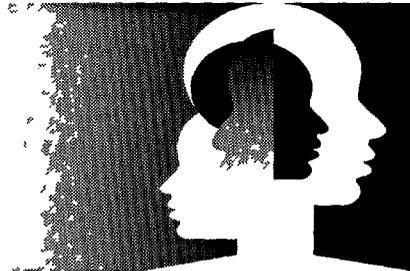


April 24-25, 1997 • Washington, D.C.  
**Seventh Meeting**



**AIDSCAP**

**T** echnical

**A** dvisory

**G** roup

**R E P O R T**



**Project 936-5972 31-4692046 • Contract HRN-C 00-94 00001-17**

The AIDS Control and Prevention (AIDSCAP) Project implemented by Family Health International is funded by the United States Agency for International Development

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# INTRODUCTION

The seventh and final meeting of the AIDS Control and Prevention (AIDSCAP) Project Technical Advisory Group (TAG) took place on April 24-25, 1997, at the Latham Hotel in Washington, D C The TAG, composed of thirteen experts in public health and HIV/AIDS prevention, has been an integral part of the AIDSCAP Project In its meetings, the TAG has evaluated the project and provided advice to AIDSCAP and the U S Agency for International Development (USAID) on strategies to achieve the project's mandate

At this meeting the TAG reviewed the lessons AIDSCAP has learned in sexually transmitted infection (STI) treatment and prevention, in reducing sexual risk, and in working with nongovernmental organizations (NGOs) and communities since the project was established in 1991 Discussion and recommendations focused on the status of the pandemic, AIDSCAP's accomplishments and legacy, future USAID HIV/AIDS prevention projects, producing and sustaining behavior change, monitoring and evaluating prevention programs, and the role that a TAG could play in future USAID HIV/AIDS projects At a number of points during the meeting, TAG members applauded AIDSCAP for the efforts that the project's staff and the implementing agency partners around the world have made and the growth in knowledge that AIDSCAP has helped produce

Dr Theodore King, president and chief operating officer of Family Health International (FHI), welcomed participants to the meeting He lauded the TAG members for helping AIDSCAP greatly expand the knowledge of successful HIV/AIDS prevention approaches

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# AIDSCAP UPDATE

Dr Peter Lamptey, the director of the AIDSCAP Project, gave an update on the HIV/AIDS pandemic, the AIDSCAP Project's activities and accomplishments, epidemiological and technical advances in HIV/AIDS, and FHI's possible role in future USAID-funded HIV/AIDS prevention projects

## **HIV/AIDS pandemic**

Cumulative adult HIV infections worldwide have climbed from 11 million when AIDSCAP began to nearly 30 million today. While some two-thirds of the HIV/AIDS infections so far have occurred in sub-Saharan Africa, the epidemic is also a growing problem in Asia. Approximately three-fourths of the persons who have become HIV-infected since the pandemic began are still living. Nevertheless, some successes have been achieved in the struggle against the pandemic. There have been declines in incidence in some populations in developed countries. Two developing countries have also reported decreases in HIV incidence: Uganda in pregnant women and Thailand in military recruits.

## **AIDSCAP activities and accomplishments**

In its work since 1991 AIDSCAP has collaborated with USAID, other donor agencies, and national AIDS programs. AIDSCAP has also worked with private voluntary organizations (PVOs), nongovernmental organizations (NGOs), universities, and government agencies as implementing agency (IA) partners on 540 AIDSCAP sub-projects. AIDSCAP has provided those various groups with technical leadership, training and capacity building, program funding, and technical assistance in program design, research, management of sexually transmitted infections (STIs), and behavior change intervention (BCI), on areas that include policy, contraceptive social marketing, and evaluation.

AIDSCAP has made significant contributions to the field of international HIV/AIDS prevention in the last five years. Among the project's attainments have been technical contributions, such as guidelines and how-to manuals, improved knowledge and skills of AIDSCAP and its partner institutions, and innovative approaches that include targeted intervention research (TIR), NGO clusters, rapid program design, areas of affinity programs, and behavioral surveillance surveys (BSS).

## **Epidemiological and technical advances in HIV/AIDS**

During the last six years AIDSCAP and other organizations have developed important new understandings of the HIV/AIDS pandemic. One example is the synergy between HIV and STIs. Researchers have also learned much about antiviral therapy, plastic condoms and other barrier methods, and new HIV testing approaches. In recent FHI work, investigators have found that nonoxynol-9 (N-9) is safe to use but does not reduce the transmission of HIV, gonorrhea, or chlamydial infections.

## **FHI's future role in USAID prevention projects**

FHI hopes to carry on its prominent role in USAID-funded HIV/AIDS prevention efforts after the AIDSCAP Project. FHI is competing for three large follow-on projects. In addition, many of AIDSCAP's activities will be continued through bilateral USAID Mission bridging programs and long-term programs, as well as regional programs of USAID and other donors.

## **AIDSCAP video**

The AIDSCAP videotape, "Global Partners in Prevention," was shown. Created for the July 1996 XI International Conference on AIDS in Vancouver, the videotape contains video footage and still photographs from AIDSCAP subprojects around the world. The tape highlights AIDSCAP's accomplishments and the continuing need for HIV/AIDS prevention activities.

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# PRESENTATIONS

## **STI treatment and prevention**

Gina Dallabetta, AIDSCAP's director of technical support, discussed the three major approaches that AIDSCAP has taken to STI clinical management, depending on the type of client

One major group of clients are those who are symptomatic and seek appropriate health care. In this area, AIDSCAP has focused on optimizing clinical management, upgrading acceptable, accessible services, such as by integrating STI treatment into public health and maternal and child health clinics, and providing preventive education at the time of clinical management, for example, by using targeted intervention research (TIR), a rapid ethnographic tool, to determine perceptions and local-language terms for STIs.

A second major group of STI clients are those who are symptomatic but who don't recognize their symptoms or don't seek appropriate care. AIDSCAP has applied TIR to assess individuals' treatment-seeking behavior, and such BCI strategies as peer education and mass media communication. AIDSCAP has also improved non-clinic health services. The project, for example, has worked with pharmacists in Nepal and has offered the MSTOP prepackaged STI therapy in Cameroon, an experiment now being planned for several other countries.

The third type of STI clients on which AIDSCAP has focused are asymptomatic persons. Strategies for this group have included decentralized syphilis screening and treatment, field testing of rapid diagnostic approaches, and applying risk assessment as a case finding tool for women. Another AIDSCAP strategy has been partner referral and treatment.

Based on the lessons AIDSCAP has learned, future STI treatment and prevention efforts will face a number of challenges. More effective behavior change communication strategies are needed for STIs, targeting community members and clinic attendees, as well as health care providers and policy makers. While syndromic management is a useful tool, it must be supplemented with partner referral and treatment, targeting services, syphilis screening and treatment, and rapid, simple, inexpensive diagnostic methods. Constraints in infrastructure and resources require such creative approaches as presumptive treatment strategies and the social marketing of STI treatment and prevention.

## **Reducing Sexual Risk**

Donna Flanagan, associate director of the AIDSCAP Behavior Change Communication unit, discussed four levels of project interventions to reduce sexual risk: individual, couple, community/institutional, and policy.

With individuals, much of AIDSCAP's work has focused on peer education (PE) and small media development. AIDSCAP now has 1,000 items in its database of behavior change communication (BCC) materials. AIDSCAP began an effort three years ago to evaluate the effectiveness of peer education, by looking at 21 PE projects in 10 countries. That research has shown that peer educators must master much new information and develop a broad set of skills. In addition, as the needs of a target audience change, so do the skills and knowledge required of peer educators. For example, educators only trained to provide STI/HIV awareness information are likely to be ineffective in the later stages of the behavior change process.

In working with couples, AIDSCAP has applied three primary methods: couples counseling, modeling and scripting new behavior, and special "dialogue" techniques between men and women. Of the three approaches, modeling and scripting has been the one used most frequently. In Haiti, for example, the project developed ten videos that people watched and then used to rehearse and role-play negotiating condom use and other new behaviors. Such BCC tools can help prepare and motivate men and women to hear and heed the concerns of their partners.

At the community/institutional level, AIDSCAP has sought to modify social norms through five types of interventions: care and support, condom social marketing, public relations, community mobilization, and interpersonal activities in the workplace and elsewhere. Improving condom availability and use has been a major AIDSCAP achievement; between 1991 and 1996 the project distributed more than 230 million condoms. AIDSCAP has also shown that NGOs can become important social marketing partners. That was true in Haiti, where condom sales continued to climb during a period of political and economic crisis. AIDSCAP has also found that providing low-cost subsidized condoms or even free ones has a promotional "halo effect" and does not undercut commercial condom sales.

To reach policy makers and people who advise them, AIDSCAP has used such methods as policy assessments, mathematical modeling, socioeconomic impact studies, advocacy and consensus building, cost analysis of interventions, and private sector leveraging. AIDSCAP applied a number of those strategies in Kenya, where the project produced a comprehensive book, *AIDS in Kenya*. With topics ranging from the epidemiologic aspects of the epidemic to HIV/AIDS and Christianity, the text was an integral part of a successful policy reform effort. Another AIDSCAP achievement has been tapping private sector resources for HIV/AIDS prevention. In Brazil, for example, with prompting from AIDSCAP's country office, *Claudia* magazine has devoted nearly \$3 million worth of editorial space to articles on HIV and AIDS. In the Dominican Republic, radio, television, and cable broadcasters have contributed some \$3 million in air time to carry high-quality HIV/AIDS prevention advertisements that AIDSCAP developed.

## **Working with NGOs and communities**

Gail Goodridge, associate director of the AIDSCAP Office of Country Programs, addressed the major collaborating role AIDSCAP has given to NGOs and community-based groups, such as religious organizations, the for-profit commercial sector, and coalitions and networks. These organizations offer a number of strengths, including

understanding vulnerable populations, having an established status, effectively linking prevention and care, combining flexibility and a long-term commitment to their communities, and being able to play an advocacy role

Working with community-based organizations (CBOs), however, poses a number of challenges. Many CBOs have limited skills, staffing, and funding, and lack broad geographic reach. Unaware of what other groups have already done, some CBOs fail to implement programs following "best practices." Community participation and capacity building can take time and resources away from implementation.

AIDSCAP has worked with over 400 NGOs, made more than 200 small "rapid response" grants to community organizations, and trained over 138,000 individuals in HIV/AIDS prevention. While it is often thought CBOs focus almost entirely on BCI, in some countries they have done much more. In Haiti, for example, AIDSCAP's implementing agency partners were also involved in contraceptive social marketing, AIDS care and management, and STI treatment and partner referral. AIDSCAP's Haiti experience showed that NGO training must be individually tailored, since groups vary in their levels of technical and managerial capacity. Another issue AIDSCAP saw in that country was the vulnerability of NGOs to shifts in donor priorities and funding commitments.

In Tanzania a key AIDSCAP innovation has been NGO clustering. Between ten and twenty community-based groups, each with its own specific strengths, unite to form a "cluster," with a joint workplan and budget and shared monitoring and evaluation activities. Eighteen months after that experiment began, there are now 181 NGOs participating in nine clusters. These clusters have impressive geographic reach and excellent linkages with the government. On the other hand, they can be difficult to adequately support and can become too broad and unwieldy, thus losing a clear vision and strategy.

From this deep, broad experience with NGOs and communities, AIDSCAP has learned that community-based groups can make impressive contributions to HIV/AIDS programming, and that existing organizations generally make more effective partners than newly created ones. To ensure community participation, however, there is no single "best practice." The most appropriate approach will depend on the local culture and each NGO's status or stage of development. AIDSCAP has also learned that capacity building should not be directed solely at skills needed to implement a project in the short run. Rather, capacity building should focus on "organizational excellence," in such areas as leadership, creativity, sustainability, and strategic planning.

Working with NGOs poses a number of challenges. Successful interventions will need to be scaled up. Effective models of coalition building must be identified and disseminated. NGOs need effective, easy-to-use research tools that will help them in program design, monitoring, and evaluation. Also required are better indicators of NGO capacity building and community participation, along with the ability of local groups to adapt and refine those indicators for their specific needs.

Several other major issues need to be addressed in future efforts with NGOs. One is whether or not to develop minimum criteria to select groups to work with—such as only the strongest ones. Another question is the appropriate division of resources between NGO capacity building and program implementation. A third issue is the sustainability of community led responses, given the inherent fragility of community-based institutions that deliver appropriate solutions.

## **USAID's strategic objectives and future directions**

Paul DeLay, chief of USAID's HIV/AIDS Division, reviewed the agency's major HIV/AIDS prevention activities since 1991 and USAID's plans for the next five years. Over the last ten years agency funding for HIV/AIDS programs has grown much more slowly than HIV incidence, and since 1993 that funding has remained flat. On the other hand, HIV/AIDS funding has not fallen in recent years in spite of cuts in U.S. foreign aid, including in the overall area of population, health, and nutrition.

AIDSCAP has been just one component of the USAID Global Bureau HIV/AIDS portfolio. Other activities carried out since 1991 have included policy and social science research by ICRW and IPPF, mobilization and capacity building by NCIH, the HIV/AIDS Alliance, and the Peace Corps, surveillance by the Bureau of the Census, biomedical research by PATH and the Population Council, and funding for United Nations agencies.

In planning for HIV/AIDS activities that will follow AIDSCAP and other current procurements, USAID applied a participatory planning process. Meetings and workshops that began in August 1995 led to the production of a Universal Framework of Objectives (UFO). That document identified USAID's HIV/AIDS priorities and is guiding the agency's current procurement process. The new USAID projects will continue such proven interventions as behavior change, access to barrier methods, improved STI prevention and management, policy reform, and biomedical research. Additionally, the follow-on programs will incorporate community-based responses with an emphasis on the private sector and sustainability, a "prevention to care" continuum, impact analysis that looks at costs and cost-effectiveness, biological surveillance, and improved operations research and technical assistance to USAID Missions. The new USAID procurements will include three major projects—though none approaching the scale of AIDSCAP—and several smaller ones. One of the major projects will be a "think tank" focusing on global leadership in operations research on STIs, BCI, social marketing, and other subjects. A five-year project, it will have \$40 million in funding, all from USAID core moneys.

The two other new large HIV/AIDS projects will concentrate on field implementation, one on social marketing and the other on prevention interventions that include STIs and BCI. A major challenge for USAID's HIV/AIDS Division will be to ensure that these new projects share their experiences and lessons learned with each other.

USAID expects to award the contracts for the three major new projects this summer, with the programs to be in operation by the end of this year.

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# DISCUSSION

The TAG discussion focused on the following issues

## Depth and breadth of prevention efforts

At several points on both days of the TAG meeting, members discussed the concern of depth versus breadth in the HIV/AIDS prevention efforts of AIDSCAP and other organizations. In smaller countries, such as Haiti and the Dominican Republic, AIDSCAP's programs have been almost national in scope. In larger countries, such as Brazil and Nigeria, this has not been the case.

Such terms as "depth" and "breadth," however, can sometimes be hard to define—and evaluate. One reason for that are the differences between such one-on-one approaches as peer counseling that AIDSCAP has applied in numerous countries and the broad-scale methodology of mass media campaigns, such as AIDSCAP's work with *Claudia* magazine in Brazil. Another factor can be the "intensity" of prevention efforts, that is, the degree to which persons receive the same message a number of times from various sources. Prevention efforts that focus on high intensity may be more effective than ones that concentrate on creating "perfect" messages, a TAG member suggested. Two countries that have conducted broad, intense national HIV/AIDS prevention campaigns are Thailand and Uganda, and they have had some of the best results in the world. Several TAG members suggested future USAID projects research and develop guidelines for the appropriate "mix" of prevention activities that a country should apply, including what would constitute a good "basic package" of prevention services.

## Demand for STI services and integrating them with other services

There is an ongoing need to better integrate STI treatment and prevention with family planning and maternal and child health services. This has been done effectively in Jamaica, which has applied a policy of double protection—a family planning method and an HIV/AIDS prevention method.

More needs to be done to create a demand for STI services, several TAG members suggested, such as by improving service quality and promoting prepackaged STI treatment. There must, however, be adequate resources, including condoms and drugs, to satisfy any increased demand, a TAG member pointed out.

There are still several barriers to creating effective STI programs, TAG members said. STI treatment programs lack the cost data available to family planning and some other health efforts. Improved prevention indicators are also needed, to help monitor and evaluate the effectiveness of STI treatment programs.

Prevention programs must work with policymakers to ensure sufficient STI funding and to see that STI programs are structured appropriately. National guidelines for STI programs should be created, including identifying a "basic package" of STI services.

## **Producing and sustaining behavior change**

AIDSCAP has looked at a number of behavior change theories, but has not advocated any single one, in part because many theories don't take into account the cultural differences between countries. Applying a combination of theories may be the best way to guide behavior change programs.

Several TAG members mentioned the difficulty of sustaining behavior change over the long term. This is true as people dissolve stable partnerships and as new generations of young persons must be reached with prevention messages. While some AIDSCAP focus groups have looked at relapse behavior, future HIV/AIDS prevention projects should focus more on that. HIV/AIDS prevention programs, one TAG member suggested, could learn lessons from other health issues where relapse is a frequent problem, such as smoking, exercise, and weight loss.

## **Monitoring and evaluating prevention programs**

TAG members frequently mentioned the issue of monitoring and evaluating AIDSCAP's various efforts. While individuals' behavior changes must be assessed, there is also a need for systems to monitor policymaking and entire national programs, several TAG members said. And while policy indicators are often difficult to develop, information can come from such data as free mass-media time made available to promote condom use and the establishment of policies for condom-only brothels or the acceptance and regulation of commercial sex work.

The use of surrogate markers was discussed. An AIDSCAP staff member commented it's unclear whether behavioral indicators or biological data are better, but that one can supplement the other. One TAG member noted the role that broad-based HIV testing has played in successful national AIDS efforts, such as in Uganda and Thailand. The cost of that testing, however, is high and may not be sustainable with just local resources. In Thailand, where experiments have tried out various levels of user fees for testing and counseling services, every increase in those charges has reduced the demand for the services.

## **NGO roles and capacity**

While NGOs and other CBOs have played a vital role in AIDSCAP, there are limits to the capabilities and capacities of such groups, TAG members noted. Concentrating on NGOs can sometimes create tensions with governments, which resent the loss of control and funds going to the private sector. In some cases governments may even shift inherently governmental responsibilities onto community groups. On the other hand, some governments have become more willing to work with NGOs as the need for HIV/AIDS support and care services has grown and governments have recognized how limited their own resources are. Donors themselves should also work to promote effective public/private collaborations. In Honduras, for example, AIDSCAP encouraged the government and NGOs to form a partnership. Another way to promote cooperation is through NGO capacity building. Groups can be taught analytical skills to look beyond the specific populations with which they work and see regional and national needs as well, a USAID staff member suggested.

Various approaches to measuring NGO capabilities have been tried. With self-reporting, there may be bias if NGOs feel their assessment will affect their funding, one TAG member noted. An AIDSCAP staff member commented that if NGOs do exaggerate their capacities, those embellishments will become obvious over time, such as by observing the educational materials the groups produce. Another way to judge NGOs' capabilities is by having the AIDSCAP country offices work with the groups to create annual workplans and to have periodic reviews during the year to measure the progress each of the NGOs is making toward achieving its goals.

Related to capacity building for NGOs, several TAG members noted, is the issue of sustainability. AIDSCAP has assisted organizations with this concern in a variety of ways, such as training them on fundraising, proposal writing, and diversifying revenue sources. AIDSCAP has also tried to help NGOs change their "mindset" to one of a small business, as well as through the creation of umbrella groups that can help small NGOs and CBOs be more competitive.

### **AIDSCAP's lessons and dissemination efforts**

A number of the TAG members commented on AIDSCAP's substantial achievements and valuable lessons learned over the life of the project. Many members also expressed worries about a loss in continuity between AIDSCAP and follow-on projects. Several TAG members urged AIDSCAP to focus heavily on synthesizing and disseminating its experiences during the time remaining in the project.

### **Future role for a TAG**

Asked about the function a TAG could serve in future HIV/AIDS prevention projects, one TAG member suggested the advisory group deal with both policy and technical issues. She also suggested the TAG play an advocacy role. The group could push USAID for needed policy changes where it would be inappropriate for FHI as a contractor to do that. The TAG could also serve as an advocate for the HIV/AIDS Division within the overall USAID structure.

A USAID staff member said the agency will likely want to reconvene the present AIDSCAP TAG membership during the early stages of follow-on HIV/AIDS projects, to seek the group's advice on those new efforts.

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# RECOMMENDATIONS

Among the recommendations TAG members made during their discussions were

## **USAID HIV/AIDS prevention projects after AIDSCAP**

TAG members expressed concerns about the continuity between AIDSCAP and future USAID-funded HIV/AIDS prevention projects. Some members said momentum and valuable time would be lost if USAID chooses an organization other than FHI for the follow-on contracts. One TAG member suggested USAID rethink its contracting process for HIV/AIDS prevention projects, so that contractors are not phased in and out. TAG members also suggested USAID maintain greater continuity in its HIV/AIDS programs by awarding contracts longer than five years and by using some contractor selection method other than the current competitive bidding process.

## **Monitoring and evaluation**

Several TAG members made recommendations on monitoring and evaluation of HIV/AIDS projects. They suggested that monitoring methods for national AIDS programs be put into place wherever possible, and that AIDSCAP and follow-on projects help promote that. One TAG member suggested an international conference be convened to look at such long-unresolved issues as what elements a national monitoring system should have.

## **AIDSCAP dissemination**

One TAG member suggested AIDSCAP use the project's subcontractors to help write journal articles and other materials to disseminate AIDSCAP's lessons learned. Another TAG member proposed the project contact journal editors about producing special journal issues or supplements that would gather in one place many AIDSCAP lessons. She also recommended AIDSCAP include domestic audiences in its dissemination activities because of the many lessons that could be transferred from international settings to the United States.

## **The future of a TAG**

Several TAG members suggested changes in meeting procedures. One person recommended that at each meeting members look back at the preceding gathering and assess whether the TAG's recommendations from it had been followed. Another member suggested that the TAG incorporate some of the practices of the CDC advisory board, which meets every six months and where members are asked questions in advance to discuss at each meeting. Such an approach, he said, allows the board to look at both large and small issues and helps promote continuity in its advisory function.

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# APPENDIX A.

## Agenda

Seventh Meeting of the AIDSCAP Technical Advisory Group

*April 24-25, 1997*

*The Latham Hotel, Washington, D C*

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### Thursday, April 24

8 00 a m - 8:30 a m	<b><i>Continental Breakfast</i></b>
8 30 a m - 8 35 a m	<b><i>Welcome and Introductions</i></b> Theodore King President & Chief Operating Officer FHI
8 35 a m - 9 00 a m	<b><i>HIV/AIDS Pandemic and AIDSCAP Update</i></b> Peter Lamptey FHI Senior Vice President for AIDS Programs
9 00 a m - 9 15 a m	<b><i>AIDSCAP Video</i></b>
9 15 a m - 10 00 a m	<b><i>Discussion among TAG Members about HIV/AIDS Pandemic and AIDSCAP Update</i></b> Facilitator Jane Bertrand Rapporteur Judith Wasserheit
10 00 a m - 10 30 a m	<b><i>Coffee break</i></b>
10 30 a m - 11 00 a m	<b><i>STD Lessons Learned</i></b> Gina Dallabetta
11 00 a m - 12 30 p m	<b><i>Discussion among TAG members of STD Lessons Learned</i></b> Facilitator Jane Bertrand Rapporteur Fernando Zacarias
12 30 p m - 2 00 p m	<b><i>Luncheon</i></b>
2 00 p m - 2 30 p m	<b><i>Lessons Learned in Reducing Sexual Risk</i></b> Donna Flanagan

2 30 p m - 3 30 p m	<b><i>Discussion among TAG Members of Reducing Sexual Risk Lessons Learned</i></b> Facilitator Jeff Harris Rapporteur Geeta Rao Gupta
3 30 p m - 4 00 p m	<b><i>Coffee Break</i></b>
4 00 p m - 5 00 p m.	<b><i>Continued Discussion among TAG Members of Reducing Sexual Risk Lessons Learned</i></b> Facilitator Jeff Harris Rapporteur Geeta Rao Gupta
5 00 p m - 5 30 p m	<b><i>USAID's Strategic Objectives/USAID's Future Directions</i></b> Paul DeLay
5 45 p m - 7 45 p m	<b><i>Reception/Cocktail</i></b>

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**Friday, April 25**

8 00 a m - 8 30 a m	<b><i>Continental Breakfast</i></b>
8 30 a m - 9 00 a m	<b><i>Lessons Learned in Working with NGOs and Communities</i></b> Gail Goodridge
9 00 a m - 10 30 a m	<b><i>Discussion among TAG Members of Lessons Learned in Working with NGOs and Communities</i></b> Facilitator Wendy Roseberry Rapporteur Victor Barnes
10 30 a m - 11 00 a m	<b><i>Coffee Break</i></b>
11 00 a m - 12 30 p m	<b><i>Final Discussion and Recommendations</i></b> Facilitator Helene Gayle Rapporteur Judith Wasserhert

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# **APPENDIX B.**

## **TAG Meeting Participants**

### **Members and Observers**

#### **April 24-25, 1997**

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#### **TAG MEMBERS**

**Dr Seth Berkley**  
Rockefeller Foundation

**Dr Jane Bertrand**  
Tulane University

**Dr Peter Figueroa**  
Jamaica Ministry of Health

**Dr Helene Gayle**  
CDC

**Dr Geeta Rao Gupta**  
ICRW

**Dr Jeffrey Harris**  
CDC

**Dr Allan Ronald**  
St Boniface Hospital

**Ms Wendy Roseberry**  
World Bank

**Dr Allan Rosenfield**  
Columbia University

**Dr Werasit Sittitrai**  
UNAIDS

**Dr Gary Slutkin**  
University of Illinois

**Dr Judith Wasserheit**  
CDC

**Dr Fernando Zacarias**  
PAHO

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#### **OBSERVERS**

**Mr Victor Barnes**  
CDC

**Dr Peter Benedict**  
FHI

**Mr Bob Bernstein**  
USAID

**Dr Amy Bloom**  
USAID

**Dr Ward Cates**  
FHI

**Mr Peter Clancy**  
PSI

**Mr Guy Stallworthy**  
PSI

**Mr Robert Clay**  
USAID

**Ms Lynda Cole**  
FHI

**Dr Paul DeLay**  
USAID

**Dr Barbara de Zalduondo**  
USAID

**Ms Holly Fluty**  
USAID

**Mr Alan Getson**  
USAID

**Dr Theodore King**  
FHI

**Dr Elaine Murphy**

PATH

**Dr John Novak**

USAID

**Ms Joy Riggs-Perla**

USAID

**Ms LaHoma Smith**

**Romocki**

FHI

**Dr Jim Sitrick**

USAID

**Ms Shelley Smith**

Peace Corps

**Mr Jack Thomas**

USAID

**Dr Peter Lamptey**

AIDSCAP

**Mr Tony Schwarzwald**

AIDSCAP

**Ms Sheila Mitchell**

AIDSCAP

**Mr Tony Bennett**

AIDSCAP

**Dr Godfrey Sikipa**

AIDSCAP

**Dr M Ricardo Calderon**

AIDSCAP

**Mr Mike Lavelline**

AIDSCAP

**Dr Gina Dallabetta**

AIDSCAP

**Ms Gail Goodridge**

AIDSCAP

**Ms Donna Flanagan**

AIDSCAP

**Ms Mary O'Grady**

AIDSCAP

**Dr Thomas Rehle**

AIDSCAP

**Dr Joan MacNeil**

AIDSCAP

**Dr Bill Rau**

AIDSCAP

**Mr Bill Schellstede**

AIDSCAP

**Dr E Maxine Ankrah**

AIDSCAP

**Ms Martha Riley**

AIDSCAP

**Ms Diana Randall**

AIDSCAP

**Mr Todd Fortune**

AIDSCAP

**Mr Bill Black**

AIDSCAP