation of "training" impact. The South African program has already had an internal evaluation that employed survey methods and a semi-structured, flexible interview schedule. The Mozambican program has proceeded more slowly, in part because more time has been allocated to ethnomedical research and communication strategy development.

Results: The South African program appears to be successful based on standard criteria: high percentages of the sampled healers interviewed were able to define and describe HIV accurately; describe three or more correct AIDS symptoms (and not give incorrect symptoms); and accurately describe three or more means of HIV transmission and prevention. There is also evidence of positive impact on healers' practices. Almost all healers reported providing correct HIV/AIDS preventive advice as well as demonstrations of condom use. The Mozambican program has developed along similar lines but has not yet been evaluated. Nevertheless research there has deepened biomedical understanding of beliefs and practices related to STDs in southern Africa. Indigenous ideas about pollution (conceived as a mystical force that makes one vulnerable to illness) seem to constitute the dominant explanatory model that competes with the biomedical model in the region. This has major implications for the development of culturally-sensitive AIDS/STD prevention messages that might be used regionally.

Conclusions: Program experience in both countries point to the value of ethnomedical research, the involvement of traditional healers in HIV/STD prevention programs, and the development of educational strategies that seek to build upon the common ground found to exist between indigenous and biomedical models of STDs.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 159 80 6 19 20 72

Complete as indicated on this insert

Deadline: 1 February 1995

Closing the Gap: Care is a Form of Prevention

MacNeil, Joan,*; White, R.*, Sweat, M.*, Dennison, J.*, Kamenga, C.*
*Family Health International AIDSCAP, Arlington, Virginia, USA

Objectives/Method: For the last ten years many national AIDS programs have focused primarily on prevention. Despite these important efforts, WHO estimates that over 16 million adults and 1 million children are HIV-infected, and 4.5 million have developed AIDS(WHO, 1995). As the numbers of infections increase, evidence suggests that it is not only impossible to separate care from prevention, but also that to try to do so, reduces the potential effectiveness of any prevention program. The objective of this assessment was to review the research literature for evidence demonstrating that care is a form of prevention, with the purpose of formulating a research agenda.

Results: A literature review provided mainly descriptive evidence linking prevention to care. Arguments presented include 1) people with HIV(PHIV) have the greatest potential to pass infection, thus are better targets for prevention; 2) care leads to less risk taking by PHIV's; 3) prevention messages stress compassion and acceptance; therefore a society that preaches this and does not provide care is sending mixed messages; 4) knowing a person with HIV/AIDS has a strong preventative impact, but when care and support are weak, people tend not to reveal their HIV status; 5) care and support for PHIV contributes to the economic viability of families and communities as it enables those who are infected to remain productive for as long as possible; and 6) integration of services is more cost-effective; thus merging prevention activities with care activities is less expensive. Based on these arguments, key research questions and designs can be formulated as follows:

Key Research Questions	Designs/Methods
Are prevention programs targeted at PHIV more effective than non-targeted programs?	Cohort with no partitioning
Are PHIV who feel cared for less likely to infect others?	Regression discontinuity
What are the most cost-effective ways to integrate prevention and care services?	Demonstration models/costing
Do PHIV give more effective prevention messages than people who are negative?	Reversed treatment non-equivalent control groups
How does care and support increase economic productivity of PHIV and their families?	Retrospective case studies/regression discontinuity

Conclusion: Care for infected people has not been viewed as playing a preventive role in reducing HIV incidence, yet as the number of infections increase, it is clear that care and prevention are indivisible. The findings of this review can be used to move the field forward with research that shows how care can lead to lower HIV incidence.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 7 20 77 121 139

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

A Targeted Intervention Research Study for STD Program Design in Senegal.

Niang, Cheikh Ibrahima.*; Ghee, A.**, Ndaye, A.*, Ryan, C.**, Davis, C.***, Dallabetta, G.***, Ndoye, I.****

Objective(s): The objectives of this study were to collect and synthesize qualitative (ethnographic) information in the areas of (a)Sexually transmitted disease (STD) illness terminology and symptom recognition, (b)health-seeking behavior including patterns of health service utilization, (c)perception of STDs and STD risk and to formulate recommendations for the improvement of STD diagnosis and control in Senegal through STD program design and messages and materials for clients and provider.

Methods: A total of 253 interviews using free list methods and 38 in-depth key informant interviews were conducted with community members. Entrance and exit interviews were conducted with 108 STD patients. In-depth interviews were conducted with 28 health care workers and 12 traditional healers. Interviews were conducted in five regions: Dakar, Kaolok, Fatick, Ziguinchor and Thies in both urban and rural settings.

Results: The community members interviewed described a wide range of symptoms for the terms used to describe for STDs from the western biomedical perspective. Distance was not a barrier and in fact might have been a facilitating factor, particularly for rural communities where anonymity/confidentiality are difficult. Patterns of recourse varied by urban or rural residence but in both sites included visiting traditional healers. Another common pattern of recourse was visits to retired and "free-lance" health care workers or pharmacists. All of the above led to either a delay or elimination of visits to established clinic facilities. In fact, most of those interviewed did not use established clinics at all. Partner referral by infected individuals was rare.

Conclusion(s): The findings of this ethnographic study will be important in the design of training materials for health care providers, communication materials for the community, and strategies to encourage people to seek prompt treatment for STD symptoms. Lack of confidentiality in interactions at established clinic sites should be addressed in health worker training and in designing how clients are interviewed at clinic sites, i.e., privacy for patients while they are interviewed.

* University of Dakar
** University of Washington, Seattle, Washington
***AIDSCAP
****Ministry of Health, Dakar, Senegal

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 80 59 1 159 6 10

190

Original Abstract

The Fourth Pillar of HIV Prevention: Linking Social Support Education, Medical Care, and Condom Accessibility- The Case of G Mens' Outreach in Santa Cruz, Bolivia

Authors: Wright, T.*, Von Poser, B.**, Vaca, R.*
* Programa Colaborativo de Prevención y Control de ETS/SIDA- USAID/BOLIVIA 511-0608
** Programa Colaborativo and CENETROP, Santa Cruz. Bolivia.

Objective: Education, early STD treatment, and ready access condoms are the 3 pillars of effective HIV prevention projec This 3-pronged strategy, however, may be underutilized by target population if demand is low.

The objective of Gay Mens' Outreach in Santa Cruz, Bolivia to stimulate and sustain demand for these 3 interventions by add a fourth pillar to the project; the construction of a stron supportive social environment for men who have sex with men (MS

Methods: Peer educators conduct outreach activities, link community contacts to the project-supported gay organizati UNELDYS. They also promote the project's AIDS hotline. In UNELD popular social activities are offered along with education, medi services, and condom sales. For those MSM who do not wish participate in UNELDYS, support and referrals are available thro the hotline.

Results: Process measures indicate that demand for STD/ prevention education and for condoms has grown steadily along w UNELDYS, even among non-attenders, suggesting an educatio multiplier effect and a desirable change in community nor Interview data collected over 2 years corroborate these findin

STD treatment services remain underutilized. This appears be due to remaining psychological and economic barriers and generalized custom of self-medicating. Plans are currently be made to lower these barriers.

Conclusions: As in many parts of the world, institutional reacti to homosexuals in Bolivia are generally harsh. The construction a socially supportive environment for gays, therefore, is challenging endeavor. This project demonstrates, however, that m MSM will take concrete action to protect their sexual health i supportive context exists. Since discrimination and vulnerabil are strongly correlated, the fourth pillar of prevention appears warrant careful attention in most HIV prevention projects.

Topic No. 1

Key Word Nos. 99, 22, 7, 66

Original Abstract

Review of Studies Among Injecting Drug Users in Metro Cebu, Philippines

Complete as indicated on this insert

Aquino, Carmina. Program for Appropriate Technology in Health (PATH) for the AIDS Surveillance and Education Project (ASEP)

Deadline: 1 February 1995

Objective: The objective of this review was to identify potential directions for AIDS prevention programming among injecting drug users (IDUs) in Metro Cebu, Philippines.

Methods: The Philippine Department of Health (DOH) was first to identify needle-sharing among IDUs as a risk factor for HIV transmission through an unexpected finding of a malaria outbreak investigation study conducted in March 1992 by the DOH/Field Epidemiology Training Program (FETP). Three recent studies, two by the DOH and one by a Cebu-based NGO, Ramon Aboitiz Foundation, Inc. (RAFI), conducted between 1992 and 1994 among IDUs were reviewed and key findings regarding injecting behaviors examined. Records of patients with malaria treated at hospitals in Cebu City were reviewed and in-depth interviews were conducted with malaria patients and IDUs regarding HIV/AIDS Knowledge, Attitude and Behavior (KAB). Focus group discussions (FGDs) were conducted in among 46 male and 14 female IDUs in rehabilitation centers, prisons and low-income communities during June - September 1994 among 46 male and 14 female IDUs to gather rich, first-hand and in-depth information about their injecting and sexual behaviors.

Results: Results indicate that needle sharing was the norm, even among IDUs who understood that it was risky. Respondents were unable to afford their own injecting equipment or could not locate it when the drug was available. None of the respondents reported using effective techniques to disinfect injecting equipment. They generally flushed needles and syringes with hot or cold water, or sometimes isopropyl alcohol. Reported HIV risk factors included unprotected sex with other drug users and sex workers, low levels of condom usage and previous history of STDs. In discussion about attitudes towards AIDS education strategies, IDUs suggested outreach programs using "credible" individuals.

Conclusion: The findings of this review will provide recommendations for future HIV prevention programming in Cebu including further qualitative research to identify indigenous leaders in IDU communities, and training and support of these leaders to develop educational outreach systems in areas where IDUs spend time. Current needle/syringe cleaning practices should also be strengthened and bleach introduced as a harm reduction intervention.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 20 113 6 138 _____ _____

Original Abstract

Integration of HIV/STD Prevention and Family Planning in a Community Setting in Honduras: Colonia La Laguna

Complete as indicated on this insert

Ritza Aviles de Briseño* and Julie Becker**
*ASHONPLAFA, Tegucigalpa, Honduras, **International Planned Parenthood Federation, Western Hemisphere Region

Deadline: 1 February 1995

Objectives: In 1993, the Asociación Hondureña de Planificación de Familia (ASHONPLAFA) developed a project to integrate HIV/STD prevention and family planning in a community setting. The project sought to develop a new participatory model of community partnership through collaboration with governmental and non-governmental health and social service organizations and community leaders. To achieve full integration, the project worked with all sectors of the community to promote change in attitude and sexual behavior through counselling, education and sociocultural activities. The project aimed to meet a broader range of community needs beyond that which is typically provided by a family planning association.

Methods: The project was initiated with the formation of a multidisciplinary interinstitutional committee. Community leaders were identified and trained to assist in formulating and implementing interventions directed to various sectors of the community including families, school children, adolescents, churches, teachers and community organizations.

Education focusing on human sexuality, HIV/STD transmission and family planning was combined with such sociocultural activities such a soccer matches, public events for holidays, and classes in crafts, drawing, poetry and public speaking. Sociocultural activities served not only to attract participation but also to assisted community members economically by building skills that could generate income. Home visits were provided through community-based distributors and individual counselling was provided by project staff. Interventions were developed to address the social conditions of women in the community focusing on consciousness raising, self esteem, health conditions, risk reduction for HIV/STD transmission and community organizing.

The project was evaluated qualitatively through pre and post-intervention focus groups, and quantitatively through pre and post-KAP surveys.

Results: The project has resulted in improvement in knowledge and attitudes of the population and changes in sexual behavior. The project has been accepted by the community and broad participation has been achieved.

Conclusions: Through allowing the community to make its own decisions and to fully participate in project development and implementation, a sense of community ownership has developed. ASHONPLAFA is now able to transfer responsibility for the project to organized community members and is preparing to phase its staff out while continuing to provide technical assistance.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 6 48 49 50 75 100

Original Abstract

STD/HIV Prevention for STD Clinic Attenders

Hadden, Bernadette R.;* Stein, Z.A.**; Preston-Whyte, E.***; Zulu, B.M.***; *Columbia University School of Social Work; **Columbia University School of Public Health; ***University of Natal, South Africa.

Complete as indicated on this insert

Deadline: 1 February 1995

Objectives: 1) Collect qualitative data from women and men attending an STD clinic on sexual attitudes and behaviors associated with STD/HIV prevention; 2) Develop and test a 4 session, small group, cognitive behavioral skills-building intervention that includes standard STD treatment and condom distribution in reducing risk behavior and STD re-infection among female and male clinic patients; 3) Assess the feasibility of the intervention within an STD clinic setting.

Methods: The study is an intervention trial. In the first phase, 30 Zulu women and men participated in in-depth interviews followed by focus groups. One focus group also was conducted with STD clinic staff. This information will be used to develop a questionnaire to be administered to 200 STD clinic patients -- 100 women and 100 men -- who will be randomly assigned to either the new intervention or to one session of HIV/AIDS information plus the standard STD treatment and provision of condoms.

Results: Clinic staff reported being concerned that patients were not taking the AIDS epidemic seriously. Despite providing STD/AIDS information and condoms, staff noted that the same patients kept returning to the clinic with new infections. Only 9 of the patients interviewed had ever used condoms. None reported current condom use. Desire for children was a principal barrier. The majority of women interviewed reported having one sexual partner. Most respondents said they would be more comfortable using condoms with their main sexual partner than with casual sexual partners. Men wanted to protect their partner from disease, whereas women were less fearful of a violent reaction from their main partner than from a casual partner they did not know. Women were more likely to report that condom use was an effective strategy against STD/HIV; more men identified partner reduction as an effective strategy. Respondents and clinic staff were supportive of the new intervention which will be piggy-backed on to initial and follow-up visits scheduled by the clinic.

Conclusion: Although data suggest that communication on sexual matters and AIDS is occurring between clinic patients and their partners, condom use as a strategy is not widespread. Gender differences exist with regard to preference for and ability to adopt safer sex options. The aim of the intervention will be to improve skills to support decisions about partner reduction or condom use.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 153 10 19 95 121 ___

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Challenges in Integrating HIV/STD Prevention and Family Planning

Julie Becker, International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR)

The experiences of the IPPF/WHR and its LAC affiliates demonstrate that integration of HIV/STD prevention into family planning can be positive from a client perspective and an institutional perspective, and it is possible to do with limited resources.

Family planning organizations are ideally placed to integrate prevention of HIV and other sexually-transmitted diseases into their work because they serve large numbers of sexually active people, especially women, and they already have experience in related areas of counselling, education and condom promotion. However, a number of factors, both real and perceived, present challenges to integration.

In the past, many family planning programs were apprehensive about addressing AIDS and STDs due to the associated stigma. They did not want their programs to be perceivec as associated with promiscuity, and they feared that clients would be frightened away. STDs were not considered to be a serious problem for the mostly married women served by family planning programs. There is now a growing realization that heterosexual transmission can be a serious threat to family planning clients.

Although cost is often perceived as a barrier to integration, it is not necessarily a major burden. Integration of HIV/STD prevention can make use of existing family planning structures and staff, thus keeping costs to a minimum.

It is difficult to achieve behavior change for HIV/STD prevention within the context of a single family planning counselling session. Family planning counsellors can help clients examine their circumstances and develop condom negotiation strategies, in addition to providing information. Group work can be effective in strengthining women's abilities to discuss sexual matters and negotiate condom use with their partners, and can provide women with an opportunity to share experiences and become empowered to make decisions about their sexual lives. In order to move toward programs that that are more relevant to clients' reproductive and sexual health needs and that can effect behavior change, family planning programs have often altered their approach from a traditional "top down" medical model, to a more participatory methodology.

Both family planning organizations and individual workers may need to overcome bias against condoms. Institutional bias stems from traditional views of the condom as a less effective method of family planning in terms of fertility control, although condoms can be highly effective when used correctly. Training exercises which assist staff to explore their personal feelings and experiences related to condom use, and its effects on their personal and professional lives can help in overcoming personal biases.

Many family planning organizations have been reluctant to begin integrating HIV/STD prevention into their programs and services due to these challenges, and due to a fear tha: it might dilute the mission of family planning. IPPF affiliates who have done so have actually found that it enhances the quality of their family planning services. Quality is improved by the existence of a broader range of services as well as through improved counselling using a client-centered, sexual health approach.

Topic No. i Select one from Key List

Key Word Nos. (Select four to six) 8 75 81 _____ _____ _____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Integration of Reproductive Tract Infection (RTI) Services into a Family Planning Clinic in Kenya: Cost Recovery Issues

Ogana LM*, Kairu MK**. **CEDPA Regional Office, Nairobi, *FLPS, Nairobi.

Objective: The objectives of this review are to share experiences on 1) how a Family Planning (FP) project has responded to clients' need for RTI services, and 2) how to finance integration costs of RTI services where FP donor funds cannot be used for purchase of drugs.

Methods: Focus group discussions with clients and in-depth interviews with service providers on the strategies to finance RTI treatment and related services were conducted. Client exit interviews after introducing sale of drugs and client fees were also conducted to find out clients' satisfaction.

Clinic attendance data since the introduction of RTI treatment will be analyzed to examine the trends and profiles of the clients served at the clinic and/or treated for RTIs. The cost recovery levels for RTI clients, FP clients and FP/RTI will be compared. Results of this analysis will be presented during the conference.

Results: Focus group discussions with clients indicated that clients were willing to pay a portion of the cost of medications, and that the proposed payment (KSH200) was less than they would expect to pay at the pharmacy. In depth interviews, however, showed that health care workers (HCWs) were concerned about their client's ability to afford treatment.

Exit interviews were carried out twice, soon after initiation of the drug revolving fund, and three months later. Only half of patients interviewed in the first set of exit interviews said that RTI was mentioned by the nurse. A refresher course in counseling was then conducted following which exit interviews were repeated. Three quarters of patients interviewed said they received some RTI counseling. The majority of clients said they were satisfied with the new services and were willing to pay for medications. Despite their initial concerns, HCWs with experience accepted the new program.

Preliminary analysis of the clients served by the project before and after introduction of cost recovery suggests that the introduction of client fees did not affect clients' flow nor the clients' continuation pattern.

Conclusion: The experience so far shows that introduction of cost recovery mechanisms in FP projects could facilitate the integration of RTI services into FP programs. Further, it shows that a project can meet clients' identified needs such as RTI using minimal resources. With careful planning and introduction of cost recovery mechanisms, family planning agencies could broaden their reproductive health scope to include RTI and other components.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 109 75 155 139 _____ _____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Promotion of Standard STD Case Management Guidelines in Nepal

Mugrditchian DS*, Joshi BR**, Shrestha RK***, Shrestha J***, Shrestha OL****, Pradhan M****, Pollock J*, Karki BB*****. * AIDSCAP/FHI, USA; ** Nepal Medical Association (NMA); *** Bir Hospital, Nepal; **** Nepal Chemists & Druggists Association (NCDA); *****National Center for AIDS and STD Control, Ministry of Health (MOH).

Objective: To promote a standardized approach to STD case management in Nepal.

Methods: In Nepal STD control is an integral component of the National AIDS Control Program (NACP). In 1994 the MOH published National STD Case Management Guidelines based on the WHO syndrome flow charts. In the framework of the NACP, AIDSCAP assisted the NMA and the NCDA in implementing a series of two day workshops to introduce the guidelines to physicians, chemists and alternative health care providers in central Nepal.

Results: The curricula were developed by multidisciplinary expert committees. Standard training packages were developed consisting of a facilitator's manual, overheads, clinical slides and participant handouts. The curricula stressed the syndrome approach to STD management and prevention education, and addressed provider attitudes, communication skills and condom demonstration skills. Other training strategies included a special STD session at the NMA biannual medical conference and the publication of special articles in the journal and newsletter of the respective associations. The core curriculum has been endorsed by the NACP and will be integrated into national health manpower training programs. It has been integrated into a two week family planning pre-service training program for health post staff. Other donors and non-governmental organizations (NGOs) have expressed an interest in replicating the workshops in other parts of the country.

Conclusions: National STD case management guidelines were successfully introduced to a wide spectrum of health care workers through the extensive networks of well-respected professional associations. The close coordination with the MOH, other donors and the NGO community, will ensure that these efforts will be expanded to the rest of the country.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 128 94 95 10

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

CONDOM SOCIAL MARKETING EXPERIENCE IN BRAZIL

Clemente, M.*; Ferreros, C.*; Fernandes, M.E.**
* DKT do Brasil; **AIDSCAP/Brazil-Family Health International

Introduction: Brasil launched a condom social marketing effort in Brazil i late 1991, at the behest of the Secretary of Health of the State of Sa Paulo. Its express purpose was to provide accessibility of affordabl condoms to the lower-income segment of the population.

Background: DKT International established a subsidiary, DKT do Brasil t implement the condom social marketing activity in 1991. Substantia differences existed between the Brazilian situation and the setting commo in many African countries. Importantly, Brazil has a more sophisticate retail network and media and communications infrastructure. This, combine with a large potential market (population 150 million plus; per capita GD $2,800), requires large investments for adequate marketing. In addition Brazil has a protectionist culture that favors the local condom industry Classically, this protectionism has led to the anomaly of a country wit. high rates of HIV infection with the highest condom retail prices in th world (range of $0.70 to $1.00 a piece), and some of the lowest per capit. condom use (one third of Bangladesh which has one tenth per capita GDP).

Methodology: DKT do Brasil launched a low-priced condom under the brand nam Prudence in 1992. The effort has been concentrated in the states of Rio d Janeiro and Sao Paulo, which together account for 80% of the AIDS case reported. The product was priced at a suggested range $0.17 to $0.25, affordable to low-income groups. To maximize limited marketing an advertising resources, DKT do Brasil worked with AIDSCAP NGOs and othe organizations to promote the brand and engaged in mass sampling among targe groups on occasions such as Carnival, town fairs, etc. Negotiations wer conducted with radio stations and TV channels on a local regional basis t lower total media costs. While major sales are conducted through a commercial distributor with a national sales force of 25 persons, this i complemented by DKT's promotional team (3 persons) that conduct direct sale to very small outlets, and non-traditional outlets such as gas stations, bars and saunas.
DKT and AIDSCAP have combined forces to try and effect changes i regulations and tariffs. Presently the quality control regulations ar implemeted through a burdensome procedure that has served to disincentivize importers and thus limit the quantity of condoms available in the market DKT and AIDSCAP are trying to change this to facilitate market entry o condoms conforming to internationally accepted standards. Already, som movement has been realized. Import duties have been eliminated, while th condom quality certification process is under review.

Results: Through 1994, cumulative sales were 25 million condoms, with a projected 20 million planned for 1995. The total market condom grew 25 versus last year, and since 1990 has now doubled. This can be traced to th debut of Prudence, but significantly, Prudence alone does not account fo the volume growth. The commercial market has benefited as well, with a cumulative volume increase of around 25 million over the same period.

Conclusions: More effort has to be made to ease the entry of importe quality condoms into the market. This would increase competition, lead t lower prices, and marketing investments will result in accelerated growt thus benefiting the Brazilian population. Social marketing has demonstrabl proven beneficial not only to the low income groups, but to the commercia sellers as well, in accelerating the growth of the total condom market.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 24 52 73 113 139 141

198

Complete as indicated on this insert

Deadline: 1 February 1995

Aids Prevention and Sustainable Development

Lodha, Dr.G.C.*; Seva Mandir Udaipur Rajasthan India*

Objectives : The AIDS awareness programme at Seva Mandir is an experiment in viewing HIV/AIDS as a social malady, linked to the endemic problems of poverty and path of modernization. In this tribal region, socio-economic and geographical factors combine to exacerbate the spread of AIDS. The forests, a principal income source have reduced considerably. For the women, recourse to sex is a necessity, especially along the highway, where truckers pay for it. Ironically, communication, a hallmark of development has created these conditions of potential risk. Fragmented land holdings, degraded environment and rise in material aspirations have forced migration of men to urban areas. Here they encounter casual sex, and bring back the virus. Udaipur is also a popular tourist location. With growing exposure to stereotyped media images of the West and shift in attitudes, one-off sexual encounters have become widespread. Also, old moral codes impede free discussion of sexual problems. The AIDS programme at Seva Mandir attempts to: 1. Raise multisectoral awareness on HIV/AIDS. 2. Achieve, gradually, improvements in people's quality of life.

Methods : 1. Organised an AIDS conference for 400 GO/NGO workers. 2. Met with the Hotel Association of Udaipur. 3. Foot marches along the National Highway, led to discussions with the people, hotel owners, women who prostitute and truck drivers. An audio visual van, distributed literature, and exhibhited relevant material. Condom dispensers were placed. 4. Continuous collaborations with the health authorities. 5. Using our trusted network of paraworkers to educate people. 6. Trying to augment income generating assets and knowledge of the people. 7. Attempts to make all our programmes AIDS sensitive. 8. Linking AIDS with STDs.

Results : By finding the malady's roots in the prevalent poverty, volunteerism with established grass roots standing has facilitated the introduction of this difficult and not yet visible issue with the people. Addressing such issues, by themselves, do not yield desired results. By understanding the people's socio-economic set up providing support through our various socio-economic programmes, adopting a non-judgmental stand on moral concerns, has created a sense of mutual trust. We have developed, a network of trained village based para professionals numbering 1000 and touching 400 villages. Given this base, and our integrated approach we have facilitated an open environment wherein sensitive issues are discussed. This is our strength.

Conclusions : We hope, that this experiment will be consolidated and learnings gleaned. Our attempt is to provide a policy alternative by integrating AIDS awareness with poverty alleviation.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 6 68 101 50 139 145

199

Original Abstract

Technology Transfer of HIV Diagnostic Kit Production into the Developing World and the Establishment of a South-South Network of Diagnostics Manufacturers.

Complete as indicated on this insert

Moree, Melinda; Buchanan, Ian; Maynard Jr., James; Schaeffler, Barbara A.; Brooke, Steve; and Tam, Milton. PATH, Seattle WA.

Deadline: 1 February 1995

Introduction: For years, primary health care experts and researchers have called for the development of rapid, simple, accurate, objectively read diagnostics for use in resource-poor settings. Diagnostic tests made in developed countries are often inappropriate for use in developing country health programs because of their high cost and/or the need for supporting laboratory equipment and electricity. In response, PATH has developed a HIV 1+2 diagnostic kit that is simple, rapid and inexpensive to use.
Objectives: To make an appropriate, affordable HIV test sustainable for production and available at a low price in developing countries through technology transfer to local manufacturers.
Results: Local production was established in India, Indonesia, Thailand, and Argentina ("alpha" sites). In addition, other manufacturers in Cameroon and Zimababwe ("beta" sites) are now gaining manufacturing experience by initially packaging components from bulk before phasing-in their own local production. The price of the dipsticks ranges from 20% to 60% of the cost of comparable test kits, and, in some instances, has driven down the price of ELISAs and competing rapid or simple HIV tests. The quality of the dipsticks produced by the four alpha site manufacturers was found to be very high in a recent evaluation conducted by the WHO Collaborating Center on AIDS in Antwerp, Belgium. The manufacturers achieved initial sensitivities of 100% and final specificities above 98.7% when tested on a panel of 600 sera obtained from different regions of the world.
Conclusions: The dipstick manufacturers that are connected by PATH's technology transfer efforts have established themselves as high-quality producers of rapid HIV test kits. Additionally, a network has developed among these manufacturers, and with PATH, which has started to improve, strengthen, and expand their production capabilities for diagnostics. They are now exchanging and supplying kit components; training technicians from other manufacturers; and collaborating to develop and produce new diagnostic technologies. For example, diagnostics for tuberculosis, malaria, and hepatitis B surface antigen are already in production. Now that this developing world manufacturing network has been established, it needs to be expanded, both in numbers of participants and with new technologies, which can now be more readily transferred at lower cost and in a shorter time. As simple, appropriate diagnostic tests for STDs and other diseases become available, they can also be transferred into these established production facilities.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 7 10 101 102 158 133

200

Original Abstract

Mobilizing the Business Sector to Respond to the HIV/AIDS Crisis in Africa: Findings and Experiences of the Private Sector AIDS Policy Presentation (PSAPP) Activity.

Complete as indicated on this insert

Roberts, Matthew.*; Forsythe, S.*; Nyamete, A.*
*AIDSCAP/FHI, Arlington, VA, USA

Deadline: 1 February 1995

Objectives: This paper will present the findings of the PSAPP project. The needs assessments were undertaken with businesses in Kenya, Senegal, and Botswana to determine how the private sector and parastatal organizations are responding to HIV/AIDS in the workplace; to develop economic impact and qualitative case studies of companies; and to indicate what materials would best encourage and assist businesses to establish appropriate HIV/AIDS-related policies and comprehensive, sustainable prevention programs. The testing of materials is being undertaken to evaluate the effectiveness of the materials at providing managers with the information and incentives to establish policies and programs. Results of the testing will be used to modify the materials before their production and broader dissemination.

Methods: For the assessments, interviews were conducted with managers in Kenya, Senegal, and Botswana. Focus groups with workers were also conducted in Kenya. Financial studies were done in Kenya and Botswana. Testing of the materials involves conducting short presentations and day-long workshops with groups of managers in Nairobi and Dakar.

Results: The needs assessments found that while many managers are concerned with the growing AIDS crisis, few have developed comprehensive prevention programs or policies. The financial analyses indicate that HIV/AIDS is having an impact on businesses and that prevention programs are likely to be less expensive than the cost to companies of lost productivity, increased medical expenses, and training costs.

Conclusions: Business leaders are aware of the risks HIV/AIDS poses to their organizations and are interested in learning what kinds of action they can take to reduce the impact of AIDS. The PSAPP materials, including the financial analyses, promise to provide private sector representatives with the information and tools to evaluate the situation in their own organizations and to establish effective workplace policies and programs.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 64 80 109 141 144 167

Original Abstract

Advocacy Tool For Private Sector Initiatives To Develop Workplace Policy & Programs To Control AIDS

Complete as indicated on this insert

Sankaran, Saraswathi.*;Meloot,J.*;Ganesh,V.*;
* DESH, Madras, India.

Deadline: 1 February 1995

Objectives:To develop a culture-specific, target-specific Advocacy Tool,which can enhance Private Sector initiatives to establish appropriate HIV/AIDS policies & workplace prevention programs.

Methods:Liasing with the Local Chamber of Commerce and the Employers' Federation of Industry, South India, data was collected in Madras from a)3 private sector, one public sector,and twenty small scale industrial organizations on absenteeism,productivity,profit margin, accidents,mandays lost,training cost& health care cost; b)private sector B(3500 employees)& public sector D (7400 employees) through a risk assessment study, individually interviewing at random 5% non-supervisory employees about their 'at risk'lifestyle and habits; c)from three major Employee State Insurance-(ESI) hospitals and at medical clinics within industry from the point of view of HIV/AIDS related illnesses.

Results:1)There can be approximately two-fold increase in absenteeism raising manpower cost by atleast 20%; 2)In firm 'B'about 32% and firm'D' 53% respondents acknowledged'at risk' multi-partner sex(MPS)practices which increased with levels of skill,income and productive age while the same decreased with education (X^2 significant);3)While there is no significant rise in reported cases of T.B among general population there is a noticeable rise in the prevalence of T.B cases among industrial employees & their families using ESI scheme of health care.4)By changing persons 'at risk' to 'no risk' behaviour in industry 'B',savings due to Medical & Training Costs alone will be Rs.84,00,000.

Conclusions:1)Even a labour surplus country like India cannot afford to overlook the strong correlation between skilled workforce and 'at risk' behaviour leading to HIV/AIDS which can result in heavy losses for the industry due to increased absenteeism,relocation & training costs.2)Findings of risk assessment underline need for HIV/AIDS policies and workplace prevention programs. 3)This paper can be used as advocacy tool to private sector initiatives

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 4 103 18 161 54 167

Complete as indicated on this insert

Deadline: 1 February 1995

Title: Promoting a Sense of Ownership as a Critical Aspect of Capacity Building

Wienrawee, Pawana.*; Bennett, T.*; Brenden, N.*. *AIDSCAP/FHI, Bangkok, Thailand.

Objectives: To develop organizational linkages between the public sector (the Bangkok Metropolitan Administration/BMA) and the private sector (local NGOs and universities) which are durable and will be maintained and sustained following the termination of AIDSCAP's financial and technical support.

Methods: "Expanding the capacity of host country institutions..." (the purpose of AIDSCAP) requires attention to institutional relationships as well as internal organizational capacities.The Comprehensive Bangkok Program (CBP), the HIV/AIDS control program in Bangkok, evolved through the initiative of AIDSCAP under the sanctioning authority of the BMA and in collaboration with NGOs, community groups and universities. The AIDSCAP methodology included financial and technical support to the individual components of CBP, while concurrently promoting a sense of identity among the participants as being part of a larger purpose. In addition, a sense of ownership of the larger program was being promoted through project-wide seminars organized by the participants, the development of a generic prevention logo which had no reference to external funding sources, the promotion " World AIDS Day " events as " their " initiative, etc.

Results: The AIDSCAP timetable for completing work in Thailand was altered with the decision to phase out the USAID Mission one year before the planned termination of support to the CBP. Under the pressure of the potential premature phase out of AIDSCAP, the participants in the CBP were able to identify their interdependence and collaboratively to seek ways to continue the partnership which AIDSCAP has promoted.

Conclusions: "Capacity building" requires an analysis of both the internal functioning and external relations or networks of implementing partner by time-limited international donor agencies. Sustainability often requires that the donor's attention be directed at the network of public and private agencies which are dependent on each other for comprehensive, community-based interventions. These community networks of public and private, bureaucratic and grass-roots organizations can be created by external agencies and develop the capacity to be self-sustaining if strategies for creating identity and ownership are intentionally pursued.

Topic No. 2 Select one from Key List

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Title: Building Alliances Across Borders: Women Networking on HIV/AIDS Prevention in Southeast Asia

Singhanetra-Renard, Anchalee*; Burian, C.**; Hartwig, K.**. *Women's Studies Center, Chiangmai University; **AIDSCAP Asia Regional Office.

Objectives:

(1) To bring together women from Thailand, Myanmar, Laos, Cambodia, Vietnam, and the Yunnan Province of China, across the fields of NGOs, GOs, and academia to develop action plans for their respective countries with regard to women role in HIV/AIDS prevention in the family;

(2) Share experiences on policy making and interventions between countries and across spheres of experience/expertise;

(3) Develop a network in the region on women and HIV/AIDS.

Methodology: The Women's Studies Center (WSC) of Chiangmai University, organized a regional workshop on "Women, Family and HIV/AIDS Prevention." Three participants each from Thailand, Myanmar, Laos, Cambodia, Vietnam and the Yunnan Province of China came together for four days to share experiences and develop country specific action plans. Each country sent one representative each from a non-government organization, the government, and from a university. During the course of the workshop, opportunities were provided for each "sector" to meet and discuss strategies with a culminating day's workshop in which each country group presented an action plan. International facilitators participated in guiding discussions and sharing international lessons learned in gender power relations in HIV/AIDS prevention and care; and in the establishment and maintenance of women and AIDS networks.

Results: An action plan for HIV/AIDS prevention strategies, research needs and policy implications was completed for each of the six countries represented. Further, the bridging of representatives from NGOs, the government and academia brought together groups which do not meet "naturally" thus creating new alliances for HIV prevention initiatives.

Conclusions: The workshop composition and agenda could be used as a model for influencing policy, research and intervention initiatives regarding HIV, particularly those affecting women, in other countries.

Topic No. 2 Select one from Key List

Key Word Nos (Select four or [illegible]) 141 14 15 68

Original Abstract

AIDS Policy Program in the Dominican Republic: ~~Keeping AIDS in~~ KEY agenda.

Butler, M.*; Gomez E.**; Sweat, M.*
* - Family Health International, AIDSCAP
** - SESPAS/PROCETS, Dominican Ministry of Health/NACP

Objective: To describe the AIDS policy program implemented in the Dominican Republic in support of HIV prevention.

Policy Environment: Awareness of policy makers in the DR of the growing AIDS epidemic has been low. AIDS has been viewed as a health issue affecting stigmatized populations with little attention paid to the impact on economic development, the workplace, tourism, families and local communities. Prevention efforts have been implemented with little coordination.

Goals: To: 1) develop consensus on the current status and projected impact of the AIDS epidemic in DR; 2) raise awarer stimulate dialogue and elicit support among the private and p sector regarding AIDS issues/prevention programs; 3) foster coordination of prevention efforts.

Methods/Activities: Analysis of current and projected impact of the AIDS epidemic was conducted and a presentation held for senior leaders in government, tourism, and the church. Since then a program to disseminate, promote and analyze different aspects of the AIDS Law has been implemented. A second stage of this program is being designed targetting policy leaders and businessmen.

Results: Attributing policy outcomes to specific activities can be difficult. However, soon after the senior level presentation on October 1993, the AIDS agenda began to move: 1) national AIDS legislation was signed into law; 2) various AIDS Law dissemination/analysis sessions were held with other opinion leaders; 3) regulations for the application of the law have been developed; 4) current status and projected impact of the epidemic has been widely disseminated; national press has reported multiple times on this; 5) coordination of prevention efforts has improved and, 6) other international/ national donors support for AIDS interventions has increased.

Conclusions: AIDS policy reform is most likely when: 1) goals are clearly defined; 2) scientific analysis is available to ground policy decisions; 3)issues are articulated in terms of concerns of target audiences 4) interest is maintained through individual follow-up. Maybe serendipity favors advent of events, or committed people struggle and keep believing to make it happen.

Topic: 2
Key Words: 4,62,64,141

BEST AVAILABLE COPY

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

SPIDNET: A Tool for Russian AIDS Policy

Gardner, Kevin.*; Bozhko, L.*; Rozhkov, R.*; Stachowiak, J.**. *AESOP Center, Moscow, Russia; **AIDS infoshare russia, Moscow, Russia.

Objectives: The objectives of this work were to: 1) widen the circle of discussion about the 1994 draft HIV/AIDS law in Russia, formulate and advocate specific changes in the draft, and influence the decision-making process; 2) integrate the new USAID-funded SPIDNET project ("SPID" is the Russian acronym for AIDS) with the AESOP Center's on-going AIDS policy work; 3) Recruit, train and cooperate with other organizations to conduct similar "electronic" policy work.

Methods: A press conference was organized in June 1994 to draw attention to the draft HIV/AIDS law and advocate specific changes. This event marked the beginning of the AESOP Center's AIDS policy work. As the draft law made its way through the legislative process, the AESOP Center organized a successful letter-writing campaign by publicizing the issue in the media and through electronic networking. An English translation of the legislation was also completed and distributed electronically. The SPIDNET STD/HIV/AIDS electronic information system was established and began handling requests for information from AIDS policy makers.

Results: The initial closed circle of "experts" who wrote the draft law was opened up, public discourse about the issue was increased, and policy-makers were pressured to change controversial provisions in the legislation, such as mandatory HIV testing of all foreigners in Russia. President Boris Yeltsin vetoed the draft law in its current form, and returned it to the legislature for reworking. Government and international agencies began working with AESOP, other non-governmental organizations (NGOs), and with each other on Russian AIDS policy and information exchange in general.

Conclusions: Electronic information systems are revolutionizing global AIDS work, and increasing dramatically the effectiveness and stature of NGOs. The success of AESOP's efforts, supported by its American partnership, in influencing AIDS policy and monitoring government enforcement procedures on a local level represents a clear example of the role NGOs can and should play in the development of democratic processes in public health policy.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 140 141 133 4 152 77

BEST AVAILABLE COPY

206

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Title: THE IMPACT OF POLICY STUDY PROGRAMS: THE CASE OF INDONESIA

Gunawan, Suraidi.*; Hessler-Radelet, C.**; Chamratrithirong, A.***; Burian, C.****; *Institute of Health Research & Development, Indonesia Ministry of Health, **USAID-Jakata/AIDSCAP, *** Institute for Population and Social Research of Mahidol University, ****AIDSCAP/FHI, Bangkok, Thailand.

Objective: The objective of this case study are: 1. to identify the impact that policy study programs had on the development of Indonesian policies related to HIV/AIDS from the perspective of Indonesian participants; 2. to determine which aspects of the policy study program were most useful, and 3. to make recommendations for future policy study tour programs.

Methods: Four policy study programs were developed by AIDSCAP Asia Regional Office and managed by IPSR at the request of the Indonesian Government and USAID/Jakata during 1993/4. In order to evaluate the impact of the program, a survey was conducted among all 25 policy study program participants and in-depth interviews held with 12 participants from at 9 different ministries. Researchers reviewed participant workplans to access the degree to which participants have been able to accomplish the goals they established for themselves at the completion of their policy study program.

Results: A total of 25 senior policy makers from 17 different ministries/government agencies participated in four 5-day policy study programs during 1993-4. The objective of the study program was to expose senior level Indonesian policy makers to issues related to HIV/AIDS and options for the development of national AIDS prevention programs. The study programs were tailored to the needs of individual participants. Special topics covered during the course of the program included: STD control and AIDS prevention, condom promotions, cultural/religious traditions and HIV/AIDS programs, AIDS and the military, counseling services, the role of NGOs in National AIDS Program, HIV testing, legal issues surrounding the HIV/AIDS epidemic, women and AIDS. Indicators of the impact of the policy study program upon return to Indonesia was the actives involvement of participants in the development of the new National AIDS Strategy and National AIDS Program planning. Results from a qualitative analysis of the impact of the policy study program planning on the development of policies related to HIV/AIDS from the perspective of the participants will be presented.

Conclusions: Policy study programs can be an effective means of reaching senior policy makers and enabling them to learn from the experiences of other countries. Through exposure to the positive and negative consequences of various HIV/AIDS policy and programmatic actions, policy makers and avoid unconstructive policies and countries can progress more rapidly to effective prevention programs. Findings of this case study can be used to guide development of more effective policy study programs in future.

Topic No. 2 Select one from Key List

BEST AVAILABLE COPY

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

From Denial to Response: Factors influencing the Evolution of HIV/AIDS Prevention Policies of the Royal Thai Government (RTG)

Porapakkham, Yawarat.*; Pramanpol, S.*; Atipha, S.*; Mills, S.**. *ASEAN Institute for Health and Development, Mahidol University, Bangkok, Thailand. **AIDSCAP/FHI, Bangkok, Thailand.

Objectives: To study and analyze the policy process in Thailand in response to the HIV/AIDS epidemic and to identify "triggers" which moved the RTG from an initial period of denial and non-response to the promotion and implementation of resource-intensive interventions.

Methodology: Methods included 1) key informant interviews with HIV prevention personnel in the Ministry of Health and non-government organizations, policy-makers, academics, community leaders who have been involved in the response to the epidemic since 1984 and 2) content analysis of major newspapers to track the press response to the epidemic. Key policy indicators are defined as 1) yearly budgets of the RTG and foreign donors for HIV prevention activities in Thailand and 2) shifts in key HIV-related legal and regulatory policies regarding prevention strategies (e.g. quarantine, 100% condom use in brothel policy), immigration, and disease reporting.

Results: Data suggest that an economic boom throughout the 1980s and high tourism revenues associated with the RTG's declaration of 1987 as Visit Thailand Year impeded efforts to actively address HIV as a public health problem during the early period of the HIV epidemic in Thailand. Barriers to change from this initial period of non-response were dissolved only gradually by 1) increasing amounts of epidemiologic data showing high rates of seroprevalence, 2) appearance of people with AIDS, and 3) pressures from non-governmental organizations. Furthermore, public debate and attention to prostitution - together with long-term government STD service infrastructure - led the government to a formulation of the 100% condom use policy for brothels.

Conclusions: Serologic surveillance documenting an epidemic, the presence of non-governmental organizations and people with AIDS in the public arena promoted public debate and government response to HIV in Thailand. These can be supported in other countries to promote enhanced governmental responses to HIV.

Topic No 2 Select one from Key List

Key Word No.s

Original Abstract

Raising Awareness about HIV/AIDS in Kenya: An Application of the AIDS Impact Model (AIM).

Complete as indicated on this insert

Stover, John.*; Johnston, Alan**; Kizito, P.M.L.***, Balthazar, G.M.**** *The Futures Group International, Glastonbury, CT USA; **Research Triangle Institute, Research Triangle Park, NC, USA; ***National Council for Population and Development, Nairobi, Kenya; ****National AIDS Control Programme, Nairobi, Kenya

Deadline: 1 February 1995

Objectives: The objective of this project was to raise awareness about HIV/AIDS amon various audiences in Kenya, including senior national government officials; district government planning and health officials; NGOs involved in AIDS, health or family planning; college and university staff; and private businesses. Our assumption is that increased awareness of the nature and severity of the epidemic and the means to prevent will lead to a greater consensus in support of effective AIDS prevention interventions. The activity focussed particularly on building support for a strong multi-sectoral program, increased government and donor funding for HIV/AIDS and inclusion of AID in the national development plan.

Methods: A computer-based presentation was prepared by adapting the AIM model for Kenya. Training was conducted for presenters from several Kenyan organizations and presentation equipment was provided. A dissemination strategy was developed and carried out during 1993-1994. A booklet containing the charts and main text of the presentation was prepared and printed. At the end of the first year, the activity was evaluated and a new dissemination strategy was developed for the second year. The presentation includes the latest sentinel surveillance results, as well as charts on basic AIDS epidemiology, the impact of AIDS and the effects of AIDS interventions.

Results: The presentation was shown to over 100 audiences including over 3400 people during the first six months of the dissemination activity. About six thousand copies of tl booklet have been distributed. The evaluation indicated that the presentation had a significant impact in increasing knowledge about the epidemic. The activity also contributed to the chapter on AIDS in the National Development Plan and to sections oı AIDS in a number of District Development Plans. After the evaluation, a new strategy was developed to provide more presentations to high level government officials at both the national and district levels.

Conclusions: Dissemination of policy relevant information through AIM or similar activities can have a major impact on knowledge of the AIDS epidemic, particularly in countries like Kenya were the dissemination of information had previously been weak. Although it is difficult to measure, it appears that this activity has contributed to a stronger consensus in support of more effective AIDS control programs. Similar activit in other countries could help to speed the process of developing effective AIDS control policies and programs.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 4 109 141 _____ _____ _____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

"Cabaret Prevenção": Expressionist Theatre and HIV/AIDS Prevention for Men Who Have Sex With Men in Brazil

Almeida, Vagner de*; Parker, R.*; Quemmel, R.*; Terto Jr., V.*; Guimarães, K.+; Pimenta, C.++; Fernandes, M.E.L.++. *ABIA; +Grupo Pela VIDDA-RJ; ++AIDSCAP/Brazil

Objective: Based on research documenting high levels of knowledge about AIDS but low rates of behavior change, this project seeks to provide support for AIDS prevention among men who have sex with men in Brazil.

Methods: The development of an expressionist theatre workshop on sexuality and AIDS. Regular weekly meetings focus on bodywork and expressionist pantomime, dramatization of sexual negotiation and interaction, and collective discussion of issues such as sexual identity, desire and pleasure, the impact of HIV infection and AIDS, and the experience of stigma and discrimination in Brazilian society. Impact of workshop activities has been documented through the use of video recordings and pre- and post-workshop interviews with participants.

Results: Regular meetings, for more than a year and a half now, have involved between 25-50 individuals per session. The workshop has proven especially effective at involving poor and working-class men who are often considered hard to reach through AIDS prevention work. Pre- and post-workshop interviews demonstrate an increase in the positive erotic value associated with safer sex practices. The workshop has also been linked to an increased ability to discuss homosexuality and gay lifestyles and the formation of increasingly dense friendship networks. Workshop participants built upon these themes to write and stage an expressionist play, "Cabaret Prevenção" (Prevention Cabaret). In January of 1995, "Cabaret Prevenção" began a four month run in a professional theatre in Rio de Janeiro, with performances presented three times a week for audiences of between 50 to 100 spectators.

Conclusions: Risk-reducing behavioral change on the part of men who have sex with men is particularly difficult in settings which lack strong community support structures. Information and education activities aimed at HIV/AIDS prevention are often not enough to provide incentive for behavioral change. Cultural activities such as theatre can play an extremely important role in stimulating community attachment, affirming the value of safer sexual practices, and providing a context for a positive collective response to the HIV/AIDS epidemic.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 99 19 49 59 48 24

Original Abstract

Complete as indicated on this insert

Behavioral Interventions for Reduction of HIV/STD Transmission among Female Sex Workers and Male Clients in Bali, Indonesia

Deadline: 1 February 1995

Ford, Kathleen*., Wirawan, D.N.**, Meliawan, P.**, Fajans, P.***, MacDonald, K.*, Thorpe, L.*.
*University of Michigan, USA; **Udayana University, Bali, Indonesia; ***WHO, Switzerland.

Objectives: The objectives of this intervention research were to 1) increase community knowledge and awareness among low price female sex workers and male clients regarding STDS, including AIDS, 2) increase condom use among female sex workers and clients, and 3) study the effects of individual and community factors on individual behavior.

Methods: Intervention activities included an education program for female sex workers, pimp training, condom sales and distribution, and client media. The educational program was based on the results from a large behavioral study. The theoretical basis for the study was the Health Belief model and social cognitive theory. A baseline and an evaluation survey were included to evaluate the intervention activities. Fieldwork was conducted during 1994 in Bali, Indonesia.

Results: Levels of AIDS and STD knowledge as well as condom use increased over the study period. Multivariate analyses were conducted to assess the influence of demographic and program variables on sex workers AIDS and STD knowledge and condom use. Analyses showed that the woman's education, the number of educational sessions that she had attended, and reading and understanding the project brochure were all related to AIDS and STD knowledge and condom use.

Conclusions: The evaluation findings have demonstrated the feasibility and effectiveness of educating female sex workers, their pimps, and their clients in increasing both knowledge of AIDS and other sexually transmitted diseases and use of condoms.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 9 102 150 52 82 ___

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

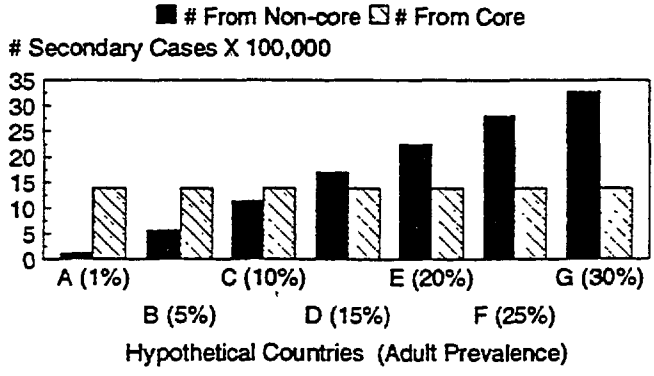
Targeting Interventions for the Prevention of HIV Infection in Developing Countries: When to Begin Targeting Non-Core Groups

Kamenga, Munkolenkole*; White, R.*; MacNeil, J.*; Denison, J.*; Sweat, M.*
*Family Health International, AIDSCAP, Arlington, Virginia, USA

Background: Interventions to prevent HIV/AIDS have focused primarily on special populations defined by their risk for acquiring HIV (truckers, gay men, IV drug users, commercial sex workers, etc...). These groups are often referred to as 'core' groups. Although there are many successful programs targeting core groups, the macro public health impact of such interventions have not been well described. The purpose of this analysis is to identify when targeted interventions should appropriately be expanded beyond core groups.

Methods/Results: One case of a sexually transmitted infection prevented in the most sexually active group averts more secondary cases than one case in the general population; justifying targeted HIV prevention interventions. However, as prevalence in the general population increases, the relative proportion of secondary cases from core groups declines. The table below shows estimates of the number of secondary cases of HIV infection from core and non-core groups for 7 hypothetical countries. Assumptions: (1) total adult population in each country is 10 million; (2) 2% of population is in core group; (3) core group prevalence is constant (60%) in all countries; (4) each HIV case in core groups produces 11.5 secondary cases while each case in non-core groups produces 1.15 secondary cases. Adult HIV prevalence was varied in the following scenarios to examine the relative number of secondary cases that result from core and non-core groups.

Secondary HIV Infections from Core and Non-Core Groups



Conclusions: These hypothetical scenarios show that as HIV prevalence in the general population increases, a higher proportion of new cases result from non-core group members. The results indicates that when HIV prevalence approaches 5% of the adult population it is imperative that interventions begin to also target non-core groups. This will result in a maximum reduction in both primary and secondary HIV infections.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 20 48 67 7 6

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Community-based Aids Education and Prevention in Nine Menoua Villages of Western Cameroon

Authors· KENGMO,P.*; Metangmo, P-M, Dr.*; Lurie, M.**; Mariel, C.**, *Project AH TA-AH in cooperation with ACSD, Dschang, Cameroon; **Both working in health programs in Africa,more information to be forwarded pending availabilit

Objectives: 1) Convey AIDS education and prevention methods using traditional music,dance, proverbs, story-telling. 2) Involve all levels of the community in participatory decision-making re. AIDS prevention strategies. 3) Develop ways to sustain and expand the project.

Methods: In each village, meetings were held first with key village leaders and then with other segments of the community. Meetings provided 1) information on AIDS; 2) means to create community support and involvement. Meetings/group discussions culminated in a village celebration that used music, dance,proverbs and speakers from the village to emphasize AIDS prevention and education messages in a manner consistent with cultural practices. Following this even: groups of villagers met to develop village AIDS strategies. Oral pre and post-evaluation was conducted in the local language. Efforts to sustain the program through greater village involvement are underway. The AIDS songs composed for the project have been recorded for national and international distribution.

Results: Preliminary results indicate that a participatory model in which villagers develop their own AIDS strategies is far more effective in this region than outside education campaigns. People at all levels of the village hierarchy came forward with practical strategies that could be enforc in this highly cohesive culture. Oral evaluations were less successful than hoped because of mistrust of the paper form used to record responses. In a culture where many cannot read, paper has often been used against the people. A bette approach must be found. Anecdotal reponses indicate a high impact in target villages, e.g., two years after the pilot program children still sing the AIDS prevention songs as a continual reminder to their community.

Conclusions: The findings of this pilot program are being used to build a regional network for AIDS education in Menoua. In addition,distribution of tape recordings through personal channnels will provide a means to reach people in bars,at social events and in the home where family members can discuss the lyrics. This program also has broad implications for other health programs at the national and inter national level.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 6 7 29 59 ____ ____

213

Origin[redacted]

BEST AVAILABLE COPY

omplete as dicated on this insert

Deadline: 1 February 1995

AN INNOVATIVE INITIATIVE FOR TARGETING COMMUTERS IN TRAFFIC JAM IN LAGOS, NIGERIA THROUGH THE AIDSCAP RAPID RESPOND FUND

UMOZURIKE, JULIANA*; ESU-WILLIAMS. E*; OMOKHUALE, E**: UJOMU,P**; AIDSCAP/FHI, Nigeria*. HEALTH MATTERS INC**

OBJECTIVES: The objectives of the traffic jam project were to: 1) determine the temperament and disposition of traffic jam commuters; 2) assess HIV/AIDS knowledge and condom practices of commuters; 3) based on 1 and 2, to develop an innovative approach for reaching urban commuting workers with HIV/AIDS education.

METHODS: Three main traffic jam sites in Lagos were chosen. 1)Apongbon bridge 2)Maryland junction and 3)Idi Mangoro. Commuters in 300 vehicles selected from each of the sites were used for the baseline survey for HIV/AIDS. Based on the results of the survey, six health educators termed "mobile health educators" (MHEs) were trained for basic HIV/AIDS education and awareness campaigns, public relations, condom social marketing, and condom use. Two MHEs were assigned to each of the three sites where they conducted one-on-one and group educational sessions three days each week for two months. Using information from the baseline data, posters. stickers, and pamphlets, were developed and produced for distribution. Condoms were also distributed free for promotional purposes. Garments worn by MHEs were tailored to resemble that of the Road Safety Corps (RSC) marshals in order to identify with a popular on-going traffic project. The co-operation of the police, Local Government authorities and RSC were solicited for the work of the MHEs.

RESULTS: The uniqueness of the project generated curiosity in many ways. It was reported in a daily newspaper, the Evening Times and the MHEs became a popular feature of the project sites. They exceeded the number of target vehicles to be reached by more than 200%, instead of the 12,000 projected. all sites recorded 40,000. Condoms distributed exceeded by 50% the number projected. 22, 000 as against 10.000. In addition 1,500 posters. 8,000 pamphlets. and 8.000 stickers were distributed to over 32,000 commuters and pedestrians reached during the duration of the project. Specific approaches were adopted to reach various sub-groups of commuters encountered eg couples. solo male or female drivers, group commuters etc.

CONCLUSION: Commuters in an urban city such as Lagos spend between 3-4 hours daily travelling to and from work and as such have limited time to benefit from organised HIV/AIDS prevention programs. The experience from this pilot project demonstrated that it is possible to effectively reach such a group and to enlist their participation. The lessons learnt include the need to: adapt activities to reflect the time. mood and disposition of commuters. seek policy and legal endorsement: fashion intervention to take after already existing and accepted programs. The traffic jam project has provided key lessons. and the need to expand the project to other sites and to involve itinerant hawkers along Lagos highways is pertinent.

Topic No. 1 Select one from Key List

BEST AVAILABLE COPY

214

Complete as indicated on this insert

Deadline: 1 February 1995

ALTERNATIVE COMMUNICATION: A PREVENTIVE STRATEGY

Velandia Mora, Manuel Antonio. Fundación APOYEMONOS, Santafé de Bogotá, Colombia.

Objectives: To motivate reflection in the general public about attitudes, behaviors and practices concerning condom use, through alternative communication.

Methodology: Work with a group of actors, training them on AIDS prevention issues and developing short performances conveying AIDS prevention messages and seeking to foster specific behavior changes among the audience. Performances were to be highly participatory, motivating spectators to get involved in the creation and delivery of messages about AIDS prevention, attitudes and behaviors that must be changed in order to prevent infection. A set of four performances were prepared in order to be presented in public places. After each show, and taking into account people's comments, changes were introduced in order to reach the public in a more effective way. These performances included brief lectures, questions and answer period and condom use demonstrations after the show.

Results: People among participating audience, under the leadership of the trained actors, rediscovered capacities they did not recognize within themselves. The shows were able to reach many different groups in Bogota, as they were presented all around town, in communities of different social and economic backgrounds. At the end of each show, condoms were distributed to the audience after demonstrating its correct use. Since Dec 1992, 500 shows have been presented in shopping centers, streets, bars and parks. After each show, lectures concerning AIDS and STD have also been included. Based on the needs of specific communities, a condom performance had to be created, adding an extra explanation about its usage.

Conclusions: Impact generated through alternative communication techniques need little or none underlying structure. Performances require a minimum acting staff and are programmed in an impromptu fashion. Activities always motivated dialogue and individual reflection among the audience. Due to these techniques, people felt encouraged to reviewed their life styles, their attitudes, behaviors and practices. Many people in the audience approached the leading staff (actors or NGO's staff) after the show, to request more specific and in depth information. As communities in Bogota begun to hear about these performances, they spontaneously requested APOYEMONOS to perform in their neighborhoods and offered to participate as actors in performances. This response became a useful tool to facilitate spaces where these performances could be shown.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 7 19 46 ____ ____ ____

215

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Title: DEVELOPING A CENTER OF EXCELLENCE IN HIV/AIDS TRAINING

Burian, Chalintorn.*; Taqueban, C.**. *AIDSCAP/FHI, Bangkok, Thailand, **Asia-Pacific Development Communication Center (ADCC) of Dhurakijpundit University, Thailand.

Objective: To increase and sustain an Asia regional capacity for communication and training activities in HIV/AIDS prevention through the establishment of a Center of Excellence in HIV/AIDS Training.

Methodology:. ADCC is an international training center chosen as a potential Center of Excellence to work side-by-side with AIDSCAP communications and training experts to develop and deliver a series of courses in behavior change communication and training skills for HIV/AIDS professionals from throughout the region. Contact with the course graduates was maintained by the ADCC and AIDSCAP staff to sustain a network of skilled trainers.

Results: During the two-year project, two competency-based training curricula in Communication Strategies and Techniques for Sexual Behavior Change, and Training of Trainers for HIV/AIDS Communication Prevention Programs were developed; 50 participants from 9 countries were trained; all trainees implemented what they learned back on the job; and more than 60% of trainees served as active members of a Network of HIV/AIDS Trainers. In addition, these two courses were incorporated into ADCC standard course curricula, thereby sustaining them as a regional AIDS training center. AIDS communication officers and trainers developed a sense of ownership of the initiative which increased the prospects for the sustainability of the Center.

Conclusions: One of the most effective ways to build individual and institutional capacity is through the establishment of comprehensive training programs which will train key people to become effective trainers and communicators. Training "master trainers" builds human resource capacity, especially when a multiplier effect is utilized. For institutional capacity building, selection of a collaborative agency and establishing a working relationship that will enhance the sustainability of a Center of Excellence is an appropriate strategy.

Topic No 1 Select one from Key List

Key Word Nos (Select up to 4) 66 10 82 144

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Rapid Response Funds: Supporting Community-based Initiatives in HIV Prevention

Githens, Wendy*; Bashore, K.*; Goodridge, G.*.*AIDSCAP/FHI, Arlington, VA.

Objectives:
To assess the use and resultant impact of a community-focused, micro-grants program on HIV prevention programming at community level. To recommend how such programs can be further strengthened.

Methods:
A content analysis and assessment of AIDSCAP's Rapid Response Fund (RRF) was conducted to examine the range, types, and outcomes of community-based activities funded through the mechanism. The RRF was designed 1) to provide opportunities for indigenous non-governmental (NGOs) and community based groups (CBGs) to demonstrate their capability in the implementation of HIV/AIDS small projects; and 2) to facilitate networking among NGOs and CBGs. Through locally administered funding mechanisms, small grants of up to $5,000 are awarded for short term (generally up to 6 months) HIV/AIDS behavior change education, information or other HIV/STD prevention intervention activities. RRF was expressly designed to facilitate application for funding by community based groups which have little or no experience in obtaining grants.

Results:
From November 1993 to November 1994, RRF supported 102 activities. A total of $US 264,265 financed a wide variety of projects such as dramatic productions, HIV perception studies, public awareness campaigns. The analysis of these projects found that (1) the RRF has been extremely successful in getting funds to small community-based groups; (2) communities have demonstrated tremendous creativity in the use of these funds resulting in a much wider range of activities than originally conceived of by program designers, and (3) the impact of these activities also extends beyond the initial assumptions made by RRF designers. For example, in Kenya, $5,000 funded the Rotaract Club's presentation of the play "All Positive" in X colleges, universities and training institutions. Over 16,000 Kenyan students were reached through the play and 22,000 condoms and HIV/AIDS prevention pamphlets distributed. In India, $4,200 funded a team of researchers to conduct a rapid assessment of public perception of HIV/AIDS media messages which provided baseline data about adolescents awareness and a foundation for India's behavior change strategy. In Jamaica, $2,805 funded a candlelight service where political and business leaders -- some, including the country's President, for the first time publicly -- pledged support of HIV/AIDS prevention efforts. Based on the results of the first year of activities, AIDSCAP has decided both to continue and to further decentralize the management of this important initiative.

Conclusions:
The successes of these 102 short term activities demonstrate that small funds can effectively be used by NGOs and CBGs to help them contribute to HIV/AIDS prevention programming. In several cases, the experience of designing, implementing, evaluating and reporting the RRF activities, has given NGOs the confidence to design larger, longer term projects. RRF activities have provided model projects which are being replicated on a larger scale.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 2 6 7 10 49 133

217

Original Abstract

Enhancing NGO Capacities in HIV/AIDS Materials Development: Experiences from Nepal's NGO IE&C Coordination Committee

Pyakuryal, N.; Frey, M.

Complete as indicated on this insert

Deadline: 1 February 1995

Objectives: 1) To form a sustainable Committee with representation from major Nepali NGOs involved in the development of HIV/STD educational materials; 2) to facilitate the provision of technical feedback through a process of peer review; 3) to create a forum in which NGOs can coordinate materials production in order to minimize duplication of effort;

METHODS: In November, 1993, Save the Children US (SC/US) spearheaded the formation of an NGO IE&C Coordination Committee consisting of members from 8 NGOs and a Ministry of Health representative. An annual materials production plan is prepared collectively. Draft materials are submitted along with a cover sheet describing the material, the intended target audience, and pretest methods and findings. Committee meetings are held monthly on a rotating basis at different members' offices where feedback is provided to NGOs. Once finalized, a photocopy of the material is mailed to a wide range of potential purchasers together with an order form so as to approximate demand for the material.

RESULTS: In the past 15 months, the Committee has reviewed and given feedback on 60 different educational materials, added an additional 6 member organizations, developed operational bi-laws, agreed on a comprehensive set of culturally appropriate HIV/STD prevention messages, and completed two annual material production plans. While NGOs initially objected to delays introduced by the review and revision process, this resistance has evolved into an enhanced appreciation for the time and steps required for the production of quality materials. The peer review process has evolved in a manner which is constructive and supportive and has resulted in the dissemination of more accurate, and consistent HIV prevention messages. In addition, there has been a significant reduction in the use of fear-inducing, and negative messages. Plans are currently being developed to phase over the coordination role of SC/US to other members in the interest of long term sustainability.

CONCLUSIONS: The Committee has proven to be an excellent forum for the efficient provision of technical assistance and the overall strengthening of the materials development and distribution process in Nepal. As a result of Committee activities, NGO skills in market segmentation, materials design, and pretesting have increased markedly. As an effective vehicle for cross-fertilization, transfer of technical skills, coordination, and sound resource allocation, this model merits consideration in other country settings.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 10 128 133 136 _____ _____

Original Abstract

Maintaining enthusiasm to sustain HIV Peer Education in Zimbabwe: Experiences to be shared.

Complete as indicated on this insert

Sibanda, T.*; Wilson, D.**; *Obstetrics and Gynaecology Department, University of Zimbabwe, ** Psychology Department, University of Zimbabwe, Harare, Zimbabwe.

Deadline: 1 February 1995

Objectives: The objectives of the study were to identify: 1) factors that are pertinent to maintaining enthusiasm in HIV peer education; 2) What factors are most important in sustaining enthusiasm.

Methods: Over a period of two years peer educators and project coordinators participated in a qualitative study to determine what factors were crucial in maintaining enthusiasm in order to sustain peer education projects. Qualitative data were obtained from group discussions, informal conversations and informal individual inter views and key informant interviews. Information was also obtained through the projects manager's participant observation. The data were then thematically analysed.

Results: Results showed that while there may be many factors involved in maintaining enthusiasm factors that were identified, fell into five categories or themes. These themes were psychological, social, management, health and material. The psychological category covered factors such as raising self esteem, instilling confidence and showing respect to peer educators. The social theme covered issues such as positive engagement in support of PWS, peer educators mingling with authority figures in social gatherings, unconditional acceptance of the groups and response to their repeated requests. The Management theme covered factors such as devolving responsibility among peer educators, delegating, encouraging leadership roles, flexibility and peer educator self-discipline. The Health theme included factors such as free treatment, bereavement assistance and sick leave and home visits during illness. The material theme covered factors such as revolving funds, T shirts, bags, for carrying condoms and books, refreshments and to a less extent income generating activities. The factors that were most important in maintaining enthusiasm were psychological. But the psychological factors tended to be most important during project inception. Thereafter, a mixture of factors became more crucial than before.

Conclusions: Sharing of these findings may bring to light that most successful community wide projects on HIV prevention are not spontaneous but a product of interaction of often over looked factors. Such factors need to be carefully identified so that they are exploited to strengthen peer education projects.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 6 68 172 146 19 113

Original Abstract

Evolving Training Needs of Community-Based Health Agents in a Long Term Commercial Sex Workers AIDS Prevention Project.

Complete as indicated on this insert

Szterenfeld,Celia*; Peterson,C.*;Alves,A.B.*.
*Health in Prostitution Project/ISER, Rio de Janeiro, Brazil.

Deadline: 1 February 1995

Objectives: To report on the development of a training program for community-based health agents in STD/AIDS prevention among sex workers over a five-year span.

Methods: Training needs assessments were conducted yearly. Training Programs were established in consultancy with the group, covering a wide range of topics from preventive health issues to peoples's advocacy to art and culture interventions. Training included informative lectures, group discussions, audio-visual presentations, role playing and sharing of personal experiences.

Results: Low drop-out rate among health agents and high adherence of volunteer sex workers in training courses indicate acceptance of both the contents and methodologies employed. Health agents and volunteers grew increasingly committed as their identity in the new role was strenghtened. Interest in other issues related to citizenship was heightened as self-esteem was raised. Preliminary conclusions indicate a low burnout rate among health agents.

Conclusions: Group's participation in establishing and evaluating training courses was crucial to the program's success. Diversity of methods used and topics covered helped to touch and affect all members. Experience shows that the public's demand over a long term health agent - often the community's only resource - requires from her/him prompt action, not always related to AIDS prevention in the strict sense but indirectly, related to the capacity of improving one's quality of life. Training programs should contemplate these evolving needs.

Topic No. 47 I Select one from Key List

Key Word Nos. (Select four to six) 24 47 49 19 ___ ___

220

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Local NGO Perceptions of HIV/AIDS Needs and Priorities

O'Malley, J W and Trillyas, I. International HIV/AIDS Alliance, London, United Kingdom

Objectives: In 1994, the International HIV/AIDS Alliance consulted with local NGOs in nine developing countries, to identify their perception of needs and priorities in HIV/AIDS prevention, care and community support. Unlike traditional, and more formal, needs assessments, the Alliance was initially interested in the perceptions and analysis of local NGO leaders, as opposed to an analysis of international staff or consultants.

Methods: The countries ranged from low to high HIV sero-prevalence, and from strong to weak in terms of the organised NGO response to the epidemic: Bangladesh, Burkina Faso, Ecuador, Morocco, Pakistan, Tanzania, Senegal, Sri Lanka, and the Philippines. Two Associate Consultants, usually one from the region and another from a different part of the world, facilitated the needs-identification process through in-depth interviews with at least 15 representatives of CBO/NGOs. In addition to individual interviews, workshops were conducted with large numbers of NGOs in some countries.

Results: Despite the many differences, a number of priorities were identified across countries: attention and technical support for the promotion of symptom-recognition and treatment-seeking for STDs; support to self-organising and self-help for people with HIV; support to community and neighbourhood level groups and interventions; linkages of action research to programme development; and availability of subsidised condoms to small NGOs, and not just government and large social marketing agencies.

Consulted NGOs in most of the countries also cited the need for more action on the "contextual" factors which increase vulnerability to HIV, such as gender inequality, but this was frequently cited as an area which would require significant technical co-operation with others, as NGOs found it difficult to identify appropriate programme development or intervention strategies. Finally, NGOs across all countries cited a critical need for technical support for project design, management and evaluation.

The most striking difference between countries was the uneven development of the "AIDS specialist" sector, and, consequently, services to marginal populations. Certain countries, especially with a legacy of external support from AIDSCOM and/or AIDSTECH, had better developed specialist service organisations, but relatively few broad based health or development NGOs had added an HIV/AIDS component to their programmes. These countries included the Philippines, Ecuador, Senegal, and Morocco. A priority in these countries was reaching larger numbers of people outside city centres, particularly the poor. In Sri Lanka, Burkina Faso, and Bangladesh, health or development NGOs had taken the lead in the response to AIDS, and they identified a need for both more specialist prevention and care services, and particularly, more effective work with marginal populations.

Conclusions: The findings from these initial needs assessments will be used as a starting point for programme planning for locally-based and governed grant-making organizations. With financial and technical support from the International HIV/AIDS Alliance in strategic planning, management and aspects of HIV/AIDS/STDs, these 'linking organizations' will catalyse and support community based interventions to address locally articulated needs.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 133 49 6 7

Original Abstract

Knowledge of AIDS in India.

Lahiri, S.*, Deborah Balk**, and K.B. Pathak* *International Institute for Population Sciences, Bombay, India; **East-West Center, Honolulu, HI USA,

Objectives: This papers presents data on awareness of AIDS, knowledge about how AIDS is transmitted, and knowledge on how to prevent AIDS; and conducts an analysis on socio-economic and demographic determinants of this knowledge. Further, the relationship between knowledge of family planning methods and AIDS will be explored. Data come from India's National Family Health Survey (NFHS), which was conducted in 1992-93. The survey questions on AIDS were asked only in those states where AIDS is currently perceived to be an emerging problem. These states are: Delhi in the north; Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Tripura in the northeast; West Bengal in the east, Tamil Nadu in the south; and Goa, Gujarat, and Maharastra in the west. This permits an investigation into AIDS awareness in Indian's biggest cities (Bombay, Calcutta, Delhi, and Madras) and into special regions of interest.

Methods: This study is based on the NFHS, the first national representatively-sampled demographic survey in India. About 32,000 women (and households) were interviewed in the above mentioned states, from urban and rural areas. Standard bivariate and multivariate statistical techniques will be used in analyzing the data.

Results: Preliminary results show that there are large discrepancies across states in the percentage who have heard about AIDS. For example, fewer than 10 percent of the women surveyed in Assam and West Bengal had heard of an illness called AIDS, whereas, 72.5 percent of women in Manipur and 84.8 percent of women in Mizoram had heard about AIDS. About 35 percent had heard about AIDS in Delhi; this number is considered quite low given the considerable media attention which has focused on AIDS in this capital district. Preliminary results from Maharastra, a state where only 19 percent of women had heard of AIDS, show that the television was overwhelmingly the primary source of this information, whereas only 7 percent of women stated that they heard about AIDS from a friend or relative. Of these women, about 57 percent knew that AIDS could be avoided by practicing "safe" sex; however, fewer women stated explicitly that using a condom during intercourse could prevent AIDS. As to be expected, more educated women were more likely than less educated women to know many of the ways in which AIDS can be prevented. However, urban residents did not consistently identify more ways to prevent AIDS that rural residents. These relationships will be examined across many regions and in-depth in the paper.

Conclusions: The findings from this study will be used to inform public health policy in India, and to assist the Indian government and USAID and other donor agencies in developing a strategy for AIDS prevention. This study should reveal the extent to which AIDS prevention activities are compatible with family planning activities.

Topic No. 3

Key Word Nos. 101 20 75 66 139

Original Abstract

Sexual Behavior and Condom Use by Sex Workers in Nepal.

Dr. Karki, Benu B.*; Dr. Subedi, B.K.*; Dr. Guerma, T*. *NCASC, Kathmandu, Nepal.

Complete as indicated on this insert

Deadline: 1 February 1995

Objective: To study the sexual behavior and condom use of sex workers in Nepal. Commercial sex workers (CSWs) exist in Nepal in different forms: traditional, cultural and commercial. However, there are no "red light" areas, and it is often quite difficult to learn about the CSWs and their behavior.

Methodology: This study was carried out in four areas across Nepal. Traditional, or cultural sex work is found in two of the areas, while sex work is relatively "hidden" in the other two study areas. A total of 289 CSWs were interviewed: 281 women and 8 men.

One of the general study areas included Kailali and Doti where the traditional CSWs (Badi) and the cultural CSWs (Deuki) are well known. A second area, Butwal, is at the cross-roads of two highways. The third area, Kaski, is a tourism center near the capital city Kathmandu, with a relatively high number of HIV cases. The fourth study area, Sunsari and Jhapa in Eastern Nepal, also has a relatively high prevalence of STDs and HIV. Local NGOs were utilized in all of the above locations to approach and interview the sex workers. Where necessary, sex workers helped interview other sex workers.

Results: It was found that while 26 was the average age women began to work as CSWs, some started as early as age 13. The majority of the sex workers interviewed, 43.2%, were married; 38.1% were unmarried; 14.5% divorced; and 4.2% widowed. Nearly 67% of the sex workers, particularly the married ones, engaged in this business for economic survival. Another 21.4% reported that they engaged in sex work for pleasure. The youngest reported age of first sexual act was 12 (not necessarily for money). Nearly 25% of the CSWs entertained more than 20 clients a month; 22% entertained 3 to 5; and 18% entertained 6 to 19 clients a month. Only 10.4% reported that their clients always used condoms; 11.1% said their clients used condoms most of the time; 25.6% said they sometimes used condoms; and 40.5% said their clients never used condoms. Among the CSWs themselves, nearly 25% did not know anything about condoms. Out of 75% who knew about condoms, 48.2% provided condoms to their clients. Otherwise, 31.4% of the clients brought the condoms themselves. Nearly 52% of CSWs reported that they had suffered from an STD during the last year. Only 64% had taken some precaution (ranging from condom use to taking a bath after sex) and 55% had taken treatment for their STD.

Conclusion: Economic hardship is the main reason people engage in commercial sex work in Nepal. As a result, women as early as age 13 and married women who have children and live with their husbands are among those who become commercial sex workers. The literacy level is quite low and there is a high stigma attached to prostitution. Therefore, it often remains in a hidden form which makes it difficult, if not impossible in many instances, to provide health education and support for these women. The national HIV and AIDS prevention program has given much importance to a targeted intervention aimed at these women, particularly the very young women. It is hoped that this intervention will be helpful in continuing the presently low prevalence of HIV in the country.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 20 47 52 128

Original Abstract

Sexual Behavior and Behavior Change Among Men Who Have Sex With Men in Brazil, 1989-1994

Mota, Murilo*; Parker, R..*; Lorenço, L.*; Almeida, V.*; Pimenta, C.*; Fernandes, M.E.L**. *ABIA, IMS/UERJ; **AIDSCAP/Brazil.

Complete as indicated on this insert

Deadline: 1 February 1995

Objective: To assess levels of risk behavior and behavioral change in response to HIV/AIDS from 1989 to 1994 among men who have sex with men in Rio de Janeiro.

Methods: In an initial cross-sectional study carried out in 1989/90, 503 structured interviews were conducted with subjects recruited through friendship networks and targeted outreach activities. In 1993/94, drawing on the same sample design and recruitment strategies, a second cross-sectional study was carried out, and 300 structured interviews were conducted using a comparable question schedule. In addition, between 1989 and 1994, 150 semi-structured, life-history interviews were conducted, and ethnographic observation was carried out at intervals throughout the period of the study.

Results: High levels of knowledge and information, as well as an accurate perception of HIV risk, were found throughout the period of study. In 1989/90, although 40% of the sample reported having made significant behavioral changes, high risk behavior continued to be widespread, and 54% reported unprotected anal intercourse. By 1993/94, however, 63% of the sample reported having made significant behavioral changes, and unprotected anal intercourse had dropped to 25%. In 1989/90, adoption of safer sexual practices was most evident on the part of more educated men with higher socio-economic class standing. By 1993/94, both education and social class had ceased to show any significant correlation with risk reduction, with roughly equivalent levels of condom use characterizing all levels of education and class. While education and class had ceased to serve as an important indicator of behavior change, both sexual identity and gay community mobilization and community attachment had emerged as key factors associated with adoption of safer sex.

Conclusions: Over the course of a five year period, important behavioral changes have been documented, suggesting that even in the context of developing countries adequate support for HIV/AIDS prevention programs can result in a significant reduction of behavioral risk. Findings suggest that risk reduction is closely linked to the development of social support structures and community mobilization.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 99 19 20 59 74 24

Community HIV/AIDS Pilot Project (CHAMPS) Phase 1

Lesley du Toit [1], Jacquelyne Conley [2], Pamela Onyango [3], Sibongile Manyathi [4]

1. Executive Director, NACCW; 2 AIDSCAP/South Africa; 3 AIDSCAP/AFRO; 4 Program Manager, NACCW

OBJECTIVE: To maintain HIV/AIDS prevalence focusing on women who are heads of households in Kwazulu/Natal region, through the promotion of attitude and behavior change among 100 HIV+ women.

APPROACH: The design of Phase 1 of this project was based on the CHAMPS project carried out by the Children's Hospital, Washington, in collaboration with CWLA. The National Association of Child Care Workers (NACCW), a nongovernmental social service agency working with families and children, was identified as the implementing agency, in conjunction with two government referral hospitals.

The approach replicated during this phase was case management, with the aim of preventing further sexual or perinatal transmission of HIV/AIDS as well as supporting HIV/AIDS infected families. When a mother or child were identified as seropositive, a Health Worker from one of the referral hospitals discussed the possibility for enrolling her for prevention, education and support services. Upon acceptance, the project Field Worker was assigned to the client and provided education and support services to the client and the family twice a month at home or any other venue chosen by the client (in most instances it was the referral hospital clinic).

LESSONS LEARNED: To be truly effective and culturally relevant, the project will need to move from a case management approach to a group/community education and development model. The case management approach tends to emphasize a one-on-one approach which is not always culturally relevant and tends to isolate the client from the very people we hope to give support to i.e., the family and community. This approach also tends to encourage dependency and thus disempowers the client.

The project's emphasis on the use of condoms in isolation to care and management, as well as the targeting of women only, is neither realistic nor effective. Socio-economic disadvantage coupled with traditional culture, simply do not allow women to easily negotiate condom use with their partners.

Field workers have limited education and training; the latter focusses only on counselling. They have been faced with challenges associated with community work/social work and have felt ill-equipped to respond. This has led to feelings of despondency and inadequacy. Clients, whose needs go well beyond HIV/AIDS, desperately want to be treated more holistically. The case management approach has in a sense "trapped" both clients and workers.

The geographic restrictions built into the project leads to ineffective services. Some clients are in the metropolitan areas (to seek employment) when diagnosed and thus receive counselling from Project CHAMPS. When they become symptomatic they often return to their rural communities, losing all support from the field worker who because of the case management model has built a close relationship. This is also linked to the emphasis on prevention where no provision is made for the terminally ill client. Transport is a serious problem to the field workers, restricting their travel to their local communities. The referral hospital and the field workers often struggle with this "picking and choosing" of clients and it inevitably leads to loss of credibility for the project.

CONCLUSION: The focus of the project has been women (and their children) as the referrals are usually women. The project should diversify and become family oriented, where the client referrals could be a woman, man or child. Family strengthening and support would be in the communities best interest and would serve to meet a range of goals rather than just HIV/AIDS in isolation. An integrated approach, teaching life skills, parenting and social skills could enable youth and adults to avoid prostitution, sexual abuse and abandonment.

225

Original Abstract

Sexual Decisionmaking and AIDS-Risk Among Young Unmarried Working Women in Mauritius

Complete as indicated on this insert

Schensul, J.J.*; S.L. Schensul**; G. Oodit***; *Institute for Community Research, Hartford, CT. U.S.A. **University of Connecticut School of Medicine, Farmington, CT. USA; ***Mauritius Family Planning Association

Deadline: 1 February 1995

Objectives: The objectives of this two year research and intervention effort were to: 1. identify changes in family, work and peer settings in Mauritius as a result of rapid industrialization, leading to increased opportunities for sexual behaviors; 2. identify the range of sexual behaviors of young women and their male partners and the settings and situations in which these behaviors occurred; 3. collect indepth interview and survey data on the relationship between sexual behaviors including risky sex, knowledge of AIDS, and perceptions of AIDs risk; .and 4. to incorporate these data into a pilot intervention.

Methods: Methods of study included observation in work, peer and community settings, indepth semistructured interviews with 90 unmarried young women in the industrial sector and 30 unmarried males; a survey constructed from data collected through indepth interviews, and administered to 500 young women (200 Hindus, 200 Creoles and 100 Muslims) to explore through quantitative data analysis factors associated with entry into sexual activity, reasons for engaging in risky sex, the relationship between knowledge of sex risk and risky behavior; and the conduct of a pilot intervention in two culturally, economically and contextually differentiated factory settings through which information was collected in intervention techniques and gaps in information about sex, sex risk, AIDS, and reproductive health.

Results: Quantitative data confirm qualitative results showing four trajectories with regard to sexual behavior: a) women who are not yet sexually active and do not have partners(31% of total sample); b) women who are presently or are becoming sexually active and enjoy it; c) women who are presently or are becoming sexually active and do not enjoy it; and d) women whose "hearts have been broken" by men who have "stolen their virginity" and left them. None of the women in groups b - d use condoms. While virginity remains important for young women in Mauritius, opportunities for sexual engagement have resulted in risky unprotected penetrative sex activities which are believed to protect against loss of virginity but do not protect against pregnancy, STDs or HIV infection. The more women are sexually involved, the more likely they are to view themselves as at risk of pregnancy. But few women see themselves at risk for STDs and fewer still for AIDS.

Conclusions: 70% of women in our sample are currently or potentially engaging in risky sexual activity without condoms, and without accurate perception of their own risk of pregnancy, or infection. Women know little about their own bodies, or reproductive health, are not empowered to insist on condoms and many are being pressured into penetrative sex without condoms with negative consequences for their reputation and sense of self esteem. The value placed on virginity precludes discussions around sexual concerns with partners, friends and family members. These results while generally valid, vary somewhat by ethnicity, family status and income, education level of the respondent and size and diversity of peer network. Interventions must address reproductive health issues for women in an environment of trust and confidence, include anatomy, women's sexual rights and realities,and condom knowledge, involve examination of those sexual behaviors listed on the Guttman scale for potential risk and offer opportunities for young women to discuss their questions about sexuality in private.

Topic No. 1/3 Select one from Key List

Key Word Nos. (Select four to six) 2 80 103 121 17 19

Original Abstract

Monitoring of Condom Use by Female Sex Workers in Rio de Janeiro and Implications for Participatory Education in AIDS Prevention.

Complete as indicated on this insert

Deadline: 1 February 1995

Peterson, Christopher; Szterenfeld, C.*; Alves, A.B.
*Health in Prostitution Project/ISER, Rio de Janeiro.

Objectives: To identify frequencies and factors associated with condom use by female sex workers with paying and nonpaying partners, with an aim towards planning and evaluation of educational intervention activities.

Methodology: The Health in Prostitution Project is based on the recruitment, training, and empowerment of sex workers as community-based health agents in STD/AIDS prevention and primary health education. Since 1991, the Project has trained over 50 female and transvestite male prostitutes in peer education and condom distribution in 20 different commercial sex areas in Greater Rio. This paper reports on ongoing research aimed at factors associated with condom use by female sex workers with paying and nonpaying sexual contacts. Two cross-sectional surveys were conducted with female prostitutes (1991, n=125; 1993, n=92) in 5 commercial sex areas in Greater Rio, using a short interview conducted during the FCSWs working hours by a health professional in collaboration with community-based health agents. Dependent variable was defined as inconsistent condom use with paying sexual contacts (and alternatively, as lack of possession of condom at time of interview).

Results: The study showed an increase in consistent condom use with clients, from 56.8% in 1991 to 73.4% in 1993, while consistent condom use with steady partners remained low (11.9% in 1991; 11.1% in 1993). Inconsistent use with clients and lack of possession of condom at time of interview were associated with incorrect response concerning vaginal transmission of HIV (OR=3,47 in 1991; OR=12,20 in 1993) and other factors. "Trust" was the reason most frequently cited by interviewees for not using condoms with clients.

Conclusions: Results suggest that female commercial sex workers in Rio as a whole have been receptive to safer sex messages, but: a) that a sub-group continues to practice unprotected sex with clients; b) that condom use with steady partners is exceptional; and c) that "trust" in sexual relations must be reinterpreted to facilitate protection of one's health and that of partners. Results of the third cross-sectional (1995) and qualitative survey will also be presented.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 24 27 47 19 53 ___

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

AIDS Prevention in a Society in Crisis:
The case of Rwanda refugees in Tanzania.

Benjamin, Judy*; Widmeyer, Greg**; De Buysscher, Rose***; Makinwa, Bunmi***; Wondergem, Peter**** ; Vogel C; Brady B.

*CARE International, Atlanta, GA; **PSI,Washington,DC;***AIDSCAP/ Nairobi, Kenya; ****JSI,Washington,DC.

Objective: To reduce the transmission of HIV and STDs among Rwandan refugees in NW Tanzania camps. Moreover, to provide free condoms to sexually active refugees.

Methods: A collaborative intervention program was implemented using the following methods: a) AIDS community educators (ACEs) disseminating HIV/STD prevention information and educational material directly in the community sectors; b) free condoms were widely distributed through the refugee camps by traditional and non-traditional outlets; c) treatment and counselling for STDs was made available to the population; d) mass education campaigns were initiated which included special events designed to reach target sectors of the refugee population; e) focus group discussion sessions were held with different representative categories of refugees; and f) audio visual technology was introduced in the form of culturally specific educational videos produced in Kinyarwanda language to promote knowledge and behavior change

Results: Preliminary results suggest that AIDS/STD awareness levels among the target population of 170,000 have risen since program inception; an effective network of condom distribution is in place making condoms readily available throughout the camps; a trained staff of 120 community educators and 13 counsellors distribute approximately 157,000 condoms per month. An initial assessment and KABB survey were performed at program inception which provided baseline data. Results of the final program evaluation and KABB survey are being analyzed.

Conclusion: Refugee populations are at great risk for the transmission of HIV and STDs. High density habitation coupled with a lack of employment opportunities lead to boredom, and possibly an increase in sexual activity. These factors, added to the high HIV and STD prevalence found in Rwanda prior to the war, point to the critical need for rapid intervention. Women refugees are especially vulnerable. Many are without husbands and families, and are often culturally defined as subordinate to men. Many women are powerless to exert any choice in practicing safer sex and may be subjected to violence, coercive sex, and rape. They may also be forced to trade sex for economic survival. The lessons learned from this intervention among Rwanda refugees can be used to improve strategies and develop model intervention programs applicable to other refugee settings. Moreover results of this pilot intervention suggest the need to target women and youth along with the generally sexually active population in program design.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 19 73 80 147 149 113

MEN INVOLVED IN THE COMMERCIAL SEX INDUSTRY AND HIV/AIDS PREVENTION IN PUERTO PLATA, SOSUA AND MONTELLANO.

De Castro, Milanés; Gómez, B., Ferreiras, J.

Objectives: Design and implement an STD/HIV/AIDS prevention intervention targeting Men Involved in the Commercial Sex Industry (MICSI) as part of an overall strategy to reach CSW in Puerto Plata, Sosua and Montellano.

Methods: Information collected from CSW and bar/brothel staff show that 98% of CSW's sexual encounters occur with MICSI. In order to design an appropriate intervention for MICSI, data was collected in 78 bars/brothels in Puerto Plata, Sosua and Montellano. Meetings were held with bar/brothel owners and local authorities to understand problems/concerns related to the Commercial Sex Industry. Finally, focus group discussions (FGD) and interviews were held to create and validate educational materials to be used amongst the MICSI. In May/1994 AIDSCAP formalized support by financing a MICSI component within the existing CSW project. The project contemplates the following activities to reach this target audience: Bi-monthly STD/HIV/AIDS awareness training workshops and follow-up meetings for bar/brothel owners and staff; monthly theater presentations for clients and other MICSI; educational material designed for this target audience and condom distribution.

Results: Of the 78 Commercial Sex Industries visited 95% were integrated into the STD/HIV/AIDS prevention project. 90% of the bar/brothel owners attended basic STD/HIV/AIDS prevention workshops. The project has gained support from local authorities for conducting STD/HIV/AIDS prevention amongst MICSI. Bar/brothel owners have integrated into the project, as evidenced by their support for CSW monthly medical check-ups, STD/HIV/AIDS prevention educational activities and condom use promotion inside their establishment. The project has expanded to other MICSI, including bar/brothel staff and taxi drivers. 80% of the owners abide by the law which states that their establishment must provide condoms in their bars. Of the 78 bars/brothels associated to the project, 64% give a voluntary monthly fee, to COVICOSIDA to maintain the STD clinic.

Conclusion: To ensure project success, educational strategies must target both CSW and MICSI. Targeting MICSI plays a dual role in AIDS prevention: it educates a population at risk for contracting STD/HIV/AIDS and "opens doors" for reaching CSW at their worksites. A post-KAPB study will determine the impact of interventions with MICSI and its overall effect on AIDS prevention.

Topic No. 1
Key word Nos. 47, 52, 62, 66.

Complete as indicated on this insert

Deadline: 1 February 1995

Lessons Learned from HIV Risk Reduction Interventions in Rural Brothels in Northern Thailand.

Celentano David D*, Bond KC*, Phonsophakul S**, Chachawan S**, Leepreecha P**, Fongsri K**, Vaddhanaphuti C**. *Johns Hopkins University School of Hygiene and Public Health, Baltimore, MD; **Social Research Institute, Chiangmai University, Chiang Mai, Thailand.

Objectives: Objectives were to initiate and observe processes of HIV risk reduction in brothels and to understand benefits and obstacles to behavior change using three risk reduction models.

Methods: In collaboration with 24 brothel owners, 50 brothel workers, and local organizations, we developed three approaches for HIV risk reduction, including: 1) reproductive health and safer sex education; 2) vaginal lubricant distribution for use with condoms; and 3) handicraft production to supplement current and future incomes. Responses by female brothel workers and owners were documented using qualitative research methods, HIV rates and incident STD infections.

Results: Many women had limited reproductive health knowledge despite high awareness of HIV. Health concerns related to contraception and STD treatment were voiced. Condom use with clients increased and reports of vaginal irritation decreased when combined with water-based lubricants *not* containing nonoxynol-9. Barriers to sustained use included issues of access, cost and tube size. Income generation schemes provide both financial and interpersonal support for behavior change while continuing brothel-based sex work and which may be sustained after leaving the brothel. This is especially salient as the majority of these women were HIV infected but not yet symptomatic.

Conclusions: When combined, these models offer a wider range of strategies for risk reduction, diminishing HIV and STD transmission and improving social support. Reproductive health education is essential for all young women during the period of mandatory schooling. Most of these women were from the rural north, and received only a primary level of education. Lubricants should be distributed along with condoms in brothels, as they improve condom use. However, the fundamental concern of women in, and those leaving, brothels is securing sustainable income sources. Concerted efforts to develop home-based employment opportunities must be pursued, especially for those already infected with HIV. Commonly, as HIV disease symptoms become manifest, patients leave their place of employment and return to their home villages; income maintenance at this phase of life is especially life sustaining, especially for women with dependent children.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 158 150 52 113 19 10

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Togolese Transporters against AIDS: Impact of an education intervention (April 1992 to September 1994).

Chevallier Marcelle.*; Akolatsé A.*; Mensah K.*; Mathé S.*; *CARE International, Lomé, TOGO.

Objectives: To pilot test a peer education program aimed at taxi and truck drivers in Togo, who represent a group known to engage in high risk behavior and who have been a principal vector for the spread of HIV/AIDS. The projectaimed at increasing knowledge levels and inducing behavior change among this population.

Methods: A baseline knowledge-attitude-practice (KAP) survey of taxis and truck drivers was conducted in the capital city of Lomé. The survey showed that 98% knew that HIV/AIDS was contracted through sexual intercourse. However, 30% cited the use of condoms as a preventive measure and only 46% had ever used a condom; only 21% knew how to use them correctly. During the two year pilot project, 75 peer educators were trained and carried out 3300 small group education sessions. This was accompanied by a wide variety of awareness raising activities (e.g, distribution of t-shirts, stickers, posters, flyers etc...). The educational efforts were complemented by making low cost condoms readily available.

Results: Condom sales by the project increased from 35,000 the first year to 140,000 the second year. An end of project survey is being conducted to determine the extent of changes in knowledge and behavior among taxi and truck drivers. The results of the survey and changes from the baseline findings will be presented at the conference.

Conclusions: Based on anecdotal evidence of impact, the project has been extended to cover the whole of Togo. The end-of-project KAP survey will provide quantitative data on the magnitude of the project's impact, as well as information that will help refine the approaches used in the expanded phase of the project. Furthermore, the results will be used in implementing the national AIDS prevention strategy.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 19 52 66 72 ____ ____

Comparison of STD Prevalence and the Behavioral Correlates of STD among Registered and Unregistered Female Sex Workers in Manila and Cebu City, Philippines

Abellanosa IP[1], Manalastas R[2], Ghee AE[3], Whittington WL[3], Wi TE[4], Shoultz DA[3], Tan M[5], Mugrditchian DS[4], Perine PL[3], Holmes KK[3].
[1] STD/AIDS Cebu AIDS Center, Cebu City Health Department; [2] Department of OB/GYN, Philippines General Hospital; [3] CASITA program, University of Washington, Seattle, WA; [4]AIDSCAP/Family Health International; [5] Health Action Information Network, Quezon City.

Objectives: Current STD/HIV control efforts are largely confined to female sex workers (FSWs) registered with the local Social Hygiene Clinics. This study was conducted to compare the prevalence of gonococcal and chlamydial infections and their behavioral correlates between registered and unregistered FSWs in two major urban centers.

Methods: FSWs in Manila and Cebu City consented to undergo a STD physical examination and a standardized interview to measure socioeconomic markers and STD-related practices. The questionnaire was pretested in a series of four focus groups in Manila and subsequently administered in Tagalog and Cebuano by trained interviewers. Infection with *N. gonorrhoeae* was determined by culture and infection with *C. trachomatis* was defined by antigen detection.

Results: From July through September 1994, similar numbers of women were recruited in Manila (n=311) and Cebu City (n=300). However, thanks to the abilities of an interviewer who was previously a FSW, Cebu City was more successful at recruiting unregistered FSWs (50%) than was Manila (18%). The gonorrhea prevalence was 5 times greater among unregistered FSWs (70/185 or 37.8%) than among registered FSWs (29/403 or 7.2%)($p<0.05$). Prevalence of chlamydial infection was 2 times greater among unregistered FSWs (30.5%) than among registered FSWs (14.6%)($p<0.05$). Unregistered FSWs reported fewer years working as a FSW, more partners in the prior week and less current use of contraceptives, and were more likely to have never used condoms with regular clients than registered FSWs ($p<0.05$). Rates of antibiotic use in the last week and of douching in the last 24 hours were similar between the two groups.

Conclusions: This study shows that unregistered FSWs are at a higher risk for acquiring and transmitting STDs including HIV infection than registered FSWs. There is an urgent need to implement interventions to reach this vulnerable group of women.

Complete as indicated on this insert

Deadline: 1 February 1995

Title: Behavioral Effects of HIV Outreach Communication and Peer Education to Male Laborers in Factories in Bangkok, Thailand

Wongsawat, S.*; Pramanpol, S.*; Ramasutra, P.*.*ASEAN Institute for Health and Development, Mahidol University, Bangkok, Thailand.

Objectives: To evaluate the behavioral effects of an HIV outreach and peer education program to male laborers in large factories in Bangkok, Thailand.

Methodology: Outreach workers (ORW) conducted HIV prevention education in small groups of laborers and then trained individuals within factories to serve as peer educators for continued and sustainable outreach. ORWs then returned periodically to support the peer educators in outreach. Evaluation methodology consisted of pre- and post-intervention surveys. Interviewer-administered surveys of 707 male laborers at a total of 30 factories were conducted at baseline and then of 450 laborers at the same factories 6 months after the intervention. Laborers were chosen by personnel managers for participation in both surveys in order to cause the least amount of disruption to factory operations.

Results: Slightly over one-third (38%) reported contact with outreach workers as a source for information regarding HIV at follow-up. Increase in consistent use of condoms (every time) with commercial sex workers (CSWs) approached significance (72% to 83% $p<.08$). Consistent condom use with non-regular and non-commercial sex partners was much lower and not significantly different between baseline and follow-up (33% and 42%). In the follow-up survey, condom use with CSWs did not differ between individuals who reported receiving information from outreach workers (84%) and those who did not (82%).

Conclusions: Results suggest that outreach and peer education can lead to increases in condom use with CSWs. However, behavioral changes with non-commercial sex partners may require specialized communication strategies which address characteristics of this relationship. The finding of no difference between individuals with or without outreach contact suggest that information had diffused to others in the factory.

Topic No. 1 Select one from Key List

Original Abstract

Lesotho Footballers Against AIDS: An Innovative Approach to AIDS Education

Complete as indicated on this insert

Anderson, J.S.** , Bhatt, P. *. *CARE International, Atlanta, Georgia, ** CARE in Lesotho, Lesotho, Southern Africa.

Deadline: 1 February 1995

Objectives: The objectives of this initiative are two-fold: 1) to raise awareness among soccer players and coaches about important health issues, most importantly the transmission and prevention of HIV/AIDS and other STDs; 2) by utilizing the 'hero' status of the soccer players, CARE hopes to reach the general fan community with HIV prevention messages. The players are an excellent target population because of their appeal as role models to Lesotho youth and because their own age group puts them at high risk of HIV infection.

Methods: Using a Peer Education model, CARE has trained players and coaches from the Division A teams in HIV/AIDS issues and sports health. These players and coaches will then go back to their teams and hold a series of 'sports clinics', educating their peers about these issues. Players are speaking out through the media with interviews and human interest articles. A campaign of *'Footballers Against AIDS'* has been started whereby players attend matches and distribute a comic developed for the programme and wear T-shrits and other clothing bearing the *'Footballers Against AIDS'* logo. In addition, HIV/AIDS exhibition matches are being held between favorite teams and players are using the venue to educate fans and distribute the comic.

Results: Thus far, CARE has held one Training of Trainers with 17 participants from 10 teams throughout Lesotho. Participant response was overwhelmingly enthusiastic and positive. Their commitment and interest in the initiative was strong and solid. Since the training, two international matches have been held where participants attended, wearing the T-shirt and distributing the comic. Response from the fans has been positive and regardless of the soccer match taking place, players have been discussing issues related to HIV/AIDS transmission and prevention with those attending the match.

Conclusions: Initial indicators show this initiative to be incredibly effective. The players themselves have realized the importance of HIV/AIDS education and have recognized the responsibility that they have to use their positions to educate the general community, as well as changing their own behavior so as to be truly good role models. CARE has been approached to work with other sports (netball, boxing, women's soccer). By utilizing the young athletes in Lesotho, CARE can conclude that an innovative and apparently effective approach to HIV/AIDS education has been identified.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 2 7 19 112 152

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Haiti Condom Social Marketing Program, "Rara" Celebration: Integrating cultur activities with condom promotion and sales

Grimard, Bertrovna*; Cato, M.*; Génécé, E.**. *PSI/Haiti; Port-au-Prince, Haiti; **AIDSCAP/Haiti, Port-au-Prince, Haiti.

Objectives: The objective of the activity was to see if behavioral change could be brougl about by integrating cultural activities with the promotion of condom education and sales. Success would be determined by the increased use of condoms (as evidenced by increasec sales) in a region where the population was reluctant to use condoms.

Methods: Project-brand condom samples (PANTE) and coupons were distributed in larg quantities during the "Rara" celebration (Ash Wednesday through Easter Sunday) in the region of Léogane. The Rara celebration is a high-risk (for HIV transmission) event whic involves street dancing after midnight by groups of people who parade through the town dancing, chanting and carrying "bobêche" (rustic gas lamps). Influential community leade were recruited to draw large crowds and the various Rara groups for the condom promotio activities.

Results: The activity proved successful in increasing awareness and condom use. The number of condoms sold in the Léogane region increased dramatically after Easter. Sales jumped from 5,760 in 1993 to 59,328 n 1994. The increase was due largely to the distribution of the "buy-one-get-one-free" coupons which promoted safety at an affordable price and encouraged first time users.

Conclusions: Behavioral change can be facilitated if condom promotion activities take advantage of cultural practices common to the community. The promotion of condoms at t Rara celebration produced positive results. Condom use, typically an uncomfortable topic, more easily introduced in an environment in which the target population feels comfortable and at ease. Condom promotion is further aided by the supportive collaboration of trusted local leaders. The Rara project paved the way for a similar activity in Artibonite (a region where most of the community leaders are voudou priests).

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 50 6 50 50 70 82

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

The Role of Traditional Medical Practitioners in Preventing the Spread of HIV in Senegal.

* Montaocean, Kaiya.; ** Gdousseau, E.; *** Niang Cheiki, I.; *Center for Natural and Traditional Medicines, DC, USA; ** Centre Experiemental de Medecine Traditionnelle de Fatick; *** Institute des Sciences de L'Environnnement,

Objective(s): The objectives are to determine: 1) how effectively traditional medical practitioner's can transmit AIDS education and prevention messages to vulnerable populations; 2) to investigate the informal network of traditional medical practitioners in Senegal where traditional medicines are illegal; and 3) to assess the benefit of formalizing and legalizing the traditional medical practitioner's role in primary health care to help prevent the spread of HIV/AIDS.

Methods: Interviews and focus groups were conducted with an equal number of male/female, urban/rural traditional medical practitioner's to obtain knowledge, attitude and practice (KAP) information with specific information on AIDS awareness. In-depth interviews and extensive focus group discussions covered all aspects of the current political and practical reality for traditional practitioners as well as the government health care system. Projection models were constructed estimating the number of traditional practitioners in Senegal which could be mobilized as part of an AIDS awareness and prevention campaign to work collaboratively with the existing biomedical health structure.

Results: Survey and focus group data indicate that the current medical practice of more than 90% of the Senegalese population does not conform to the legal and political constraints placed on traditional medicines. In fact, the majority of sexual education for the young people takes place inside closed networks of traditional practitioners and in the Muslim community sexual information for women is very restricted with the primary source being the traditional birth attendant. Although sexuality is not openly discussed, traditional practitioners indicated they could devise ways to incorporate safer, sexual practices into their work. They also indicated a willingness to alter ritual ceremonies, particularly circumcision and scarification, to help prevent the spread of AIDS. Projection models showed that by mobilizing traditional medical practitioners more than 50,000 trained health care workers could be advising clients about HIV prevention.

Conclusions: Senegalese traditional practitioners are in a very precarious position in the face of the AIDS epidemic. Currently, they are illegally treating the majority of the sick in Senegal and they have been left out of the arena of AIDS education and prevention. Unless traditional medical practitioners are incorporated into the HIV prevention strategy of Senegal while the prevalence is still low, the people face conditions similiar to other African countries in which HIV/AIDS has reached epidemic proportions where traditional medical practitioners are still outsiders. Findings will be used in development of prevention and education programs.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 1 4 6 7 9

Original Abstract

Integration of Traditional Women's Associations in HIV Prevention in Kolda, Senegal

Complete as indicated on this insert

Niang, Cheikh I., Benga H., Thiam Y., Nguere R.; Institut des Sciences de l'Environnement, Université Cheikh Anta Diop, Dakar, Senegal

Deadline: 1 February 1995

Objectives: Identify ways to integrate STD/HIV prevention messages into the traditional interactions between the local community and Dimba and Laobe women's groups. Assess the impact of the intervention strategy on knowledge, attitudes, and behaviors of Laobe and Dimba women and community members.

Methods: Key informant interviews, group discussions, participant observation, and questionnaires were used to determine STD/HIV risk factors for women and men, understand the structure and functions of Dimba and Laobe groups, and determine whether the Dimba and Laobe integated STD/HIV prevention messages into their interactions and the extent to which the sexual knowledge, attitudes, and behaviors of community members have been modified.

Results: The Dimba is a membership organization that focuses on fertility and child health. Its members conduct community rituals and provide therapeutic counseling to women and couples. The Laobe are an itinerant ethnic group who make and sell products to enhance sexual pleasure. Findings showed the influence of the Dimba and Laobe in Kolda is widespread: one-third of 250 women surveyed said they were Dimba members; among non-Dimba women more than one-half had participated in Dimba ceremonies; and more than one-half of women and men (N=250) said they had bought products from Laobe women. Working with the Dimba, messages were developed that stressed the link between STD/HIV prevention and child health and were incorporated into community ceremonies. As a result of these ceremonies, the number of individuals seeking services from formal health care providers increased and youth groups asked the Dimba if they could play a role in community prevention activities. The Laobe nicknamed the condom "make it hard" and marketed it as an erotic product, together with a piece of lingerie. The Laobe also developed erotic dances and songs about the female condom.

Conclusion: Findings indicate that the Dimba and Laobe play an influential role in the reproductive health and sexual lives of Kolda residents, are enthusiastic in integrating STD/HIV prevention messsages into their traditional interactions, and that their activities have increased health seeking behavior, mobilized other community members to become involved, and developed creative ways to foster condom use. Data collection to assess other project outcomes is planned.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 10 50 59 80 121 _____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

A Community-Based Approach To Behavior Change: HIV/AIDS and STD Education Among Devadaasi Women and Their Community, Experiences From Rural Karnataka, India

Sivaram[1], Sudha M.P.H.; Gowda[2], Belle; D'Souza[3], Harry; and Sogunro[4], Remi, M.D., MPH.

Objectives: The objectives of this project were as follows:
1) To learn about the knowledge, attitudes, and practices of devadaasi women, and their communities with regards to HIV/AIDS and STDs;
2) To identify how women and their communities access health care and their attitudes towards health professionals.
3) To design education programs for HIV/AIDS and STDs so as to foster a process of prevention that involves the whole community.

Methods: Focus group discussions were conducted with devadaasi women, their communities, as well as with the medical care providers in the area. The purpose was to elucidate personal and community behavior and responses with regards to HIV/AIDS and STDs. Based on the information collected, appropriate education materials were designed. Many participative methods to disseminate information and foster behavior change were implemented. These included learning-centered training programs about HIV/AIDS and STDs with a sex education and women's health component ; street theatre performances; interpersonal counselling; and distribution and use of visual materials. Street play themes stress the importance of integrating devadaasi women into mainstream society and the effect of multiple sexual partners on the community at large.

Results: Preliminary results point towards immense interest within the community to learn more about HIV/AIDS and STDs, and to participate in prevention education programs. This is evident from the questions asked during training programs, requests for training , and the number of people in the community, including the devadaasi women, who volunteered to be peer educators. The results of the focus groups indicated that most devadaasi women had heard of a disease called AIDS. However, knowledge of HIV and how it is transmitted was lacking. In the general community, only 20% had heard of AIDS. Furthermore, information about HIV/AIDS and STD transmission and prevention was similar to that in the devadaasi population. 80% of the devadaasi women sought care from their village doctor. The common complaint about health care was ineffective medication and waiting period.

Conclusions: The results reinforce the importance of focusing prevention strategies on the entire community rather than only on those who are already marginally discriminated against. Although devadaasis are a high risk group in the community, focusing on these women would further perpetuate the belief that AIDS and STDs are devadaasi-related ailments. In this community-based education process, one of the important lessons learned is the importance of community group dynamics and community participation in promoting behavior change.

Key Word: Devadaasi: Women in the community who have been pledged to the service of the gods at a very young age. Historic precedence and economic need have now used this custom to sanction multi-partner sex among these women. Devadaasi women live in the community and partake in all community events.

[1] Project Officer, AIDSCAP Project - PLAN International, New Delhi, India
[2] MYRADA, Bangalore, India
[3] MYRADA, Bangalore, India
[4] Senior Health Advisor, PLAN International USA, Washington, D.C.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 1 33 66 94 95

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

The Use of Street Theater in Commercial Sex Workers AIDS-Prevention and Citizenship Education.

Szterenfeld,Celia*; Alfama,M.*;Alves,A.B.*;Peterson,C.*.
*Health in Prostitution Project(ISER),Rio de Janeiro, Brazil.

Objectives: 1.To develop community-based health agents communication skills and 2.To reach out to street prostitutes-women, young men and transvestites - at their worksite along with their clients and the general public aiming at challenging the inhibitions and taboos jeopardizing a clear understanding of the risks of this turn-of-the-century epidemic known as AIDS.

Methods: A theater group from the Federal University in Rio de Janeiro called "Copo D'Alma" (Chalice of the Soul), made up of students from various fields, does the training. The group has met twice a week, with an average of 35 hours a month of workshops, meetings and outings, over the course of six months. This gave rise to the CIVIU Group (a play on words with "to see" and "civil"). A five-skit play entitled "Ao Alcance da Mão" (Within Hand's Reach) was enacted fifteen times in public squares and byways of Rio de Janeiro, reclaiming public space.

Results: Sex workers participating in the group reported an enhanced sense of power after their theater experience. Relegated to ghettoes, they have found in the theater an important channel to the world, thus interfering in it and changing it. Audiences often felt sufficiently at ease with the themes to intervene in acts with opinions and gestures.

Conclusions: Results have shown that the use of theater in AIDS and citizenship education is a worthy experience. Because of the liberal nature of Rio's society, a street theater group is able to stimulate discussion with the public on issues such as violence, health, sexuality and living standards. In addition to its didactic work on the risks of HIV infection, the CIVIU Group has been successful in raising individuals awareness as to their role as members of society.

Topic No. 27 Select one from Key List

Key Word Nos. (Select four to six) 24 27 47 19 ___ ___

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Premarital Screening for Human Immunodeficiency Virus Infection: Issues to consider

Kamenga, Munkolenkole*; MacNeil, J.*; Denison, J.*; White, R.*; Sweat, M.* *Family Health International, AIDSCAP, Arlington, Virginia, USA

Background: Existing literature on premarital screening for human immunodeficiency virus (HIV) infection have concluded that premarital screening is not effective in the prevention of HIV infection. However, most of the studies conducted to date to reach this conclusion are from low prevalence countries (mainly the US) and have focused only on the mandatory aspect and the cost of premarital screening. Potential public health impact of such interventions has not been fully assessed.

Methods: HIV screening before marriage may play a significant role in the prevention of HIV transmission. Advocating premarital screening to make it routine practice without making it mandatory may offer a unique opportunity for people to discuss and negotiate HIV risk at the beginning of their marriage. The issue of premarital HIV screening may be of paramount importance especially for women as they often lack power to negotiate safe sex after they enter a marriage. Using hypothetical data, calculations were made to determine the number of HIV positive persons identified; the total cost of the program; and the cost per case identified. HIV prevalence was varied across three hypothetical cities to demonstrate the impact of a premarital screening program for low, medium, and high prevalence areas. Finally, the number of marriages per year and the cost per person were kept constant for the three cities.

COMPARISON OF THREE HYPOTHETICAL CITIES

	number of marriages per year	HIV prevalence	number of HIV(+) identified	Total cost*	Cost/case identified
CITY A	120,000	30%	72,000	8,400,000	$ 117
CITY B	120,000	5%	12,000	8,400,000	$ 700
CITY C	120,000	1%	2,400	8,400,000	$ 3,500

* Assuming cost/person tested and counseled equal to $ 35

Results: The calculations from the above table suggest that: 1) in some areas, a significant proportion (30%) of couples entering marriage have at least one partner infected. Informing these couples about their HIV status would not only help them to make an informed decision, but it may also prevent secondary cases of infection; 2) the cost per case identified varies with the HIV prevalence in the area where the intervention is implemented, with cost increasing as HIV prevalence decreases.

Conclusions: Premarital HIV screening is likely to become more of an issue for people everywhere, particularly in areas with high prevalence in the population between 18-45 years, as people become better informed and especially as HIV testing becomes more accessible. Further studies should be undertaken to evaluate: 1) the acceptability of premarital HIV testing; 2) the potential human rights implications of premarital HIV screening; 3) readiness to pay for the service; and 4) the public health impact of such an intervention in various settings.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 20 58 77 139 152

Original Abstract

HIGH RISK BEHAVIOR AND AIDS TESTING AMONG MARRIED RESPONDENTS IN UGANDA

Complete as indicated on this insert

Karungari Kiragu*, Cheryl Lettenmaier, Jennifer Sengendo**, Ham Mukasa Mulira*** and Michael Galiwango***. *JHU/PCS/PIP (Baltimore), **DISH Project (JHU/PCS/PIP-Uganda), ***Polytechnic of Information Technology, Uganda**

Deadline: 1 February 1995

Objective: In July 1994, we conducted a survey among 1323 married adults aged 20-40 to explore perceived risk, AIDS testing and preventive behaviors adopted as a result of the AIDS epidemic. These data were to serve as a baseline survey for the Delivery of Improved Services in Health (DISH) Project, a five year USAID-funded reproductive health intervention being implemented in 10 districts.

Method: Data were gathered from four cities (Kampala, Jinja, Masaka and Mbarara) and from an adjacent peri-urban area in each city. The sample was selected using a multistage stratified procedure. Eligible respondents were interviewed by trained research assistants using a pretested questionnaire.

Results: About 50% of the sample was male, 80% resided in urban areas and 96% had some type of formal education. The mean age for men was 32 years, for women 27 years. Respondents had an average of 3.6 children and 43% did not want any more.

Virtually all (99%) had heard of "diseases that can be transmitted through sex", and the most commonly mentioned STD was gonorrhea (84%) followed by AIDS (83%). Nearly 80% of those who heard of STDs said they had changed their behavior since learning of the disease. However, only 40% considered themselves at low risk for AIDS, and only 62% felt that condoms could protect against it.

About 20% of the respondents had had extramarital sex in the preceding year, 29% of the men and 9% of the women. Roughly 60% had used a condom at their last extramarital liaison, 63% of the males and 52% of the females. There were sharp education differentials in condom use, and only 10% of the respondents with no education had used condoms compared to 84% of those with post-secondary education. About 22% of those with extramarital experience had been tested for AIDS, compared to 20% of the general sample. AIDS testing was strongly and positively associated with education. Among those who had not been tested, 60% said they would consider being tested and 90% knew where they could go for a test.

Conclusions: The data suggest that awareness of AIDS and STDs is nearly universal, but confidence about personal risk is low, especially among the uneducated. Because AIDS testing and condom use were sharply and positively associated with education, there is a need to make these services accessible to less educated populations. In addition, many Ugandans mistrust condoms, therefore policy makers and programmers should address these concerns.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 17 52 66 139 ____ ____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

RESPONDING TO THE HIV EPIDEMIC IN A RURAL DISTRICT HEALTH SERVICE IN NORTHERN KWAZULU, SOUTH AFRICA.

McCoy, David.*; Stein, Z.**. *Hlabisa Hospital, Kwazulu, South Africa; **Fogarty Fellowship Training Programme, USA.

Objectives: The objectives of this paper are to describe: 1) a rural district health service's response over 3 years to the growing HIV epidemic in a province of South Africa; 2) the need for the health services to move their focus away from HIV the disease and its surveillance, and more onto the health sector's response to the epidemic, and health systems surveillance; 3) why the incidence of HIV has decreased at the hospital when the community prevalence of HIV is increasing.

Methods: Information for this paper has been gathered from informal discussions with key people who have worked on the Hlabisa AIDS Programme, as well as with other health workers and members of the community. Information on HIV testing and outcome has come from an on-going prospective audit that was started in 1992.

Results: Between 1990 and 1994, the prevalence of HIV amongst ante-natal women in Kwazulu rose from an estimated 2% to an estimated 19%. In the Hlabisa Health Ward, the incidence of HIV Positive patients rose from 283 in 1992, to 451 in 1993. However in 1994 this figure dropped down to 296. The reason for this was that fewer people were being HIV-tested, as part of a deliberate policy change. However, surveillance of health activity related to HIV has shown progress over the last 3 years, as well as an emphasis to increasingly take health activity out of the hospital and into the community.

Conclusions: The reduced frequency in HIV testing was due to a decision to limit HIV testing to those cases where a result would involve a change in clinical management, unless the request for testing came from the patient. Counselling that focuses on the individual's HIV test and the result was seen to be ineffective, inefficient, prone to increasing the stigmatisation of HIV, as well as being costly. Too much of the AIDS Programme was seen to be centred around the issues of testing and disease surveillance, and a decision was made to shift towards more education involving all patients. Greater community involvement in the AIDS Programme was defined as a more productive avenue to follow. This represents an initial biomedical and hospital-centred perspective, which has evolved to recognise the fundamental importance of a primary health care approach and a socio-cultural perpective. This experience has important implications for policy and practice in other areas of South Africa. Lastly, it is important for AIDS Programme managers to be able to monitor and assess local programme initiatives by simple measures of health systems surveillance.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 10 48 58 66 113 153

Does the "Fleet of Hope" hold water? An evaluation of a controversial campaign to provide a personal assessment of risk.

Manchester, Timothy G; Population Services International: Tanzania AIDS Project/Social Marketing Unit.

Objectives: When a Catholic parish priest in Tanzania discovered his parishioners wedged between the dogma of the church and an aggressive condom distribution campaign, he developed a simple pictorial approach to presenting an assessment of personal risk that avoided the political controversy. Most people in Tanzania knew of AIDS and many had lost friends and family members to what is believed to be AIDS. Most believed that they were not at risk or had little usable information that allowed them to assess risk; information campaigns were not effectively communicating an understanding of "at risk" behavior. Though preliminary experience seems to indicate that the educational message does work well at explaining personal risk in a non-confrontational way, the program has raised no small amount of controversy in Tanzania and elsewhere. The TAP assisted with an evaluation of the campaign to determine its relative effectiveness, and its appropriateness to adolescents. A series of questionnaires and focus groups were conducted in two communities close to Dar es Salaam in order to judge the effectiveness of the educational program with young people.

Methods: A combination of questionnaires and focus groups was used simultaneously. The sixteen groups of eight individuals from two communities in and around Dar es Salaam were pretested, presented the curriculum and then interviewed a week later, initially with a questionnaire and followed up with a focus group.

Results: The "Fleet of Hope" attempt to take risk assessment out of the context of skills and facts to be learned, and looks at the individual in a context of an AIDS "flood" (epidemic). This attempt to take a more "spiritual" context seems to effectively situate young people in a context where they can evaluate their own risk. This runs counter to most behavioral change communication campaign designs.

Conclusion: The "Fleet of Hope" is able to avoid direct confrontation with political and religious factions while it establishes a simple model for personal "risk assessment". The model seems to give a young population a clear idea of the risks involved in a way that they are able to judge "risk" for themselves. The program is under consideration for school and workplace programs.

Complete as indicated on this insert

Deadline: 1 February 1995

A Study of the Impact of HIV Counseling and Testing on Behavior Change in Tanzania: Justification and Methods

Sangiwa, Gloria[1]; Hogan, M.[1]; Kamenga, M.[2]; Grinstead, O.[3]; Sweat, M.[2]; O'Reilly, K.[4]; Coates, T.[3] [1]Muhimbili University College of Health Sciences, Dar es Salaam, Tanzania [2]Family Health International, AIDSCAP, Arlington, Virginia, USA [3]Center for AIDS Prevention Studies, University of California, San Francisco, California, USA [4]Global Programme on AIDS, World Health Organization, Geneva, Switzerland

Background: Human immunodeficiency virus (HIV) counseling and testing (C&T) has been advocated in many countries around the world including Tanzania, for the prevention of HIV/AIDS. Studies conducted to date suggest that C&T may lead to behavior change. However, most of these studies were conducted among special groups and did not include control groups. Moreover, the public health impact of C&T has not been fully investigated.

Findings: As seen in the figure below, Tanzania is among the most hard hit countries by the HIV/AIDS epidemic.

SITUATION IN TANZANIA

Total population	25,000,000
Adult population HIV prevalence	10-12%
Estimated number of HIV infected	800,000
Cumulative AIDS cases reported (Dec 94)	42,244
Population AIDS awareness*	80%

** Correctly citing at least 2 modes of HIV transmission*

Despite the apparent high AIDS awareness, very little behavior change to prevent HIV infection has been demonstrated. With the growing epidemic, the family, a traditional mainstay for social and psychological support, is unable to continue to meet the needs of the growing number of people with HIV/AIDS (PWA). In response to the situation created by the HIV epidemic, one of the strategies considered by governments and non-government organizations is the provision of HIV C&T aimed at psychosocial support to PWAs and the prevention of HIV/AIDS through behavior change. However, the efficacy of C&T in the promotion of behavior change is still questioned.

Method: To address this issue in Tanzania, the Muhimbili University College of Health Sciences has joined AIDSCAP and GPA to conduct a multicenter randomized controlled trial of the efficacy of HIV C&T. In this study, a group of 800 participants receiving HIV C&T will be compared to 800 participants receiving health information. The primary outcome measures will include self-reported sexual behavior, psychosocial impact of HIV result, and incidence of sexually transmitted diseases. Cost analysis of HIV C&T will also be performed.

Conclusion: Findings from this study will have important public health policy implications for the Tanzanian government and donor agencies working in Tanzania on the appropriate allocation of limited resources. These findings will also make a significant contribution to the scientific world.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 19 20 58 67 157 169

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

RiskAdvisor: A Computer-Based, Interactive Tool for Risk Assessment and Risk Reduction Counselling.

Wittet, Scott.*; Elswit, D.*; D'Agnes, L.**. *PATH, Seattle, WA, USA; **AIDS Surveillance and Education Project/Philippines.

Objectives: The *RiskAdvisor* interactive behavior change communication tool was developed to help AIDS counselors and educators more effectively assess risk and discuss risk reduction with clients. The colorful, graphical nature of *RiskAdvisor* makes it attractive to both service providers and clients and helps them visualize relative risk levels for complex sets of behaviors. It creates a personalized behavior summary, provides feedback on why some behaviors are more risky than others, and offers suggestions for reducing risk. After analyzing current levels of risk, clients can "change their behaviors" and watch risk levels fall or rise.

Methods: A 1994 focus group discussion (FGD) with commercial sex workers in the Philippines revealed an interesting variation on the "KAP gap." Rather than a gap between factual knowledge of AIDS and sex practices, the FGD exposed a gap between being able to articulate facts about AIDS and the ability to accurately assess personal risk. Since the sex workers didn't believe they were in danger, they were not motivated to change unsafe behaviors. A review of existing AIDS/STD counselor training curricula revealed a shortage of tools to help counselors and clients discuss the linkages between behaviors and risk level. *RiskAdvisor* was developed to meet this need. *RiskAdvisor* is being tested in AIDS prevention programs in the Philippines and Seattle, and as part of the AIDSCAP program in Nepal. *RiskAdvisor* was developed in part with funding from USAID/Manila.

Results: Preliminary feedback from counselors and trainers in the trial programs suggests that *RiskAdvisor* is useful in the following contexts: (1) as a counselor training tool; (2) as a support material for client counseling; and (3) as a stand-alone self-instructional tool for educated clients. The graphical representation of relative risk, and the ability to simulate the results of behavior change, were seen as especially powerful features of the program.

Conclusions: *RiskAdvisor* is a prototype; as counselors and trainers gain more experience with the program, it will be improved. The potential for using computers as counseling and educational aids is increasing every year -- *RiskAdvisor* is just the beginning. Paper-based versions can also be developed for "where there is no computer."

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 7 58 19 138 150 128

Original Abstract

The role of the media in the developing world in HIV/AIDS prevention: ongoing assessment

Complete as indicated on this insert

Foreman, Martin; Deane, James. Panos Institutes, Washington DC and London.

Deadline: 1 February 1995

Objectives: To analyze the actual and potential role of the media (press, radio, television) in advising their publics as to the extent and implications of HIV/AIDS and how to prevent transmission of HIV. To devise means of informing and training the media to report more positively and effectively on the epidemic.

Methods: (i) analysis of research by a number of non-governmental organizations (NGOs) worldwide indicates that the media frequently plays a negative role in HIV/AIDS prevention, through inaccurate reporting, reporting which focuses on risk groups rather than risk behaviors, reporting which focuses on the epidemic in other countries and lack of reporting. (ii) collaboration with nationally respected NGOs in Africa, Asia and the Americas in holding sensitization and training workshops. (iii) commissioning experienced reporters to produce in-depth informative reports. (iv) dissemination of such reports and other documentation specifically designed for media use in over a dozen African, Asian and American languages.

Results: Training workshops and the development of media programs have resulted in significantly higher quality and quantity reporting on HIV/AIDS in Bangladesh, Ethiopia, Malawi and Tanzania. Preliminary results suggests similar improvement in Central America.

Conclusions: Those working in the media are conscious of their potential role in diffusing information on HIV/AIDS. However, few can specialize in the subject and many need both training and documentation to assist them. Press editors and radio and television producers also need sensitization in HIV/AIDS to help them devise consistent editorial policies on reporting the issue.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 120 10 113 139 ____ ____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

EFFECTIVENESS OF MASS MEDIA CAMPAIGNS AS CATALYST FOR BEHAVIOR CHANGE COMMUNICATION

Garba, M. Lawal*, Esu-Williams, E.*; Mohammed, G.**;Mayaki, M.**; Falana, S.*.
*FHI/AIDSCAP Nigeria; ** Jigawa League of NGOs.

Objectives:1)To determine the extent to which mass media campaigns affect people's behavior with regards to HIV/AIDS; 2)To find out people's responses to mass media campaigns on HIV/AIDS 3)To determine the most effective type of media campaigns; 4)To determine the extent to which mass media campaigns influence an on-going AIDSCAP targeted intervention in Jigawa State.

Methods: A baseline KABP survey was conducted among two populations: i)the long distance drivers in Jigawa State which constitute a focus group for the FHI/AIDSCAP project in the state and ii)the general population in the same environment. In both groups a total of 450 persons were interviewed, 300 from the general population and 150 long distance drivers. All participants were randomly selected. Two media outfits, Radio Jigawa and the Triumph Newspapers with a target coverage of over 3 million people in Jigawa State of Northern Nigeria were used for the interventions. Intensive media campaigns covering various aspects of HIV/AIDS/STD were featured weekly in both the radio and newspaper programs over a three month period, September to December, 1994. A final survey was re-conducted in both groups to discern any changes in knowledge and perception of HIV/AIDS and to determine behavior modifications.

Results: The results showed that 88% of the sampled general population had listened to the radio programs at least three times, compared with 60% who had read published newspaper articles. Sixty-six percent of the respondents preferred the radio programs because of simplicity in language, and accessibility. Many were unable to afford the cost of newspapers, limiting their access to this source of HIV/AIDS information. Through the radio program, many also were readily able to respond to issues of interest/concern by letters and telephone and to readily receive answers. Sixty percent of the population reported behavior modification in relation to partner reduction and condom use as a result of these media programs. Up to 98% of the long distance drivers surveyed reported listening to the radio programs at least thrice compared with 51% who read published newspaper articles. Also, 70% of them reported behavior modification by way of reduction in number of partners. and greater consistency in condom use. This result is a major improvement compared with 33% at baseline who reported consistent condom use. The change in reported partner reduction and condom use practices were associated with better understanding and awareness about HIV/AIDS among long distance drivers.

Conclusion: This study showed that mass media campaigns, particularly through the radio could be an effective catalyst for changing peoples attitudes, perceptions and behavior in targeted HIV/AIDS interventions and for the general population. It is recommended that all targeted intervention programs should incorporate some elements of mass media activity, which need to be readily available, accessible and providing the opportunity for a feedback from program beneficiaries.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 9 19 52 132

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

AIDS, SEXUALITY, SEXUALLY TRANSMITTED DISEASES.. EVERYTHING YOU HAVE ALWAYS WANTED TO KNOW AND HAD THE COURAGE TO ASK: a book for Commercial Sex Workers (CSW)

Hughes V.; Linhares, Iara Moreno*.; Miranda, S.D*.; Santos, M.F.Q.*; Pinel, A.****; Fernandes M.E.L.*** - * University of São Paulo,SP-Brazil ** São Paulo State Department of Health, SP-Brazil *** AIDSCAP/Brasil, Family Health International, **** Genus International - SP-Brazil**

Objectives: Develop a manual of HIV/AIDS/STD prevention for low income CSWs based upon their specific needs to be used in face to face interventions.

Methods:
From 1991 to 1992 a multiprofessional team from the State Department of Health, AIDS Program in São Paulo worked 2 afternoons per week in a face to face intervention inside 4 buildings of low income prostitutes in the heart of São Paulo City (each building with an average of 300 prostitutes). During this period the team asked the prostitutes to write down questions to be answered verbally by the team during the next visit. Counseling was provided and condoms were distributed weekly. Listening to those women made it clear that they had many specific needs, vocabulary and behaviors to be addressed. A total of 1500 questions in the areas of HIV/AIDS/STD, sexuality, gynecology and the use of drugs were recorded as asked by CSWs. The questions were selected by order of repetition and relevance and 120 questions were answered by specialists in the area using a very simple vocabulary.

Results:
Several private sector organizations (Ford models, W/Brazil, Grafica Burti, Levi Strauss Foundation) elaborated and funded an elegant and very well done book to answer the questions. A total of 10.000 books were donated to AIDSCAP/Brazil and are being used in four multifaceted intervention projects for prostitutes in four large urban areas in Brazil. Due to high demand of target population. The book was recognized by the Brazilian Association of Graphic Production as the best didactic book of the year 1993.

Conclusions:
We feel this experience demonstrates:
1.The importance of private sector leveraging.
2.The value of including the target populations in the development of communication materials.
3.Educational materials are more effective when linked to a comprehensive multifaceted intervention.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 7 24 47 113 136 144

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Title: Fear-based and Content-free Information, Education & Communication (IEC) Messages: The Academic Perspective vs. the Field Reality.

Authors: Mahler, Hally R.*; Flanagan, Donna*

Objectives: This paper will address the perseverance of HIV/AIDS prevention messages which employ fear-based techniques or lack message content in the face of research which discourages such message development. An analysis of the discrepancies between communication materials designed by IEC practitioners working in developing countries and the perceptions of academically-rooted communications professionals about the effectiveness of such materials will be conducted.

Methods: 1) An informal assessment of AIDSCAP-funded field-based AIDS prevention educational materials, incorporated into the AIDSCAP Behavior Change Communications Database, will be used to identify materials for further study, and assess the perceptions of the materials by field-based practitioners. 2) A more in-depth assessment questionnaire and interviews with both field-based practitioners and academician/researchers will be used to solicit additional data on specific materials. 3) Academic approaches to HIV/AIDS prevention messages will be reviewed through a literature search and interviews with academicians/researchers.

Results: An analysis of different perceptions of the selected materials, including content, credibility, visual appeal, information transfer, appropriateness for target audience, and behavior change motivation potential will be presented. Preliminary results suggest that many field-based IEC practitioners continue to believe in the efficacy and behavior change potential of fear-based messages and messages which lack explicit HIV/AIDS prevention content; the academically-based communication professionals however, remain more skeptical of their effectiveness. Several implications of this discrepancy will be presented.

Conclusions: The findings of this paper will facilitate the on-going dialogue between hands-on field-based and academically-based IEC professionals about fear-based and content-free messages. A greater understanding of perceptions of, and lessons learned by, both sets of professionals will benefit both target audiences and program planners, and will be a valuable tool for future IEC materials planning.

* AIDSCAP

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 8 19 66 73 77 113

Original Abstract

EMPOWERMENT AGAINST AIDS IN THE SEX INDUSTRY

Moreno M., Luis; Ferreira, F.; Rosario, S.; Bello, A.;
Mensajeros de Salud, COIN, Dominican Republic.

Objective: To describe how a self-produced newsletter has been a successful tool to enhance self-esteem, solidarity and health education among Female Sex Workers(FSW) as part of an AIDS prevention strategy.

Methods: In June 1993 a feasibility study with a random sample of 89 FSW group leaders was conducted in three cities of the Dominican Republic. The need to provide a communication media for FSW was determined. Initially, the newsletter, La Nueva Historia (LNH) was designed and produced by a staff comprised mostly of COIN educators. Eventually, the newsletter was turned over to FSW who select, write and review the topics to be included. The newsletter is comprised of the following sections: editorials, cultural supplement, health, news and testimonials. Newspaper staff hold two meetings per month. During the first meeting, themes are discussed and the staff is assigned their topics. During the second meeting the articles are read and critiqued for publication. LNH is distributed by FSW during educational interventions with the target audience.

Results: 89% of FSW greeted the idea of a monthly newsletter as a dream come true. Illustrated educational messages combined with news, jokes, poems and songs were preferred. Male participation was welcome; 82% were willing to write for and 93% to read the newsletter to illiterate FSW. Circulation increased from 2000 to 5000 in seven issues. Participation of FSW in the production of the newsletter increased from 4 to 12, with one technical staff member from COIN. Ownership of LNH is evident by FSW willingness to collaborate financially towards the production of the newsletter. In July/1994 a rapid assessment of the first 11 issues of LNH was conducted among 101 FSW in six zones of Santo Domingo, La Caleta and La Romana. Of those interviewed, 91% have seen a copy of LNH at least once and 94% of the readers understood the content. FSW commented that LNH promoted communication among FSW; respect for and solidarity among readers; and empowerment. FSW and client participation, mass media acceptance and public opinion support are further indicators of the success of the newsletter.

Conclusions: LNH is an excellent example of how a traditional instrument (newsletter) can be used in creative ways for program support. A basic element for its success has been the active participation by the target audience in the Behavioral Change process.

Topic: 1

Key words: 6, 47, 62, 68

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

HOW CAN INNOVATIVE COMMUNICATION CREATE AWARENESS, MOBILIZE PUBLIC OPINION AND LEVERAGE RESOURCES FOR AN AIDS PREVENTION CAMPAIGN.

Velandia Mora, Manuel Antonio;.Ortega Perez, Gloria. Fundación APOYEMONOS, Santafé de Bogotá. Colombia.

Objectives: The objective of this campaign was: 1) To mobilize the public opinion and decision makers on the need to develop a strong response to the growing spread of HIV/AIDS in Colombia. 2) To overcome the negative effects of a previous television campaign that hit cultural and religious sensitivities. 3) To renew the AIDS prevention effort as prevalence indicators were increasing and no coherent prevention program was undertaken. 4) To inform specific target groups about HIV infection risk.

Methods: A combination of mass media and a set of alternative communication strategies between Dec 1 and Dec 10, 1992 linking International AIDS day and International Human Rights day, was considered the most effective method to reach, impact and mobilize opinion leaders, decision makers and the general population, due to specific context situation in Colombia.
1) Mass media support chosen was one of the largest national newspaper with wide distribution throughout the country. A supplement presenting information, editorial articles on AIDS and a condom, was inserted in the December 1st, 1992 edition of EL Espectador newspaper, with a circulation of 250,000 copies. 2) Alternative communication activities consisted of public events gathering decision makers, opinion leaders and personalities to convey messages of the need to respond to the AIDS epidemic in Colombia. This campaign closed Dec 10 with a large event at the National Public Library in Bogota linking the issue of AIDS prevention with the Defense and Promotion of Human Rights. 3) A poster campaign conveying 8 different messages, was created to reach specific target populations selected on the base of epidemiological data.

Results: 1) 205,000 copies of a 24 full color pages supplement were distributed. Each copy included a condom. 1,000,000 readers were reached by this supplement according to readership factor established for this newspaper. 2) 21,000 posters expressing 8 different topics were distributed during the campaign. Total estimated exposure of the poster campaign was calculated at 8,000,000 people, following calculations of viewers by points of exposure. 3) A total of 224,000 condoms were distributed at the end of the 10 days campaign. 4) As a result of a counterpart resource mobilization funds totaling 80% of the total project final cost were raised. USAID investment was therefore multiplied by 4.

Conclusions: Campaign effects measured to 1 year later. Ministry of Health printed second edition (36,000 copies) of 6 campaign posters. Schools, colleges, health providers and church organizations increased requests of information and presentations to the local implementing agency. The campaign did not receive a negative image. The issue was restored to the public agenda.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 7 9 19 46 50 152

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Assessment of Knowledge, Attitudes, and Practices on Sexuality and HIV/AIDS among Kenyan Church Going Youth.

Ijumba, Petrida; Guturo, F.; Dortzbach, D.; Kiiti, N.; Wangai, A.
MAP International, P.O. Box 21663, Nairobi, Kenya.

Objectives: The overall objective of the study was to gather relevant information on sexuality, HIV/AIDS and STDs, from Kenyan churched youth, to assist in the development of culturally appropriate curricula for youth education in these areas, through church related groups and institutions.

Methodology: A structured survey, using a self-administered questionnaire and focus group discussions, were the methods used to obtain quantitative and qualitative data regarding churched youth's knowledge, attitudes and practices (KAP) on sexuality, HIV/AIDS and STDs. Information was obtained regarding: (i) the role of the church in prevention and control of HIV/AIDS among the youth, and (ii) the type of information the youth need regarding sexuality and relationships. A total of 300 youth aged between 11 and 19 years, from Eastern, Central and Western Kenya, responded to the questionnaire, and 3 focus groups consisting of 10 people each, participated in the discussions held in Mombasa, Nakuru and Nairobi.

Results: Preliminary results indicate that the majority of the youth (97%) acknowledge that AIDS is a problem in Kenya, and it can be prevented. All the interviewed youth were single, and about 40% of them admitted to having had sex with one or more partners, mainly due to peer pressure. Many of the youth were not satisfied with the current methods of disseminating information on HIV/AIDS. They prefer to get the information through discussions with their parents, clergy, youth workers and teachers, rather than only through peers and the media, because they consider these sources to be more credible. The youth felt that the church can assist in AIDS prevention among youth. Encouraging open and frank discussions on AIDS and sexuality among the clergy, youth and parents was one example they highlighted.

Conclusion: The findings of the study will be used to develop appropriate curricula for youth education programs on sexuality, relationships and HIV/AIDS prevention. The youth value their parents' information on sex, but parents are not teaching youth. The active involvement of the church in educating and supporting parents to participate in youth education programs, will have a significant impact on molding behavior in the control and prevention of HIV/AIDS among the youth.

Topic No. 3 _____ Select one from Key List

Key Word Nos. (Select four to six) 17 66 109 34 _____ _____

Original Abstract

Perspectives on AIDS Education in Primary Schools: Evaluation of the HIV/AIDS Education Orientation for Primary School Teachers in Malawi.

Complete as indicated on this insert

Kornfield, Ruth; Domatob, A.; JSI-STAFH Lilongwe, Malawi. Gunsaru, C.; Ministry of Education, Lilongwe. Robbins, M.; AIDSCAP/FHI, Lilongwe.

Deadline: 1 February 1995

Objectives: 1) Assess the effectiveness of the HIV/AIDS Education Orientation for Primary School teachers in Malawi as part of introducing a new AIDS curriculum; 2) Identify teachers' concerns towards teaching about AIDS in their classrooms; 3) Obtain the input of the teachers for program planning for AIDS school activities.

Methods: Observations were made and reports gathered for three regional level trainings for facilitators who were to prepare trainers to orient teachers to a new AIDS education module. Teachers' reactions were judged by pre-test and post-test questionnaires to a sample of 10%, totalling 1600. Follow-up observations of the teachers actually teaching about AIDS in the classroom indicate the quality of the implementation of the curriculum.

Results: Results indicate enthusiasm for the new HIV/AIDS curriculum suggesting great change in a short time. Data show positive attitudinal changes towards teaching about AIDS, changes in their concerns about discussing sexual transmission and the use of condoms in the classroom, and towards developing AIDS extracurricular activities in the schools.

Conclusions: Trainees expressed the opinion that it is necessary for the Ministry of Education on the national level to take a strong position before the lower-level officials will formally introduce the AIDS curriculum in the classroom. The data identify specific cultural problems concerning the appropriateness of teachers discussing sexual activities. One recommended solution is to have health professionals invited to supplement the teacher's activities. Data from the evaluation provide material for further training of the teachers. The teachers suggested extracurricular activities which will be implemented to strenghen the AIDS program. Specific problems reported from this evaluation may recur in neighboring countries which are culturally and historically similar to Malawi.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 66 117 121 142 10 ___

Original Abstract

Youth Peer Education: An HIV Intervention Strategy in Rakai District, Uganda.

Complete as indicated on this insert

Mireego, Eddie*, Kelly R.**, Coghlan, A.***, Dombo, E.* Ssembatya, J.*
*Rakai AIDS Information Network, Uganda,, **Columbia University, USA, ***Cornell University, USA.

Deadline: 1 February 1995

Objective: To evaluate the effectiveness of the Rakai AIDS Information Network's (RAIN) peer education program in 1) increasing correct knowledge of HIV transmission and prevention and 2) increasing self-reported adoption of safer sex practices.

Methods: The evaluation was a longitudinal panel study. A baseline KABP survey was conducted in June 1993 with 567 randomly selected respondents (ages 15-40) from 30 villages. Four hundred and seventy (83%) of the original respondents were again interviewed in June 1994. Analysis included frequency distributions and logistical regression to deduce cause and effect relationships.

Results: Highly significant increases were found in correct knowledge of modes of transmission and prevention measures, and ever use of condoms.

Variable	% at baseline	% at follow up	% change
Knowledge of:			
sexual transmission	85.5	95.6	10.1*
vertical transmission	0.4	52.4	52.0*
asymptomatic transmission	57.9	93.0	35.1*
condom use as a preventive measure	6.6	67.9	61.3*
Safer Sex Behavior:			
ever used a condom (n=454)	8.1	27.5	19.4*
used condom at last sex (n=33)a	26.4	61.6	35.2*

a) those who ever used a condom at baseline *p<.001

We then devised a cumulative knowledge score. By conducting linear regression and controlling for baseline knowledge, sex, age, education and sources of information, we found that peer educators and peer education contacts significantly increased their knowledge by 2.85 points and 1.65 points beyond those who had no exposure to RAIN's programs. By conducting logistical regression and controlling for sex, age, education, other sources of information, and having multiple partners, we also found that peer educators and peer education contacts were, respectively, six and five times more likely to use a condom than those who had no exposure to RAIN's programs.

Conclusion: These data suggest that highly significant improvements occurred in people's correct knowledge of HIV/AIDS and reported use of condoms. They also suggest that exposure to RAIN's peer education program is the most significant factor in influencing these changes. Thus, RAIN's peer education program may serve as an effective model for an HIV intervention strategy for youth in rural settings.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 73 2 6 80 ___ ___

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Knowledge, Attitudes, Beliefs and Behaviours Regarding the Sexual Activities of Girls in Traditional Authority Kalolo, Lilongwe District, Malawi.

Ngaunje, Marjorie*; Chaima,C.**; Chilambe, T.*; Domatob, A.**; Samu, S.M.***; Shawa, M*.*; Sulanowski, B.K.***. *SAA-M; **AIDS Secretariat; ***University of Malawi; Lilongwe, Malawi.

Objectives: The Society for Women and AIDS in Africa-Malawi gathered baseline data for designing information, education and communication interventions to help girls delay sexual intercourse. Specific areas of interest were: problems, responsibilities and aspirations of girls; knowledge about sexuality, pregnancy, and STDs; attitudes and beliefs about sexual intercourse; age of first sexual intercourse; and reasons for starting sexual intercourse.

Methods: Thirteen focus groups consisting of 90 participants were interviewed in Lilongwe District. The groups were composed of school girls and out of school girls(8 to 16 years old), school boys and out of school boys(8 to 18 years), parents, traditional counsellors, teachers, and three groups of religious leaders.

Results : All Children interviewed indicated that they had sexual intercourse. Reasons included money, pleasure, desire and force. Parents and traditional counsellors attributed early sexual behaviour to disobedience and lack of discipline.
Factors leading to early sexual intercourse included opportunities for sexual pairing, peer and parental pressure, community leniency lack of parental guidance, early initiation ceremonies, social changes which destroy traditional ways, and difficulty in dealing with desire.
Misconceptions included beliefs that pregnancy cannot result from "bush sex", sexual intercourse lasting less than five minutes, if girls remain still and hold their vaginas tight, or by tying a string of herbs around a girls waist. Myths included that girls must sleep with men to mak their breasts grow and induce menstruation. Semen is believed to contain vitamins and is essesial for female orgasm. All groups were aware that AIDS is sexually transmitted and has no cure, and that HIV infected people may not show signs of AIDS.
Condoms were blamed for bursting, sticking inside women, and encouraging promiscuity.
Suggestions for delaying sexual intercourse included: reviving traditional values, involving governmnt in moral education, educating traditional counsellors, increasing discipline among youth, and encouraging people living with HIV/AIDS to testify.
Conclusions: This study revealed that some girls start sex as young as 8 years. Reasons and contributing factors were identified as were myths and misconceptions about sexuality. People aware of STDs and HIV/AIDS. Suggestions on how to delay sexual activity and recommendations for designing educational and policy initiatives are made.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 6 17 20 72 117 ____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

ATTITUDES TOWARDS VIRGINITY & ITS EFFECTS ON SEXUAL BEHAVIOUR IN A SAMPLE OF SRI LANKAN YOUTH

RATNAYAKE P.H.*; SILVA T.U *; DE SILVA M.W.A. Schensul S **; * U.of Peradeniya,Peradeniya, Sri Lanka.; ** UCONN Health Centre, Farmington, CT.USA.

OBJECTIVES : The objectives of this assessment were to look at: 1. Attitudes towards virginity 2. Whether these attitudes have a direct bearing on the sexual behaviour.

METHOD: Structured open - ended interviews were conducted by trained peer interviewers among undergraduate students in the University of Peradeniya and unmarried youth of the same age group in an urban working class area of Kandy, Sri Lanka.

RESULTS: Preliminary analysis of the results show that 20/31 strongly believe that virginity should be preserved till the time of marriage. There is no significant difference between males and females and both groups seem to hold this attitude very strongly.When the actual practices were analyzed of the twelve who have had premarital sex only one has had penetrative sex. The most frequently indulged in premarital sexual behaviour was interfemoral sex. (described as using the thighs). Of the twelve who have had premarital sex 8 have had interfemoral sex. The main reason for these practices is the concern for preservation of virginity rather than fear of pregnancy.

CONCLUSION: Concern about virginity appear to have a protective effect in the spread of HIV/AIDS due to other sexual practices taking the place of penetrative sex. These findings will be used to educate the undergraduates and the working class youth about risk behaviour related to HIV/AIDS.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 17 19 48 154 ___ ___

BEST AVAILABLE COPY

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Mothers and Daughters: How the Relationship Affects HIV Risk of Low Income Adolescent Females in Recife, Brazil

Ana Vasconcelos; Garcia V. Casa de Passagem, Recife, Brazil.

Objectives: 1) Identify the factors that place adolescent girls at risk of HIV infection. 2) Analize the processes by which sexual attitudes and behaviors of adolescent females are influenced by those of their mothers.

Methods: In phase 1, group exercises were conducted with 10 adolescent girls to obtain qualitative data about family relationships, sexuality, pregnancy, and STD/HIV. These girls were trained to administer a questionnaire to 255 young women aged 13 to 19 from low-income communities. In phase 2, a series of focus group discussions were conducted with young women and mothers of adolescent females to better understand adolescent's perceptions about virginity, marriage, fidelity, and their self-esteem and autonomy. A meeting is planned with adolescent girls and mothers to discuss the findings.

Results: Young women's communication patterns, information and health seeking behaviors are influenced by the importance attached to preserving virginity. They fear that talking about sex or carrying condoms will label them as sexually active regardless of the true extent of their sexual activity. To take precautions against pregnancy and STD/HIV is to assume an active sexual life which is not in line with traditional norms of conduct for young women. Mothers act as gatekeepers in preserving their daughter's virginity. For example, according to one girl, "for an adolescent to go to a health post she has to go with her mother. Imagine if I ask my mother to take me to a gynecologist, she will say I am no longer a virgin." Mothers expect that their daughter will marry as a virgin even though they were not. For girls from low income communities, virginity is linked to perceptions of self-worth and value. Despite these pressures, many girls are sexually active. Although mothers were the most frequently mentioned source of information about sex for survey respondents, the information given mainly referred to menstruation and pregnancy. Mothers said they feel powerless and unprepared to orient their daughters about sexual matters. It is common for mothers to throw a daughter out of the house upon discovering she is no longer a virgin or is pregnant.

Conclusion: Findings underscore the need for interventions aimed at young women to address the mother-daughter relationship and to include opportunities for mothers and daughters to work together to improve women's sexual health.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 2 24 59 67 ___ ___

Original Abstract

Haiti Condom Social Marketing Program: Safety Net - Private Sector Condom Distribution vs. Free Condom Distribution in time of crisis

Complete as indicated on this insert

Cato, Michele*; Clark, R.*; Génécé, E.**. *PSI/Haiti; Port-au-Prince, Haiti; **AIDSCAP/Haiti, Port-au-Prince, Haiti.

Deadline: 1 February 1995

Objectives: The point to be made in raising the issue of social marketing (private sector) distribution versus free distribution is one of systems sustainability (or a "safety net") in times of crisis. The program's objective is to show the relative effectiveness of private sector condom distribution when other, free distribution, systems break down during periods of extreme political and economic strife.

Methods: Haiti serves as a case study. An international embargo, political instability and serious security concerns during the first two years of the condom social marketing project created unique conditions that allow for a retrospective study of systems effectiveness. During that period, approximately 15 million "free" condoms were distributed through Non-Governmental Organization (NGO) family planning systems. Almost eight million condoms were socially marketed for AIDS prevention and distributed through the existing commercial infrastructure. Condom distribution fluctuated over time and in response to outside stimuli (including the collapse of transport systems when Haiti literally ran out of fuel and violence in the streets caused people to stay close to home). These fluctuations and stimuli are being analyzed to confirm anecdotal information regarding possible causal relationships.

Results: Discussions with distributing agencies demonstrate the effectiveness of private sector over free distribution. When NGOs were unable to distribute products, when community based distribution broke down and when users were unable to get to clinics for supplies, private sector condom distribution increased. When free condoms were not accessible, users were willing to travel short distances and spend a modest sum to protect themselves and their partners. (PANTE, the socially marketed condom, is priced at 1 gourde or 7 cents for a 3-pack.) Condoms were accessible through the private sector in spite of political and economic constraints for three reasons: 1) demand "pulled" the product down the trade chain; 2) profit margins strongly encouraged vendors to meet demand; and, 3) sales outlets existed within consumers' walking radius. Results to date, however, are anecdotal. More quantifiable results will be available in second quarter 1995.

Conclusions: Proponents of free distribution as a "safety net" seem to expect that users will be motivated and able to access relatively centralized stockpiles of condoms when distribution breaks down. This has not proven to be the case. What is true is that the free market somehow manages to function in all but the most totalitarian environments. Private sector condom distribution simply allows market forces to work their magic.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 52 143 44 113 67 23

Original Abstract

NGO Condom Social Marketing in Haiti - A Motivating Model For Condom Promotion and Distribution.

Complete as indicated on this insert

Génécé Eddy*; Cato M.**; Frison P.***; Frey M.****.
*FHI/AIDSCAP, Port-au-Prince, Haiti; ** PSI; *** IMPACT/Interaide; **** FHI Project Consultant.

Deadline: 1 February 1995

Introduction: Since June of 1992, many Haitian NGOs collaborating with AIDSTECH/AIDSCAP have been converting from free condom distribution to the sale of Haiti's socially marketed "Pantè"(Panther)condom thru a private sector initiative funded by the United States Agency for International Development USAID/Haiti.
Objective: To increase condom distribution in Haiti while promoting the development of a more sustainable distribution infrastructure and offering NGOs an alternative source of funding.

Methods: All NGO outreach workers participating in the program receive training in basic communication skills, sales techniques, marketing strategy, product pricing structure and program logistics. Pantè condoms are sold by NGO outreach workers directly to individuals in program target areas and wholesale to boutiques, bars, and other small businesses which have not traditionally been used as condom sales outlets.

Results: During the first 9 months of the project, 4 NGOs have introduced condom sales through a vast network of over 175 community-based AIDS educators located throughout the country. Two years later, 8 additional NGOs and small youth organizations joined the network and provided Haiti's social marketing program with a greatly expanded national distribution capability. From a total of over 8 X 10^6 condoms sold during this period, 41% of the total were distributed through these NGOs.

Conclusions: A modest commission on sales through NGO was given to the outreach workers. This was highly motivating for them, and contributes to their continued interest in these activities. Most importantly, there is no conflict of interest between the actual maintenance of condom outlets and conducting educational activities. Condom sales are considerably higher in areas where the population is more AIDS-aware and the demand for condoms has been increased through prior educational interventions.

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 52 143 49 64 191 83

Original Abstract

Against All Odds; Towards a new definition of Social Marketing and the Tanzania experience.

Manchester, Timothy G; Timyan, J; Lucas, B; Clark, R. Population Services International. Tanzania AIDS Project/Social Marketing Unit.

Objectives: Traditionally Social Marketing programs have been defined in terms of communications strategies and borrowing of selective commercial marketing techniques. As social marketing programs worldwide graduate from the exotic to a necessary part of any national program, the traditional definition of social marketing becomes less appropriate. Using the Tanzania program as a example, 20 social marketing programs Africa wide were polled to determine what program managers felt were the common factors that drove the program forward and made them "successful" (or not!).

Methods: A questionnaire was prepared and administered by e-mail to 20 social marketing programs managers Africa wide. As necessary, the questionnaire was supplemented by additional questions or interviews. The observations and conclusions were framed in the context of the Tanzania Condom Social Marketing program.

Results: The traditional definition of social marketing definition does not explain why programs work in Africa, and where to continue to focus efforts if other programs are going to benefit from the "lessons learned". In many cases, the sacred tenets of Social Marketing programs are needlessly consuming large amounts of time and resources when the investment is unwarranted. Other basic tenants are ignored.

Conclusions: The authors wish to present a new and more complete definition of social marketing that takes into consideration the important successes of the past few years.

Topic No.	1					
Key Word No.	7	77	80	113	115	141

Original Abstract

BEST AVAILABLE COPY

Assessment of the Distribution Network of Condoms in Honduras

Ardón, Lombardo*; Soto, R.J.*; Coca, A.**; Loux, L. **; Núñez, (
Paredes; M.*; Menjívar, A.*; Fernández J.*
* Division STD/AIDS, Ministry of Health, Tegucigalpa, Hondura:
** Unit of Population and Health, Mission USAID, Teguciga
Honduras.

Complete as indicated on this insert

Deadline: 1 February 1995

Objectives: The objectives were oriented to identify: 1) the availability of condoms in central store as well as at periferical level; 2) the components of the distribution system the efficiency of condoms distribution system at the hea services and other distribution centers; 4) the accessibility condoms from general population; 5) the availability application of norms related to storage, need assessme distribution and transportation of condoms.

Methods: Ninety percent of the health districts were included us a non-probabilistic sample technique. Interviews using a se structured questionnaire were conducted with key-informants. Th were health personnel and some people of key-sites (bars, mote brothels). Also the storage sites and distribution centers w observed. The data entry and analysis were made using EPII version 5.

Results: Ninety-seven percent of the health services (HS) visi don't have enough amount of condoms available for distributior the moment of the visit. Furthermore, 10% of the HS deliver conc only by medical prescription. However, all the HS visited prov condoms without cost. In general, the HS make their condom r assessment every 3 months to the regional level. The servi network of the Ministry of Health (MOH) also includes Commur Health Workers (CHW) like midwifes and health volunteers, who condom providers too. Condoms are distributed directly to gene population by HS, also some specific groups are outreached, instance 98% of Commercial Sex Workers (CSW) have g accessibility, but their condom needs often are not satisfied; bars and motels can get condoms freely, but not in a peric basis; some military units get condoms from MOH through milit health facilities, however many soldiers come to the MOH cent for condoms. The warehouses and HS visited have the handbook norms related to storage and transportation, but these are not w applied.

Conclusions: In general, the condom availability at the warehou have been acceptable, but not always good at the periferical lev It is necessary to improve the condom promotion among hea personnel as well as CHW. Limitations like medical prescriptior get condoms must be eliminated. The CSW are not getting required amount of condoms to satisfy their demand. The norms storage and transportation of condoms should be reviewed in or to improve the quality control.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) ____ ____ ____ ____ ____ ____

Original Abstract

National AIDS Control Policy Planning for Condom Requirements Forecasting.

Complete as indicated on this insert

Deadline: 1 February 1995

Wasek, Glenn K.* **; Thomas S.**, Paterson P. **; Baggaley R.***, Fernandes M.E.L.****. * Harvard School of Public Health, Boston, MA, USA; **John Snow, Inc. FPLM Project, Rosslyn, VA USA; *** National AIDS Control Programme, Zambia, **** AIDSCAP, Brazil.

Objective: Developing condom requirements estimates within the policy planning cycle is essential for National AIDS/STD Prevention Programs. The objective of this project was to examine the condom requirements forecasting estimates within the policy planning cycle for National HIV/STD Prevention Programs.

Methods: Financed by USAID's Family Planning Logistics Management Project (FPLM), this project examines current practices of condom requirements estimation and procurement and includes a review of current condom requirements estimation methods. Two practical models were developed for use by National HIV/STD program planners: 1) A Policy Planning Model - integrating a condom requirements and procurement cycle; and, 2) A Forecasting Condom Requirements Estimation Model (FOCUS) - that is sensitive and reliable to population segment differences in condom acceptance and use.

Results: Project findings are that condom requirements are often considered too late in the policy planning cycle to assure an adequate condom supply. In addition, comparison of data from most condom requirements estimations models shows a tendency to under-estimate condom needs of population segments at high risk of HIV and over-estimate general population demand for condoms. The new models developed in this project increase the accuracy of condom requirements estimation and service delivery planning. FOCUS has been instrumental in identifying the need for condom programming in many National AIDS Control Projects including Brazil, Zambia, Dominican Republic and Namibia. Simulation models are demonstrated.

Conclusions: Often neglected by policy-makers, integrating a forecasting method into the policy planning cycle is critical for condom procurement, distribution, and availability for HIV/STD prevention and control activities.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 140 115 146 52 24 171

Original Abstract

Brazil Logistics Management of Essential Commodities for AIDS Prevention

G.Wasek*,P.Paterson*,L.G.M.Rodriguez**,A.Machida**,A.M. Plucienik**,T.Ninomya**,F.Lopes**,M.E.L.Fernandes***.
*Harvard University/JSI,**Brazil Public Health System, ***AIDSCAP

Complete as indicated on this insert

Deadline: 1 February 1995

Objectives: The majority of prevention and treatment efforts, including government programs, NGOs, and community-based interventions, rely on the Government of Brazil(GOB) Public Health System (PHS) for STD and AIDS pharmaceuticals as well as condoms for free distribution. However, lack of essential commodities is a grave impediment to controlling the AIDS epidemic. This logistics management project is a multi-year collaboration of the Government of Brazil and JSI, supported by USAID and AIDSCAP. The objective is increasing the availability and accessibility of pharmaceuticals and condoms through improved logistics management systems in the PHS.

Methods: A four-part strategy includes: 1.Creation of an Essential Commodities Distribution System (ECDS) vertically in the PHS under the control of AIDS Division Directors, 2.Implementation of an Essential Commodities Management Information System (ECMIS) to control inventory and evaluate results, 3.Identification and training of AIDS Division Logistics Coordinators, 4.Technical support for PHS forecasting, health planning, and procurement of condoms, pharmaceuticals and other essential commodities.

Results: 1.The ECDS has been implemented, resulting in greater security and control of commodities, 2.The ECMIS has been implemented, linking stock control information between the States and Federal levels, 3.Logistics coordinators have been transferred from other section of the PHS to the AIDS Divisions, 4.The GOB has received a World Bank loan for a USD $250 million AIDS Prevention Project. Logistics management systems will be used for stock control and program evaluation of this project.

Conclusions: This Project has applicability to many nations with historical problems with control of commodities within the public health system. For effective AIDS Prevention efforts, essential commodities must be available and accessible to people at high risk of HIV. This Project demonstrates the practical steps, strategies, and systems necessary in assuring commodities are controlled and distributed effectively.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 24 95 115 121 139 16

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Integrating HIV/AIDS Prevention into the Royal Thai Army Reduces HIV and STD Risks Among Young Thai Conscripts.

Celentano, David D.*; Bond, K.*; na Chiangmai, C.**; Vaddhanaphuti, C,**; Eiumtrakul S.***; Beyrer C.*; Nelson K.E.*. *Johns Hopkins University, Baltimore, MD, USA; **Chiang Mai University, Chiang Mai, Thailand; ***Royal Thai Army Medical Corps, Chiang Mai, Thailand.

Objectives: We estimate the impact of behavioral interventions designed by and with men conscripted into the Royal Thai Army in the upper north provinces in May and November 1993 on HIV and STD incidence and behavioral risk reduction. We determined how frequently men who were assigned to the experimental intervention acquired new STDs, and compared these rates to men in a control condition.

Methods: We conducted baseline assessments of behavioral risk factors for HIV infection and obtained sera for ascertainment of antibodies to HIV, as well as tests for prevalent STD infections. Serial blood draws and interviews were conducted at six and 12-months following conscription. Sera reactive to ELISA were confirmed with Western Blot. The behavioral intervention was limited to men conscripted in November 1993, and focused on reducing alcohol use and brothel patronage and improving sexual negotiation and condom use skills. This occurred in intensive small group sessions, with messages reinforced during basic training, by continuing education instructors, by the monks, as well as by the company officers and enlisted men. Battalions and companies in eight camps were assigned to the intervention, and adjacent (near-by) units were designated as "diffusion" groups, in which we sought to determine the "spill-over" of our intervention. Men conscripted in the May 1993 lottery were assigned to be controls.

Results: Through the 12-month follow-up interview and specimen collection, significant differences in the different treatment groups have been identified. For the experimental subjects, there have been no HIV seroconversions during the period of observation, as compared to 0.9 per 100 person-years in the control condition. While approximately 30% of conscripts reported a lifetime STD at induction, incident STDs were reported as 1.5 per 100 person-years in the experimental group, as compared to 0.45 in the diffusion condition, and 2.50 in the control group. Experimental subjects were less likely to visit CSWs (24% at 12 months) than diffusion (30.8%) or control subjects (42.6%), although nearly all visitors reported condom use. Finally, condom use with girlfriends was significantly higher in experimental than control subjects (53% vs. 40%).

Conclusions: These results demonstrate that significant behavior change can occur,

Topic No. 1 Select one from Key List

Key Word Nos. (Select four to six) 5 10 19 52 73 158

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Participatory Evaluation Methods for Community-Based AIDS Programs: Lessons from Uganda.

Coghlan, A.*; Ssembatya J.**; Mireego, E.**; Lumala, R.**; Lwanga, T.**. *Cornell University, U.S.A.; **Rakai AIDS Information Network (RAIN), Uganda.

Objectives: The objectives of this study were to: 1) devise and implement a feasible evaluation plan that uses participatory evaluation methods and satisfies major stakeholders' evaluation requirements and 2) assess the effectiveness of the participatory evaluation methods in empowering communities to respond to HIV/AIDS.

Methods: To further empower communities in their fight against HIV/AIDS, community members were involved in different stages of the evaluation through the following participatory evaluation methods: a series of participatory design workshops; participatory sample selection; evaluation presentation and feedback sessions; and community assessment and action planning sessions. In this last method, community members identified remaining HIV-prevention problems based on evaluation results, and devised their own program objectives and action plans.

To assess the effectiveness of the participatory evaluation methods, key informant interviews and reflective group discussions were held with participants at the end of the evaluation, and two and four months after the evaluation was completed.

Results: As a result of using the participatory evaluation methods, community program implementors and community leaders reported increased community acceptance of and support for RAIN's programs, a greater sense of community ownership for the program, and increased motivation and cohesion among community implementors. In addition, implementors reported an increase in the distribution of condoms and community members being HIV tested.

Conclusions: There are numerous advantages in incorporating participatory evaluation methods into evaluation efforts, particularly when trying to empower communities. Although these methods may be demanding in terms of time and resources, they should be an integral part of any community-based AIDS program. RAIN's use of participatory evaluation methods may serve as a model which can be adapted to other circumstances.

Topic No. 7 Select one from Key List

Key Word Nos. (Select four to six) 74 68 6 80 ___ ___

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Sample design and selection for social research: the experience of conducting quantitative KABP surveys on AIDS in Eastern Caribbean countries

Gayle, C.*; Davis, J.,**; O'Neil, C.,*; Taylor, N.,*; *Caribbean Epidemiology Centre (CAREC) (PAHO/WHO), Trinidad; **Systems Caribbean Limited, Barbados.

Objectives: Baseline surveys were conducted in four Eastern Caribbean countries in 1990 and 1991 to support the design of USAID funded AIDS/STD communication and education campaigns. The surveys were aimed at gathering information about knowledge, attitudes, beliefs and practices (KABP) with respect to HIV infection, AIDS and the other STDs, as well as safer sex practices and condoms as a method of risk reduction.

Methods: Study populations comprised individuals aged 15 years and over in four countries, the population sizes of which ranged from 50,000 to 130,000. For this first round of studies considerable effort was put into applying random sampling methodology. Stratification was based on electoral or health districts and samples of households were drawn in each stratum. (Sample size was proportionate to the population of the district). Systematic sampling was used to select households in three countries and cluster sampling methods were applied in the fourth. One respondent was interviewed in each household selected.

Results: Researchers obtained sample sizes large enough to enable them to carry out the required statistical analyses and draw inferences about the population with some confidence. The positive aspects of adopting a "purist" approach and opting for random sampling methodology were demonstrated in these studies. However, logistical problems associated with implementing this type of sample design were numerous and they impacted significantly on costs. Discrepancies between maps and descriptions of electoral districts made identification of boundaries difficult. Most countries lacked well defined systems for numbering households, thereby introducing the potential for bias in household selection. Major efforts and resources were required to find the selected respondent at home, especially if the person was a young male. Because communities tended to be small the selected respondent was often suspicious of why he or she had been singled out for the interview, especially when the subject matter was a sensitive one such as AIDS. In light of these experiences a decision was taken to use qualitative research methods in the next round of AIDS/STD KABP studies.

Conclusions: Project designers and researchers should recognize the value of using both quantitative and qualitative research. Qualitative research can serve as a tool for generating ideas, be a preliminary step in the development of quantitative studies and help researchers understand the factors underlying the target population's behaviour. However, it is not always an appropriate substitute for quantitative studies, notwithstanding the difficulties associated with designing and selecting a representative sample. It may be argued that HIV/AIDS and STD infection are not randomly distributed in the population and related studies should have designs which would allow them to target groups (using age, gender or some other attribute) as opposed to weighting the data afterwards. It could be a worthwhile exercise to compare experiences in using various sample designs in the Caribbean so that optimal strategies can be identified for future quantitative research projects in the region.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 18 20 83 121 ____ ____

Complete as indicated on this insert

Deadline: February 1995

CARE Vietnam's action research approach on HIV/AIDS, the results and ramifications for future policy and programming.

Paula F. Kelly: CARE International, Vietnam.

Objectives: To address the HIV/AIDS pandemic in a systematic but culturally appropriate and practical way in Vietnam from the very start of the epidemic, thus minimizing the spread of the virus by resoursing the institutions and community.

Methods: An action research methodology was developed and utilized (plan, execute, evaluate, change, plan etc.) within the areas of (1) advice, advocacy and consultation, (2) IEC, (3) Direct assistance (e.g. research, training) and (4) Indirect assistance (e.g. locating donors). This eclectic methodology was tailored to the government, local community institutional needs and changed over the development of the HIV/AIDS pandemic. Target groups were young men, women, decision makers and health professionals. The action research was scientific, humanistic and democratic. Following these principles, it was practice-based and action-oriented.

Results: The approach has produced two major research documents which have changed the AIDS program emphasis from "at risk groups" to "at risk behaviors" and exposed the reality of attitudes and practices in the Vietnamese cultural context which impact on the spread of HIV/AIDS. It has developed, utilized and documented culturally appropriate qualitative and quantitative research and analysis methodologies some never used in Vietnam before. The approach has resoursed and trained key decision makers and HIV/AIDS workers which has augmented the following: skills and knowledge, research, analysis, communication with audience targetting, networking, evaluation and monitoring, media, funding, counseling, strategic planning, care, community involvement, consumer involvement, education. It has also developed and tested a behaviour change model which has been effective in Vietnam. Regionally CARE Vietnam has had input into Cambodia and Laos HIV/AIDS programs using lessons learned to date.

Conclusions: The approach has proven to be the backbone of the HIV/AIDS country strategy. It developed slowly but remained culturally appropriate at all times. The lessons learned have been of use to all those working in the HIV/AIDS field in Vietnam and regionally for project formulation, planning, prevention and support programs. The void in research and services which have been identified are now starting to be filled by NGOs, government and communities via international and local donor bodies through complementary programming in a coordinated and systematic way.

Topic No. 2 Select one from Key List

Key Word Nos. (Select four to six) 7 14 19 59 66 141

Complete as indicated on this insert

Deadline: 1 February 1995

Title: The Bangkok Behavioral Surveillance Survey (BSS): Methodology and Use in HIV Prevention Programming

Mills, Stephen*, Bennett, T.*, Benjarattanaporn, P.*, Na Pattalung, R.**. *AIDSCAP/FHI, Bangkok, Thailand. **Office of Population Technical Assistance (OPTA), Bangkok, Thailand.

Objectives: To track HIV and STD risk behaviors and their correlates in selected target populations over time

Methods: The BSS consists of repeated cross-sectional surveys every 6 months of seven target groups in Bangkok: service workers, factory workers, direct commercial sex workers (CSW), indirect CSWs, vocational students, male STD clinic attendees, and antenatal care clients. Target groups matched in part those of similarly scheduled HIV sero-surveys. Lists of potential sampling sites were obtained from the Bangkok Metropolitan Administration. Sites were randomly chosen and accessed through the assistance of district AIDS committees. Questions in the survey were carefully selected to measure sexual behavior, types of sexual partners, condom use, and other exclusive items of interest. Qualitative research was conducted to assist in questionnaire design and in the explanation of risk behaviors.

Results: Three rounds of the BSS have generated high risk behaviors in the sampled populations and indicated correlates of risk. Results include 1) high but inconsistent condom use between CSWs and clients 2) low condom use among CSWs and non-paying sex partners 3) different risk profiles between direct and indirect CSWs 4) low condom use between casual partners and between spouses 5) Sexual activity among single women and correspondingly low condom use.

Conclusions: In the complex decision-making process of choosing target groups and designing interventions for those groups, the BSS can assist by illustrating specific risk behaviors and their correlates. It can also provide general (non-intervention specific) evaluative indicators of whether a set of interventions have met their behavioral goals or whether certain risks persist, perhaps indicating the need for a strategic change in interventions. Furthermore, the BSS can be used as a policy tool for advocacy and funding purposes by exposing gaps in prevention coverage for specific target groups.

Topic No 3 Select one from Key List

Key Word Nos (Co...

Complete as indicated on this insert

Deadline: 1 February 1995

Strategic Planning For AIDS Prevention in Five Indonesian Cities

Wiebel, W.*; Douglas, D.**; Fernandez, G.**; Djaelani, J.**. *University of Illinois, Chicago, USA; **PATH, Jakarta, Indonesia.

Objectives: HIV is introduced and spread within previously unexposed regions through identifiable vectors of transmission. This formative research seeks to develop and refine a Rapid Ethnographic Assessment Protocol to use in association with surveillance data in order to provide a solid epidemiologic foundation for targeting appropriate AIDS prevention measures in an efficient and effective manner.

Methods: Our protocol incorporates a broad range of existing data and potential sources data in formulating regional epidemiologic profiles. These include: 1) desk survey of HIV/AIDS surveillance data and indirect indicators or markers of high risk behavior; 2) indepth interviews with local authorities and key informants to identify and characterize subpopulations engaging in high risk behaviors; 3) focus group discussions and indepth interviews with members of target subpopulations to identify the nature and scope of high risk behaviors; 4) direct observation of target groups in community settings to document patterns of interaction and the social context within which risk behavior is engaged.

Results: Data for this 5-city assessment are being collected and analyzed. Preliminary findings reveal; 1) HIV infection has already been introduced to key subpopulations who engage in high risk practices which are likely to sustain increasing rates of HIV incidence, 2) a widespread recognition among public health authorities as to the seriousness of the current situation with a willingness to accept technical assistance in formulating intervention strategies, 3) a high degree of AIDS awareness with significant misinformation among subpopulations at high risk, and 4) an opportunity to integrate STD diagnosis and treatment within HIV prevention measures targeting commercial sex workers. Once completed, the assessment findings will be made available to interested donor agencies for possible support of intervention programming. The assessment protocol transfers qualitative data collection skills that will assist provincial decision makers to design and refine appropriate prevention strategies.

Conclusion: It is possible to collect and analyze both quantitative and qualitative data of value for planning and deployment of AIDS prevention strategies over a relatively short period of time, even before HIV is clearly established in a community. The Rapid Ethnographic Assessment Protocol (REAP) developed and refined in Indonesia may prove of value to public health authorities elsewhere in need of strategic planning to allocate limited AIDS prevention resources.

Topic No. 3 Select one from Key List

Key Word Nos. (Select four to six) 18 7 102 13 ____ ____

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Partner Referral as a component of Integrated STD Services in Two Rwandan Towns.

Steen R*, Soliman C**, Bucyana S***, Dallabetta G*. * FHI/AIDSCAP; Programme de Lutte contre le SIDA, MINISANTE, Rwanda; *** USAID/Kigali.

Objectives: To reduce the prevalence of STD in the community through referral and epidemiologic treatment of the sexual partners of patients treated for STD.

Methods: Partner referral was initiated as part of upgrading STD services in primary health facilities in two semi-urban Rwanda towns. After syndromic management of the presenting complaint, index patients received prevention education and condom demonstrations, and were urged to refer sexual partners to the health center for a free examination. Partner referral coupons linked by code number to the symptomatic index patient were given to facilitate referral; no identifying information was collected on the partners of the index patients.

Results: Three quarters of the symptomatic patients seen at the two primary health care facilities were women, many of whom had clinical and/or laboratory evidence of cervicitis. Overall, the ratio of referred to index patients was 26%. Only 58% of index patients accepted partner referral coupons, however. The referral rate for those who did accept coupons was 45%. Partner referral worked best for regular partners. Most index patients and partners were married and only four index patients referred more than one partner. Women index patients, especially when pregnant, were more successful in referring partners than men. Index patients who referred partners tended to be older than those who did not. Presenting symptoms of vaginal discharge, awareness of STD symptoms in the partner, and syndrome diagnosis of cervicitis were associated with a higher rate of partner referral.

Conclusions: Efforts to improve the rate of partner referral in this setting should begin at the clinic level with improved counseling to convince more index patients of the importance of partner referral. Partner symptom recognition may be useful both for the identification of symptomatic women and for increasing the rate of partner referral. Other strategies are needed to identify non-regular partners. Policies that could negatively influence partner referral rates, such as cost recovery for STD medications, should be re-evaluated.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 149 95 17 73 ____ ____

270

Original Abstract

Complete as indicated on this insert

Deadline: 1 February 1995

Comparison of Data on Quality of Provider Performance on STD Case Management: Direct Observations, Provider Interviews, and Simulated Patients.

Franco L*, Costello Daly C**, Chilongozi DA***, Liomba NG***, Dallabetta G*.
* AIDSCAP/FHI, USA. ** John Snow, Inc., USA (Affiliated with Family Health International at the time of survey.); *** National AIDS Control Programme, Malawi;

Objectives: This study examines the reliability and validity of several methods for assessing the quality of STD case management: direct observation, provider interviews, and data from simulated patients (observers posing as STD patients), in order to provide insights into methods for supervising provider performance in STD case management.

Methods: Data were collected as part of an STD baseline survey in Malawi, using an adaptation of the WHO Protocol for Assessment of STD Case Management Through Health Facility Survey. For the purpose of this analysis, a total of 49 providers were observed managing 1 to 10 STD patients and were also interviewed. Twenty of these providers were also visited by a trained observer posing as a urethral discharge patient. Agreement between the different methods was assessed using the Kappa statistic.

Results: Examination of consistency of data from direct observation showed that providers do not carry out prescribed tasks on all STD patients: on average, only 66% of providers carried out any specific task on their STD patients. For those who were not consistent, this did not appear to be related to patient order. Provider interview data showed large variations in probed and spontaneous responses to question about their usual patient care activities, with spontaneous answers often being lower than observed performance, while probed responses indicated better performance. In general, agreement (based on the Kappa statistic) between direct observation and provider interviews was poor, with the exception of some aspects of the physical examination and treatment. Agreement between direct observations and simulated patient data was also generally poor, regardless of whether direct observation was measured on the basis of performing the task on all patients or only on some patients.

Conclusions: These results indicate that direct observation data may be the best option. However, the data should not be assumed to reflect normal levels of quality of care, but rather to reflect the best possible performance that health workers can do. Provider interviews should be viewed with caution, and taken to reflect knowledge but not necessarily practice. Probing is a useful technique during interviews, as long as the information from probed responses is recorded separately from spontaneous responses: observed performance can be expected to lie somewhere in-between. Simulated patient data is probably the best measure of normal performance, but feasibility of using this method is limited, especially given the inconsistency of provider behavior and thus the need for multiple simulated patients per provider.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 10 18 117 95 74

Origin: Abstract

Study of Urethritis Management in Pharmacies in São Paulo,Brazil.

Complete as indicated on this insert

Lima Vasco Carvalho Pedroso de*,Brito G.S**; Fernandes M.E.L.***; Fini G.I.**; Ribeiro M.A.**; Morais J.C.*; Souza,G.et Cols*-*Santa Casa Medical School,SP - Brazil
**Associação Saúde da Família, SP-Brazil; ***Family Health International, SP-Brazil

Deadline: 1 February 1995

Introduction: STD prevention and control play an important role in the Prevention and Control of HIV infection. Since diagnosis and treatment interrupts the chain of transmission of STD and reduces the changes of HIV infection curing sexual contact, this project analyze the behavior of pharmacy clerks towards men with urethrites in São Paulo, Brazil.
In Brazil men rely on STDs self-treatment through antibiotics obtained at pharmacies(estimated at 50-70% of STDs occurrences among men by MOH AIDS/STD Division).

Objective: To determinate the attitude of pharmacy clerks (P.C.) towards men with symptoms of urethritis.

Methods: This study was conducted in 93-94. The municipality of São Paulo is divided in districts. The geographic downtown district was demilited and a list of 400 pharmacies 53(13%) were randomly chosen and visited by trained medical students (T.M.S.) that presented themselves to P.C. as having pain on urination and urethral discharge. Immediately after the visit at pharmacies the T.M.S. filled out a standard questionnaire.

Results: 68% T.M.S. were diagnosed by P.C. as having gonorrhea, 11%urethritis; 9%reported that they did not know the diagnosis and 11% mentioned other causes. From a total of 53 pharmacies 74% of P.C. prescribed the treatment and only 19% recommended that T.M.S. see a physician. When we analyse the prescription of antibiotics 33% prescribed correct drugs for the treatment of gonorrhea, but none prescribed drugs for the treatment chlamydia. In 55% of the cases the drug of choice was correct, but the course of treatment was incorrect and in 12% of the pharmacies the drug of choice and the course of treatment were incorrect.
The average cost of the treatment prescribed by P.C was 21.81 USD (one third of the country minimum wage per month). Just one P.C. recommended the use of condoms and none reported that sexual partners needed a treatment.

Conclusions: 1.67% of the treatment prescribed was incorrect. 2.Chlamydia treatment was not considered by P.C. 3.Pharmacists and clerks need to be trained and be involved in STDs and AIDS prevention efforts.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 24 55 94 139 155 52

Complete as indicated on this insert

Deadline: 1 February 1995

Tutorial Training for Syndromic STD Case Management in a Kingston, Jamaica STD Clinic

Hylton-Kong Tina[1], Hoffman I[2], Williams Y[1], Brathwaite A[1], Behets F[2],Dallabetta G[3].
[1]Ministry of Health, Jamaica; [2]University of North Carolina, USA; [3]AIDSCAP, USA.

Objectives: 1) To improve the use of national syndromic algorithms for STD case management by training public health nurses, nurse practitioners and physicians ; 2) To empower nurses to make diagnostic and therapeutic decisions; 3) To evaluate the effect of this approach following training.

Methods: Training included a review of the national syndromic algorithms for urethral discharge, vaginal discharge, genital ulcer disease (GUD), lower abdominal pain and the management of sexual contacts. Learning objectives and written material on syndromic management and counseling were explained and distributed to the participants. Participants received didactic lectures and one-on-one, direct clinical observations with immediate feedback from the trainer. The training was evaluated using written, comprehensive case studies. A response was considered correct only when the diagnosis, treatment and counseling portions of each case were answered correctly.

Results: Prior to training, syndromic algorithms were not used consistently or systematically in this clinic. Although the nursing staff had been trained in the diagnosis and treatment of patients, they were reluctant to assume this responsibility. During 2 weeks in early 1995, 11 clinicians (5 public health nurses, 2 nurse practitioners and 4 physicians) participated in the training module. As the nurses gained supervised experience in the systematic use of the algorithms, a majority were observed to accept their new role as practitioners. Of the 11 trainees, 8 (73%) completed the case study evaluations (5 nurses, 1 nurse practitioner and 2 physicians). Twelve written cases: urethral discharge (2), vaginal discharge (2), GUD (3), lower abdominal pain (2), sexual contact management (3) were presented. A single point was given for each case managed correctly. Overall, 83/96 (86%) correct answers were given. All categories of providers scored above the 93% level for cases regarding urethral discharge, lower abdominal pain and sexual contacts. Only the nurse practitioner who had not been exposed to the use of a risk assessment previously, scored below the 90% level in applying the vaginal discharge algorithm. Only 67% of the nurses correctly managed GUD cases.

Conclusion: The use of individual tutoring with immediate feedback can be an effective, although labor intensive, method to improve STD case management. The public health nurses showed great improvement in their willingness and ability to diagnose and treat STDs. Although the nurses became quite proficient in applying most algorithms, one-third continued to treat genital ulcers tentatively, often based incorrectly on their clinical impression. Additional supervised training might further increase the management of GUD patients syndromically.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 107 10 95 _____ _____ _____

Complete as indicated on this insert

Deadline: 1 February 1995

STD Services for Women in Truckstops in Tanzania: An Evaluation of Acceptable Approaches

Mbuya C[1], Nyamuryekung'e K[1], Laukamm-Josten U[1], Ocheng D[1], Msauka A[1], Hammelmann C[1], Vuylsteke B[2], Outwater A[3], Dallabetta G[3], Steen R[3].
1. African Medical and Research Foundation (AMREF), Tanzania; 2. Institute of Tropical Medicine, Belgium; 3. AIDSCAP/FHI.

Objectives: To evaluate the acceptability and accessibility of four different approaches for delivering STD services to high risk women at truckstops in Tanzania.

Methods: The seven truck stops under the AMREF Truck Drivers Project were randomly assigned to one of four different STD service approaches. In approach 1, STD services were provided twice per week after working hours and outside conventional health service settings. In approach 2, services were integrated into the conventional health service settings. In approach 3, outreach STD services were offered by a team of doctors visiting the truckstops once every 3 months. Approach 4 was a control site, where services were integrated, but contrary to the other three approaches, no additional drugs were provided. In all seven sites, peer health educators (PHE) were trained in the application of a simple risk assessment for STD and to refer those found risk positive to the STD service at their site. Number of referral and attendances were monitored during the 12 months of the intervention.

Results: A summary of the acceptability of the four approaches is illustrated in the table:

Indicator	Approach 1 *Continuous*	Approach 2 *Upgrading*	Approach 3 *Intermittent*	Approach 4 *Control*
# referred and attended/total at clinic	223/553 (40%)	190/628 (30%)	360/457 (78%)	59/92 (64%)
# attending STD clinic/Average number	553/387 (1.43)	628/625 (1.00)	457/371 (1.23)	92/247 (0.37)
# referred and attended/total # referred	98/126 (78%)	62/150 (41%)	360/476 (76%)	24/36 (67%)

Conclusions: The two vertical approaches (approach 1 and 3) were found to be more acceptable to the target population of high risk women based on the indicators above. Approach 1 would be appropriate where a health facility is located in the vicinity of a truck stop and there is a clinician willing to provide these outreach services. Approach 3 would be acceptable where there are adequate clinicians and transportation. It is clear that these high risk women prefer services which maintain privacy and avoid possible stigmatization. These approaches to STD service delivery are now being implemented.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 157 7 73 47 160

Original Abstract

The MStop Experience in Cameroon: Conclusions

Complete as indicated on this insert

Crabbe Francois*, Tchupo JP**, Gruber-Tapsoba T**, Cheta C***, Timyan J **, Boupda-Kuate A****, Dallabetta G****. * Institute of Tropical Medicine, Belgium; ** Population Services International (PSI), USA; *** IRESCO, Cameroon; **** FHI/AIDSCAP, USA.

Deadline: 1 February 1995

Objectives: To improve treatment of acute urethritis in men by providing effective antibiotic regimens for gonococcal and chlamydial infection with educational material, condoms and instructions in a single package for distribution in private pharmacies and primary health care clinics.

Methods: The treatment kit contained 1 gram of cefuroxime-axetil (C-A) as a single dose and a 10-day course of doxycycline (Doxy), 200 mg/day, with eight condoms, two partner referral cards and one educational leaflet. The kit was attractively packaged and labeled with *MSTOP*. The final retail price was US$ 17.00, with the cost of antibiotics accounting for most of the price. Between June 1993 and March 1994, a limited pilot project was conducted, involving 21 health settings and 3 private pharmacies largely serving the military and student communities in the two largest cities of Cameroon. Health care providers (HCPs) were trained in syndrome management of urethritis. PSI was responsible for supplying kits and monitoring sales. At the end of the pilot phase interviews with HCPs and patients were performed as was a mystery patient survey of prescribing practices of HCPs.

Results: In 10 months 1,421 kits were sold. Lower than expected sales were attributed to poor acceptance by the HCPs and cost. The cost of drugs reflected the market price in Cameroon as the kit was not subsidized. The evaluation confirmed the HCPs' reluctance to syndrome management. Only 30% of the HCPs regularly prescribed MSTOP while 32% still requested lab tests. Cited reasons for not using MSTOP included the need for lab tests, perceived lack of effectiveness of the drugs and lower profits for HCPs. In contrast, 86% of patients receiving MSTOP were pleased with the product's presentation. Reported treatment compliance was 98% for C-A and 83% for Doxy. The educational leaflet was read by 86% of the patients and 90% reported that they were satisfied with the information. The supplied condoms were used by 84% of the patients who had sex during treatment. A total of 44% used the referral cards to notify their partners.

Conclusions: From the patient perspective the concept of a treatment and prevention packet for STDs appears promising. Major barriers, however, are physician acceptance of a syndrome management approach and cost. The concept of pre-packaged therapy prevention is valuable to ensure consistent therapy by HCPs and in settings where self-medication is widespread. Pre-packaged therapy should be evaluated in other settings based on lessons learned from this pilot project.

Topic No. 4 Select one from Key List

Key Word Nos. (Select four to six) 29 7 155 73 ____ ____

275