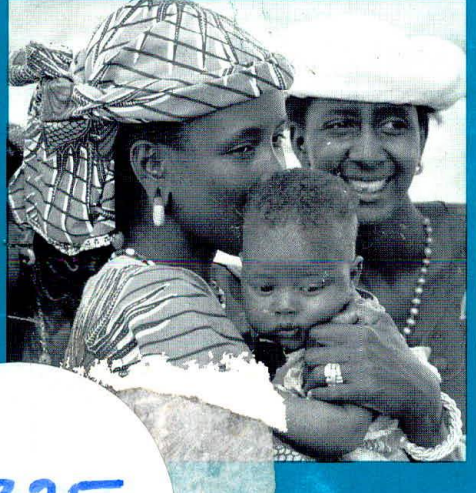
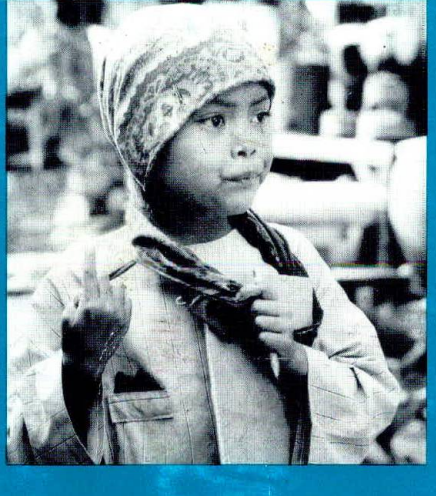
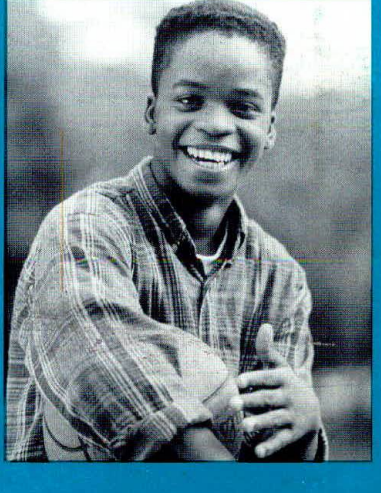
# Making Prevention Work

## *Global Lessons Learned from the AIDS Control and Prevention (AIDSCAP) Project 1991-1997*

AIDSCAP









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AIDS Control and Prevention (AIDSCAP) Project, implemented by Family Health International,
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# Acronyms

| | |
|---|---|
| **AIDSCAP** | AIDS Control and Prevention |
| **AMREF** | African Medical Research and Education Foundation |
| **ARLS** | Association Rurale de Lutte Contre le SIDA (Sengalese NGO) |
| **AWI** | AIDSCAP Women's Initiative |
| **BAP** | Bhoruka AIDS Prevention (Indian project) |
| **BCC** | Behavior change communication |
| **BMA** | Bangkok Metropolitan Administration |
| **BSS** | Behavioral surveillance surveys |
| **CAPS** | Center for AIDS Prevention Studies (University of California at San Francisco) |
| **CDS** | Centre Pour le Développement et le Santé (Haitian NGO) |
| **COIN** | Centro de Orientación e Investigación Integral (Dominican NGO) |
| **CRS** | Contraceptive Retail Sales (Nepali company) |
| **CSM** | Condom social marketing |
| **C&T** | Counseling and testing |
| **FGD** | Focus group discussion |
| **FPAN** | Family Planning Association of Nepal |
| **GLAS** | Groupe de Lutte Anti-Sida (Haitian NGO) |
| **GPA** | Global Programme on AIDS |
| **GUD** | Genital ulcer disease |
| **GWP** | General Welfare Pratisthan (Nepali NGO) |

| | |
|---|---|
| **IEC** | Information, education and communication |
| **ISSS** | Instituto Salvadoreño de Seguro Social (Salvadoran Social Security Institute) |
| **KABP** | Knowledge, attitudes, beliefs and practices |
| **KANCO** | Kenya AIDS NGOs Consortium |
| **KAPC** | Kenya Association of Professional Counselors |
| **LAC** | Latin America and the Caribbean |
| **MCH** | Maternal-child health |
| **MOH** | Ministry of Health |
| **NGO** | Nongovernmental organization |
| **PHC** | Primary health care |
| **PI** | Prevention indicator |
| **PSAP** | Private Sector AIDS Policy |
| **PSI** | Population Services International |
| **SSM** | Servicio de Sanidad Militar (Guatemalan military health service) |
| **STD** | Sexually transmitted disease |
| **TAP** | Tanzania AIDS Project |
| **TCI** | Transport Corporation of India |
| **TIR** | Targeted intervention research |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **USAID** | U.S. Agency for International Development |
| **WHO** | World Health Organization |

# Making Prevention Work

By far the most ambitious international HIV/AIDS prevention effort ever undertaken, the AIDS Control and Prevention (AIDSCAP) Project worked with more than 500 nongovernmental organizations (NGOs), government agencies, community groups and universities to strengthen the response to the epidemic in 45 countries. The project, which was funded by the U.S. Agency for International Development (USAID) and implemented by Family Health International (FHI) from August 1991 to December 1997, managed 584 projects and activities in Africa, Asia, Latin America and the Caribbean.

In six years, AIDSCAP trained more than 180,000 people in a variety of HIV/AIDS prevention skills and supported the production and dissemination of some 5.8 million videos, dramas, television and radio programs and advertisements, and printed materials. These efforts reached almost 19 million people. By June 30, 1997, the total number of condoms distributed and sold by the project had exceeded 254 million.

Evaluations of programs in 19 countries suggest that these efforts had an impact on knowledge of HIV, attitudes toward those affected by the virus, perceptions of individual risk, and sexual behavior among the target groups. In Cameroon, for example, the proportion of male students who reported having sex with more than one partner dropped from 53 to 36 percent in three years. In Nepal, 62 percent of sex workers in the AIDSCAP intervention area reported using condoms with their most recent client in 1996—up from 35 percent in 1994—while reported condom use actually decreased among sex workers in areas that had not benefited from AIDSCAP interventions. And in Jamaica, where the majority of the population now reports some kind of behavior change to avoid HIV infection, the percentage of 12- to 14-year-old boys reporting sexual experience fell from 59 to 41 percent.

AIDSCAP interventions were built on three strategies for reducing HIV transmission: communication to encourage people to avoid behaviors that put people at risk of infection, improving treatment and prevention of other sexually transmitted diseases (STDs), and increasing access to and correct use of condoms. These central technical strategies were supported by policy development, behavioral research, evaluation, gender initiatives and capacity building.

Communication to encourage behavior change was at the heart of all AIDSCAP interventions. Through technical assistance, training and distribution of a series of handbooks, the project promoted a shift from the old information, education and communication (IEC) model to a more systematic approach that gives people the knowledge, skills, encouragement and support they need for HIV risk reduction. Behavior change communication (BCC) efforts used the results of epidemiological and social science research to design creative interventions that called on the talents of artists, writers, actors, producers, counselors and community members.

AIDSCAP was one of the first organizations to adopt STD prevention and treatment as a primary HIV/AIDS prevention strategy. The project's most important accomplishment in STD programs was increasing the use of syndromic case management, an approach that has improved access to effective STD services for tens of thousands of people. AIDSCAP conducted studies to validate and adapt syndromic management algorithms, worked with local officials and providers to develop national case management guidelines, and trained providers, program managers and pharmacists in the syndromic approach in 18 countries. The project also developed a methodology for conducting rapid ethnographic studies designed to improve communication between health care providers and their clients and tested several innovative approaches to expanding access to STD treatment.

Although millions of free condoms were distributed as part of AIDSCAP interventions, social marketing was the project's main strategy for increasing condom use. Using commercial distribution systems and marketing techniques, AIDSCAP and its partners sold more than 222 million condoms in eight countries.

The project also revised the traditional social marketing model, developing innovative distribution strategies and opening thousands of nontraditional sales outlets to provide reliable, affordable condom supplies to those at greatest risk of HIV infection.

These efforts to change behavior and provide the services individuals need to act on behavior change messages were bolstered by policy development initiatives to create a more supportive environment for HIV risk reduction. Recognizing that policy development must be initiated and sustained locally, AIDSCAP provided technical assistance, training and information to strengthen the capacity of individuals and organizations to inform and influence policy. Strategic use of analytic tools, including policy assessments, socioeconomic impact models and cost analyses, helped influence the HIV/AIDS policies of governments, businesses and religious organizations in Kenya, Tanzania, Senegal, Indonesia, the Dominican Republic, El Salvador, Honduras and Nicaragua.

**Evaluations of programs in 19 countries suggest that AIDSCAP efforts had an impact on knowledge of HIV, attitudes toward those affected by the virus, perceptions of individual risk, and sexual behavior among the target groups.**

Behavioral research activities provided the scientific foundation needed to design effective interventions and built the capacity of more than 150 social scientists and 100 institutions to conduct such research for HIV/AIDS prevention. The scale of the research conducted by AIDSCAP and its host-country partners ranged from small, program-related studies of behavior among specific populations to a large efficacy trial of voluntary HIV counseling and testing in three countries. Research studies and pilot interventions produced recommendations and models for addressing emerging issues such as the role of structural and environmental interventions in HIV risk reduction, prevention options for women in stable relationships, and the linkages between HIV prevention and care.

AIDSCAP advanced the practice of HIV/AIDS evaluation by refining existing methods and testing innovative approaches. Detailed evaluation plans were designed for each of the 19 country programs at the outset, and implementation of these plans yielded important lessons for evaluators worldwide as well as evidence of changes in knowledge, attitudes and risk behaviors. New tools developed by the project will help evaluators overcome some of the limitations they face in assessing progress in HIV/AIDS prevention. One example is the behavioral surveillance survey methodology AIDSCAP pioneered in Bangkok, which enables evaluators to monitor trends in risk behavior among different target groups and has already been adapted in eight countries.

Through the AIDSCAP Women's Initiative, the project played an important role in raising awareness among policymakers and program managers about women's vulnerability to HIV infection and the need for more gender-sensitive prevention efforts. AIDSCAP used gender analysis and training to help project staff and implementing partners strengthen their interventions to meet the needs of both men and women. It also worked with international and local women's organizations to em-

power women to protect themselves from HIV infection. AIDSCAP-sponsored research offered valuable insights into the barriers to sexual communication, the role of peer support in sustaining use of the female condom, and ways to encourage dialogue between men and women.

Management systems linking AIDSCAP headquarters, regional and country offices, and host-country implementing partners created the infrastructure needed for successful implementation of technical strategies. In addition to creating systems for planning, monitoring, financial management and reporting for the world's largest international HIV/AIDS program, AIDSCAP built the capacity of more than 500 organizations to design, implement and evaluate their own prevention projects. Special initiatives were created to involve more local community-based organizations and U.S. private voluntary organizations in HIV/AIDS prevention, create indigenous NGOs to help sustain interventions, and develop models for integrating prevention into AIDS care and management programs.

Since AIDSCAP's mandate was to build capacity in prevention, its experience in HIV/AIDS care and management was limited to pilot projects in a few countries. In one country—Tanzania—AIDSCAP had the opportunity to integrate prevention and care into community-based programs in nine regions. These experiences suggest that programs are more effective when they address both prevention and care, but few studies have examined this linkage. An AIDSCAP study conducted in Tanzania—one of the first to assess whether providing support for people with HIV/AIDS can encourage them to adopt prevention measures—will offer important guidance for policymakers and program managers struggling to meet the burgeoning need for care and prevention in many countries.

AIDSCAP was also one of the first organizations to address the heightened risk of HIV infection among mobile populations. Early interventions with truck drivers and their partners along major highways in Africa were expanded to reach other mobile populations, including sailors, migrant workers, military troops and refugees. AIDSCAP's success in carrying out some of the world's earliest "cross-border" prevention projects in Asian border towns and port cities has inspired other donors to join USAID in supporting and expanding such efforts. And the first large-scale, early HIV/AIDS intervention in a refugee camp—an AIDSCAP-sponsored demonstration project in Rwandan refugee camps in Tanzania—has served as a model for reaching vulnerable refugee populations in other parts of the world.

As the AIDSCAP Project drew to a close, technical and project management staff around the world were challenged to distill what they had learned and to disseminate those lessons widely. This report presents the key lessons that applied over countries and cultures and makes specific recommendations for strengthening HIV/AIDS efforts in behavior change communication, STD services, social marketing, policy development, behavioral research, evaluation, gender initiatives, management, care and support, and programs to reach mobile populations. Each chapter ends with a list of the challenges to be met by the next generation of HIV/AIDS programs.

The replication of AIDSCAP's cross-border model, the behavioral surveillance surveys and many of its other approaches, methods and tools in countries throughout the world illustrates that one of the project's most important legacies is its experience. Learning from that experience, and using it to build more effective and sustainable HIV/AIDS programs, is the next challenge.

# 1 Behavior Change Communication: From Individual to Societal Change

Behavior change communication (BCC) for HIV/AIDS prevention has evolved into a specialized field that draws on experiences from family planning, social marketing, anthropology, psychology, education and communication. Because prevention of a deadly sexually transmitted disease is significantly different from other health promotion goals, HIV/AIDS programs have been challenged to refine traditional communication approaches to address usually private and sensitive matters such as sex, trust and death.

BCC specialists working in HIV/AIDS have also begun to broaden their approach to address the social, political and environmental factors that influence risk behavior. Experience with HIV/AIDS has made it clear that an individual can rarely sustain a change in behavior without a supportive environment.

But certain time-tested elements of health communication remain the foundation of BCC for HIV/AIDS prevention. These include identifying and segmenting target audiences, using multiple communication channels and involving target audiences in developing materials and messages. Other principles are being subtly changed to meet the needs of populations unaccustomed to sharing concerns about sexuality and of societies whose customs and structures inadvertently encourage risky behavior.

## Toward Behavior Change

AIDSCAP's behavior change communication strategy used behavioral and communication theory and research to provide a systematic framework for efforts to influence individual behaviors and the social contexts in which they occur. The project applied this strategy in more than 580 projects and activities in over 40 countries. Almost 19 million people received potentially lifesaving messages about HIV/AIDS prevention through drama, music, radio, television, video, printed materials and interpersonal communication.

AIDSCAP's BCC approach was considerably more complex than traditional health education. In many cases, it required a new way of thinking about the design and implementation of communication projects. Training and technical assistance from AIDSCAP communication officers and consultants equipped more than 180,000 outreach workers, health providers, peer educators, counselors and community leaders with the skills needed to influence and support behavior change.

UKPONG/UNIVERSITY OF CALABAR

*A Nigerian peer educator talks to her fellow sex workers about the importance of condom use.*

Technical assistance also came in the form of a series of practical "how-to" handbooks on various steps in the communication process. Project managers and BCC officers reported that AIDSCAP's series of six BCC handbooks were useful as teaching aides, reference materials, sources of new ideas, and check lists.[1] Managers of AIDSCAP-supported organizations in Ethiopia used the handbook on peer education to design all their peer education projects. The Kenyan government distributed photocopies of AIDSCAP's handbook on developing an effective HIV/AIDS communication project to 200 Ministry of Health communication officers, who were instructed to use it as their guide. In Nepal, outreach supervisors carried copies of "Assessment and Monitoring of BCC Interventions" with them so that they could use its monitoring checklists during supervisory visits. And in Laos, chapters of two of the handbooks were translated and used in workshops to develop HIV/AIDS prevention messages for projects at three different sites. "The three working teams found that the two books provided them the clearest framework for communication and BCC intervention," an AIDSCAP BCC officer reported.

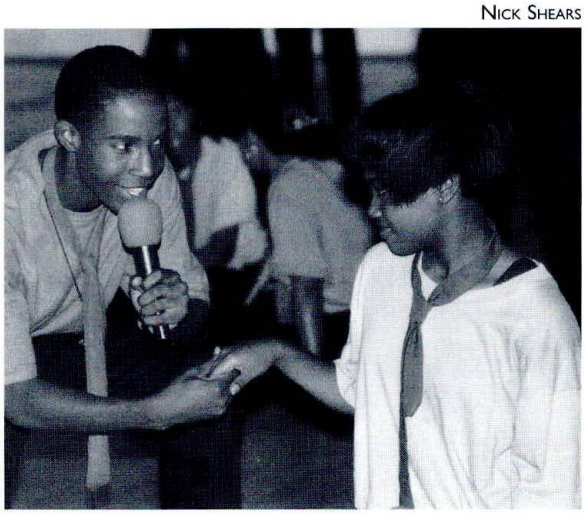
Because education by members of the target audience is an integral part of many HIV/AIDS prevention programs throughout the world, AIDSCAP encouraged its implementing partners to take a critical look at peer education projects. An AIDSCAP study of 21 such projects in ten countries examined where, when and how peer education can be used most effectively.[2] The knowledge gained from this study helped project staff develop the BCC handbook on peer education, which has been used by many AIDSCAP programs and other HIV/AIDS projects to design peer education projects and improve peer educator training curricula.

Peer educators in many countries revealed hidden talents through their participation in AIDSCAP programs. Some performed in plays, others sang about HIV/AIDS prevention, and some even showed a flair for creating cartoons to convey prevention messages. In fact, one of AIDSCAP's greatest strengths in BCC was its ability to tap the creativity of local organizations and communities to create memorable and influential BCC messages and materials. One of many examples is the Fleet of Hope, a metaphor first used by a Catholic priest in Tanzania to explain the various prevention options, which inspired actors in Ethiopia and Haiti to create HIV/AIDS dramas. In Kenya and Rwanda, groups were encouraged to write songs about HIV/AIDS in local languages that were taped and distributed to radio stations for broadcast. And the video of "Vibes" by Jamaica's Little People and Teen Players Club, with its vibrant music and its message to "wait until you have the super, safer sexual skills you need before having sex," has become an international favorite among English-speaking adolescents.

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

Evaluations of AIDSCAP programs in 19 countries suggest that BCC activities, working in combination with other behavior change interventions, moved millions of people along the behavior change continuum from knowledge to awareness to action. In Cameroon, for example, the percentage of male students who reported having more than one sex partner dropped from 53 to 36 in

NICK SHEARS



*A proposition in the schoolyard opens the popular Jamaican musical "Vibes," which encourages parents and children to talk to each other about sex, responsibility and HIV/AIDS.*

# 1.1

# Award-Winning Mass Media Campaign Reaches Youth

In quick succession, four attractive young couples—sometimes the same person but with a different partner—are each shown embracing on a couch in a dimly lit living room. In the background a singer croons the opening lyrics of a popular romantic ballad, "Solamente Una Vez": "Just one time I loved in my life, just one time and never again."

But the mood turns starkly somber as the last of the young women looks up with a grim expression and stares directly at the camera. The word "SIDA" (AIDS) in bold red letters covers her face, and a narrator takes the sweet love song and turns its meaning on its head. "AIDS. Just one time, and never again," he warns. "Protect yourself. Don't change partners. Use condoms. Because just one time is enough, and never again."

This forceful TV advertisement is one of four produced for a campaign by the AIDSCAP program in the Dominican Republic targeting adolescents and their parents. Created by the well-known Dominican advertising agency Cumbre, the spots used high-quality production techniques and attractive young actors to convey well-researched public health messages.

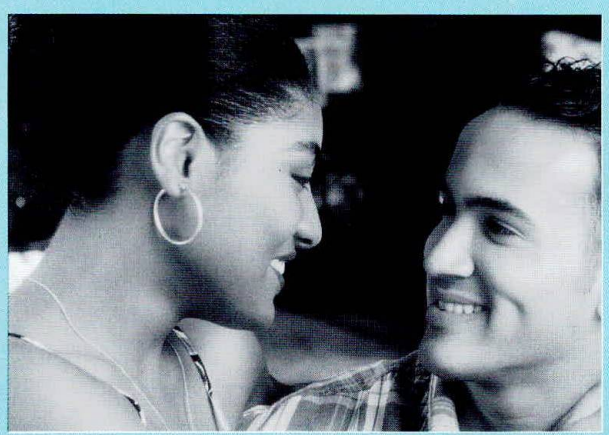
The two-year campaign confronted the attitudes and misconceptions revealed in research among Dominican youth. One ad posed a series of questions to help listeners assess their own risk. Another emphasized that "you can't guess who has AIDS" by a person's appearance. The third ad, "Solamente Una Vez," listed a telephone hot line number to call for information and referrals. The final ad encouraged parents to talk to their children about AIDS and other STDs.

Other equally polished materials developed for the campaign—including radio announcements, brochures, posters and roadside billboards—presented the same hard-hitting themes, designed to pierce young people's sense of invulnerability. "Young people don't think death exists," said Cumbre President Freddy Ginebra, "so we looked for a 'code' to challenge them and to make them think."

AIDSCAP persuaded dozens of radio and TV broadcasters and cable-

## "Solamente Una Vez"

CUMBRE



*Scenes from an award-winning HIV/AIDS prevention advertisement in the Dominican Republic show a woman embracing different partners.*

TV system operators to carry the ads for free. From September 1995 to March 1997, broadcasters contributed air time worth more than U.S.$9 million.

AIDSCAP communication officer Ceneyda Brito, who has worked on other public health campaigns in the Dominican Republic, believes one reason the broadcasters were so receptive was the high quality of the advertisements. The spots have also won praise from advertising and public health specialists throughout Latin America.

At a meeting in Mexico, for example, communication experts from 20 countries awarded their top prize to the AIDSCAP ads. And the "Solamente Una Vez" spot was the only public service announcement recognized in a nationwide competition for Dominican advertisers, receiving the second-place prize.

As attention-grabbing and persuasive as the mass media pieces may have been, they were just part of a comprehensive, well-coordinated national campaign launched in collaboration with a working group of more than a dozen Dominican youth service organizations. Print materials reinforcing the broadcast spots' key messages were distributed to government agencies, NGOs working with adolescents, radio stations, record and video stores, and movie theaters. The working group also established a referral network for adolescents' questions about HIV/AIDS and contributed to AIDSCAP's development of a manual for organizations working with youth.

Such careful coordination of numerous communication channels was vital to the success of the campaign. Close collaboration between organizations working with youth and the use of multiple dissemination paths ensured that Dominican youth received a consistent message from NGOs, the media, their parents and their peers—much more often than "just one time." ■

three years. In Thailand, 97 percent of brothel-based sex workers reported using condoms with all clients in 1996—up from 87 percent in 1993. And in Jamaica, where the majority of the population now reports some kind of behavior change to avoid HIV, the percentage of 12- to 14-year-old boys reporting sexual experience dropped from 59 to 41.

# Lessons Learned

## Beyond Awareness

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

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

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

**• If peer educators are only trained to provide STD/HIV awareness information, they are unlikely to be effective in later stages of behavior change.**

In a study of 21 peer education projects in Africa, Asia and Latin America, AIDSCAP project managers reported that they found it necessary to revisit the needs of target audiences and their expectations for peer educators.[2] When target

audiences were already knowledgeable about STD/HIV infection, peer educators needed training to acquire the skills and attitudes necessary to move on to behavior change and maintenance.

To encourage behavior change, peer educators need to know when to enlarge the basic message, when to listen, when to empathize and how to bring information on HIV/AIDS and STDs into conversations about other issues. If peer educators do not have these skills, they may be useful only in the early phases of the behavior change process, when they can promote awareness and impart knowledge.

## Private Sector Collaboration

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

For example, an AIDSCAP campaign targeting adolescents in the Dominican Republic received more than U.S.$9 million worth of free air time from the local and international media. AIDSCAP leveraged this media support by investing $53,000 in development of high-quality television and radio spots and related print materials (Box 1.1).

- **Collaboration with local communication professionals may be more cost effective than training HIV/AIDS program personnel in specialized communication skills in some settings.**

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

AIDSCAP's experience with such collaboration was rewarding. For example, a Dominican advertising agency worked with AIDSCAP staff in the Dominican Republic to design an award-winning mass media campaign for youth (Box 1.1). A Jamaican public relations firm helped AIDSCAP and the Ministry of Health design and implement a BCC strategy that created a supportive environment for individual behavior change.[3] And in Kenya, AIDSCAP worked with a Nairobi communications consulting firm to place a weekly column on HIV/AIDS in a popular national newspaper. Written by a well-known Kenyan journalist, the "AIDS Watch" column reached an estimated 700,000 people every week and generated thousands of letters from readers.

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

Condom social marketing (CSM) projects often produce excellent educational and promotional items, as well as mass media promoting brand recognition and condom use. The ability of CSM projects to place their product in the public eye helps desensitize the issue of condoms, which lays the groundwork for more focused behavior change messages.

In Nepal, for example, the CSM program developed radio and television spots and a film shown in cinema halls and from mobile film vans, which were closely coordinated with intensive outreach efforts throughout the country. By opening the topic for discussion, these mass media efforts made it easier for outreach workers to discuss HIV/AIDS with target audience members (Box 1.2). In many countries, including Ethiopia, Tanzania and Haiti, condom advertising on radio and television were an integral part of national risk reduction campaigns.

## Communication Tools

- **Because sexual issues are more sensitive for many people than other kinds of public health topics, drama and other entertaining forms of behavior modeling can be a particularly effective way of helping target audiences move beyond awareness to behavior change.**

Live and taped dramas were used throughout the AIDSCAP Project to show models of behavior change situations and to give audience members a comfortable opportunity to consider the implications of their behavior. Communication officers and project managers reported that a dramatic format is a good way to introduce and illustrate serious issues such as sexual negotiation, HIV/AIDS care and support, and stigma and discrimination.

Jamaica's Targeted Community Intervention, for example, enlisted the help of one of the island's most famous comedians to broach the subject of HIV/AIDS with residents of inner-city communities. Project manager Audrey Wilson Campbell

noted that the use of comedy was very effective because "it was non-threatening, but we were getting to the root of the issue." In the Dominican Republic, "provocative theater" (a type of street theater performed in bars or on the street, which an unsuspecting public does not know is a rehearsed drama) is used to simulate situations in which women express themselves confidently and men learn to listen to their point of view on a sexually related problem.

AIDSCAP used these models to give women and men opportunities to rehearse and develop their own sexual negotiation skills. A Jamaican communication officer noted that because it depicts the everyday life of people and "makes room" for discussion, "community theater is the most effective tool we have."[3]

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

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

An AIDSCAP study conducted in eight countries used the behavior change continuum concept to question BCC officers and program managers about the perceived impact of their work. Typical of many responses is this, from Zimbabwe: "In the beginning we were at awareness—they knew there was some problem, but they were not particularly concerned. And now I think we are bouncing back and forth between motivation and trial. We're distributing a lot of condoms—about 450,000 this year—so that's some trial."[4]

Recognition that change is a process and that messages must be appropriate to the stage of change requires considerable ingenuity from BCC specialists. In Cameroon, projects working with somewhat cohesive and homogeneous groups such as sex workers and military personnel found that members of their target population generally moved along the change continuum at a similar rate. However, university students in the same country presented a greater challenge. Because they entered the university with different levels of understanding about HIV and because upper class students had more exposure to prevention education, the large target group of "university students" was segmented according to their positions on the change continuum, and messages and approaches were tailored for these various segments.[5]

- **Some BCC messages and materials have universal appeal.**

Although BCC messages and materials should always be pretested with members of the intended audience, it may not be necessary to develop new materials for each target group. In fact, AIDSCAP has found that some messages transcend culture and nationality. A study of several AIDSCAP materials that have been used or adapted throughout the world found that they appealed to people from many different cultures because they addressed universal concerns.[6]

In Tanzania, for example, a brochure about "The Fleet of Hope," was designed to help individuals and communities with diverse religious backgrounds and moral beliefs understand the impact of HIV/AIDS and assess their own risk. It advises readers to board one of three "boats"—abstinence, monogamy or condoms—to save themselves. This metaphor and the options it offers proved popular and effective in at least eight countries in Africa,

HENRY GAKURU

*A counselor discusses condoms with a woman whose husband has "inherited" the wife of a brother who died of AIDS. AIDSCAP found that performances like this one by Kenya's Miujiza Players are a particularly effective way to address sensitive issues.*

# 1.2

# AIDSCAP in Nepal: Comprehensive Behavior Change Communication

One of the first things a truck driver espies as he enters the bustling town of Hetauda is a ten-foot-high billboard featuring Dhaaley Dai, the condom cartoon character that serves as the logo for AIDSCAP's program in Nepal. Most travelers along the road from Kathmandu to the Indian border are familiar with Dhaaley's message: "Wear condoms. Drive away AIDS."

When he stops at a friend's stand to buy a soft drink, the truck driver can buy a packet of the Dhaal condoms prominently displayed on the shelves, and he may hear a Dhaal jingle on the radio. In the early evening, he might join a few hundred people gathered around a video van to watch Hindi music videos and the HIV/AIDS prevention film, "Guruji Ra Antare."

If the truck driver spends the night in one of Hetauda's many hotels for travelers, he is likely to meet a friendly outreach worker or peer educator who will help him assess his risk of contracting HIV/AIDS or other STDs. And if he expresses concern about possible STD symptoms, the outreach worker will give him a referral card for a local center that provides diagnosis and treatment. Should he decide to go to a pharmacy instead of the STD center, the driver will probably find that the person behind the counter was trained by AIDSCAP to dispense the appropriate drugs for different STD syndromes.

This comprehensive approach to prevention education—one of the hallmarks of true behavior change communication—was typical of the AIDSCAP program in Nepal. Designed to reach truck drivers and their assistants and sex partners along the main transport routes in Nepal's Terai region, the program used a variety of communication channels and carefully coordinated them to ensure that the target audiences received consistent messages.

One example of this coordination was the creation of the program's mascot. Seeking to design a communication campaign that was memorable and not "too preachy," the Stimulus Advertising Agency contracted by AIDSCAP decided to build on the name recognition achieved by previous condom social marketing efforts for family planning in Nepal. Working with Nepal Contraceptive Retail Sales (CRS), the Nepali company responsible for the social marketing component of AIDSCAP's program, Stimulus named its condom character "Dhaaley," an affectionate version of the CRS condom brand name Dhaal (shield), and "Dai," meaning big brother.

JOY POLLACK/AIDSCAP

*Dhaaley Dai, the mascot of the AIDSCAP program in Nepal, is paraded down the streets of Kathmandu.*

This lovable cartoon character appeared on program materials, billboards, signs, advertisements, and condom packages and displays throughout the Terai region and starred in radio public service announcements. A large inflatable Dhaaley Dai even presided at dozens of public events.

The popularity of Dhaaley Dai was matched only by that of Guruji and Antare, the title characters in AIDSCAP's film about the adventures of a truck driver and his hapless assistant. Like the condom character, the film uses humor to convey a serious message: Condoms are strong, durable, and the only way to protect yourself from HIV/AIDS and other STDs if you cannot remain faithful to one partner. Video van showings of the film, along with popular music videos, drew hundreds of people to enjoy the free entertainment, and thousands more read the companion Guruji and Antare comic book.

After the film had introduced the program's messages in a village or town, outreach workers would follow to reinforce those messages with street dramas about HIV/AIDS and through informal conversations. The outreach workers of AIDSCAP's NGO partner, General Welfare Pratisthan (GWP), and the peer educators they trained reported that the mass media communication—particularly the radio spots—enhanced their credibility with target audiences and made it easier for them to talk about controversial topics such as sexuality and STDs.

But one-on-one outreach was the core of the communication program, allowing members of the target audience to ask questions and seek advice from a trusted source. Dedicated outreach workers and the peer educators they had trained reached some 50,000 people during the four-year project.

The key to effective BCC is to ensure that people can act on program messages. In Nepal, where outreach workers and mass media messages urged target audiences to use condoms and seek prompt STD treatment, AIDSCAP coordinated its BCC efforts with the services necessary for these HIV prevention measures. The condom social marketing project provided convenient access to condoms at hundreds of outlets along the highway, and STD training workshops for health providers, family planning staff and pharmacists created a reliable referral network for effective STD treatment.

The results of a 1996 evaluation suggest that this comprehensive approach was successful. Survey responses revealed that target audiences had received and understood the project's messages, and both sex workers and their clients reported increased condom use. In fact, the percentage of sex workers who said that their most recent client had worn a condom increased from 35 percent in 1994 to 61 percent in 1996, while reported condom use actually fell from 48 to 41 percent among sex workers in areas that had not benefited from AIDSCAP interventions. More than half of the clients interviewed in the project area reported consistent condom use with sex workers during the past year.

Another sign of the project's success was the communities' response to the outreach workers. At first, people seemed insulted when outreach workers approached them to talk about STDs. But they persevered, befriending anyone they met in bars, hotels, restaurants and at border check points. Now the outreach workers are considered part of the community, and men and women seek them out with questions about HIV/AIDS and other STDs.

Women who trade in sex—once an elusive audience in a region where the sex industry is clandestine and brothels are rare—came to trust the outreach workers. "Now they bring their friends to us," said GWP Director Mahesh Bhattrai. "So sometimes nowadays we are not doing outreach on the highway. Actually the clients are doing outreach to us." ■

# 1.3

# Comic Book Character Has Worldwide Appeal

All over the world, people listen to what Emma says.

The star of AIDSCAP's "Emma Says" comic book series has dispensed practical, compassionate advice about HIV/AIDS prevention and care to hundreds of thousands of people in Africa, Asia, Latin America and the Caribbean.

Originally developed by AIDSTECH (AIDSCAP's precursor) as a character in a flip chart for peer education sessions with West African women, Emma has become a trusted source of information about HIV/AIDS in more than 20 countries. Since the creation of the first comic book in 1994, "Emma Says" has been translated into six languages and distributed to more than 171,000 individuals and organizations.

Thousands more have seen dramatic performances about Emma performed by local organizations in Tanzania, Ethiopia, Nigeria and Cameroon. And in Rwanda, she became a film star when AIDSCAP's condom social marketing partner Population Services International received funding from UNICEF to create an "Emma Says" video and a companion photonovella.

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

AIDSCAP ensured that each of the books would be relevant to target audiences in different countries by developing plots in conjunction with its local field offices and partners and by pretesting them with audiences in those countries. But in many cases, the pretests found that little or no changes were necessary to adapt the materials. In a 1996 survey of communication professionals who had used the first three comics in 20 countries, 83 percent said that despite Emma's West African origin, women the world over can relate to and benefit from her messages.

The conventional wisdom is that the most effective communication materials are developed locally. But AIDSCAP's experience with "Emma Says" suggests that with careful pretesting, creative, well-designed materials that address universal concerns can influence attitudes and behavior among people from very different cultures. ■


"Emma Says"

LUQUES NISSET-RAIDON

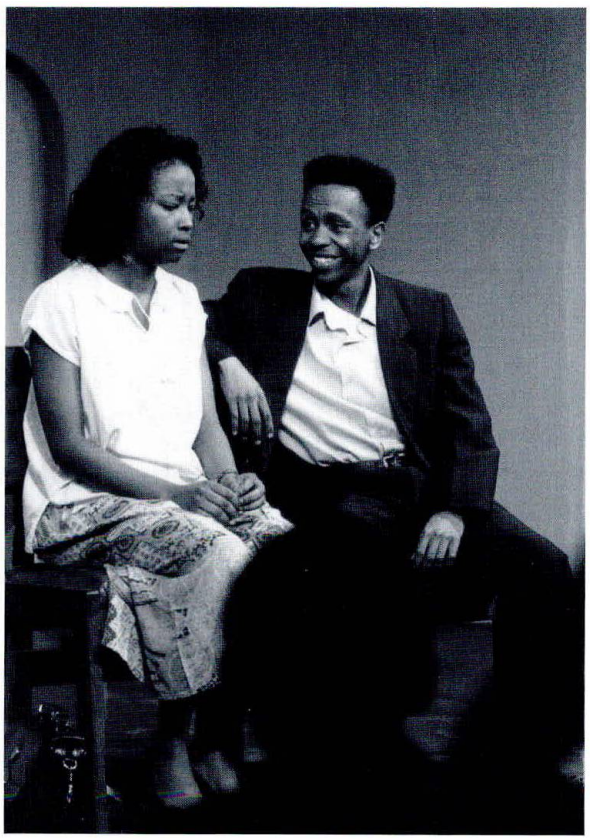
Asia, Latin America and the Caribbean. It has been used in folk media, religious sermons, videos, posters, presentations, and other media and materials. Another example is "Emma," a West African character who has spread HIV/AIDS prevention and care messages in 20 countries (Box 1.3). AIDSCAP encouraged such "cross-fertilization" of messages and materials by developing a computerized database of more than 700 BCC materials produced by the project and sharing model materials with its communication officers in all regions.

## Capacity Building

• **Capacity building in behavior change communication is critical, even for experienced health educators.**

BCC concepts and techniques of behavior change communication are not easy to grasp and apply. And because approaches to HIV/AIDS prevention continue to evolve, the initial design and implementation capacity of project managers and field workers may be weak. AIDSCAP found one cost-effective way to build capacity is through the use of practical handbooks that guide the reader through the various steps of the BCC process. However, training is necessary to enable some groups to use the handbooks.

MARY O'GRADY/AIDSCAP



*Drama performances like this one in Kenya showed audiences new models of sexual communication.*

# Recommendations

• **BCC programs for HIV prevention should address environmental conditions as well as individual behavior.**

Carefully planned, well-executed BCC strategies can help change social attitudes and norms, cultural practices, government and industry policies, and other environmental factors that influence individual behavior.

• **As the epidemic evolves, HIV/AIDS program managers should ensure that peer educators have the knowledge and skills required to address the changing needs of their peers.**

Managers should conduct needs analyses to identify topics to add to their training curricula, such as care, counseling and family planning.

• **HIV/AIDS programs should consider hiring professional advertising, public relations and communication professionals to develop BCC campaigns and materials.**

In some settings, contracting with professionals may be more cost effective than providing specialized communication training to project staff whose talents and skills may lie in other areas.

• **BCC and condom social marketing projects should coordinate their communication efforts to ensure that their shared target audiences receive reinforcing messages.**

• **HIV/AIDS programs should use a stages-of-change continuum to understand the needs of their target audiences and to develop BCC messages, materials and approaches that are relevant to audience members at different stages in the behavior change process.**

- **Before creating new materials, HIV/AIDS programs should consider whether existing materials from other programs and even from other countries might fit their needs.**

These materials should always be pretested with representatives of the target audience before production to determine whether they are appropriate and to identify any revisions that may be necessary.

# Future Challenges

## Reaching Mobile Populations

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

## Changing Social Norms

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

## Maintaining Behavior Change

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

## Understanding Stages of Change

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

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# 2 Improving STD Prevention and Treatment

The more than 333 million curable sexually transmitted infections that occur every year worldwide are a significant cause of incapacitating illness, death, infertility and fetal loss. Yet until the onset of the HIV/AIDS epidemic, the global burden of sexually transmitted diseases was largely ignored.

STD services in most countries show the effects of decades of neglect. Many, if not most, people prefer self-treatment—however ineffective or incomplete—to the inconvenience and embarrassment of seeking treatment at a specialty STD clinic. Lack of confidence in STD services is common and often justified: drug shortages, inadequate information about drug resistance, limited access to laboratory diagnosis, and health care workers' lack of knowledge or reluctance to treat STDs all contribute to the poor quality of care.

Recognizing the need to make STD treatment more effective and accessible, the World Health Organization's Global Programme on AIDS promoted an approach that enables health care workers to treat people who have symptoms suggestive of an STD during a single clinic visit. Syndromic management—the recognition of a group of clinical findings and patient symptoms and treatment for the major causes of those symptoms—makes it possible to manage the majority of symptomatic STDs without sophisticated laboratory tests or specialized skills, which means that STD patients can receive appropriate medications at primary health care facilities.

The development of syndromic management guidelines and other efforts to improve STD management and prevention at "points of first encounter" with the health system were prompted by the rapid spread of the HIV/AIDS epidemic. One reason for this new attention to STDs is obvious: the sexual behaviors that lead to STDs also promote the spread of HIV. But early in the HIV/AIDS epidemic, results of epidemiological and laboratory research suggested that STDs actually enhance HIV transmission. Given this evidence of a link between HIV and other STDs, AIDSCAP made improving STD prevention and treatment one of its main HIV prevention strategies when the project began in 1991.

Since then, the results of several important studies have confirmed the validity of this strategy. In a landmark pilot study in Mwanza, Tanzania, use of the syndromic approach to STD treatment that AIDSCAP has advocated worldwide reduced HIV incidence by 42 percent. And recent research in Malawi produced strong biological evidence that STD treatment can make HIV-positive men less infectious.[1]

Along with mounting evidence of the connection between STD treatment and HIV prevention, the past five years have brought recognition that STD control is by no means a purely medical intervention. Policymakers, health care providers and community members all have important roles to play in providing accessible, acceptable and effective STD services.

## Expanding Access to Effective Treatment

AIDSCAP's primary accomplishment in STD programs was to further develop and increase the use of syndromic management of STDs at points of first encounter in 18 countries throughout the developing world. Through research, advocacy, consensus building, training and information dissemination, the project made an important contribution to promoting worldwide acceptance of this proven approach to improving access to effective STD treatment.

# 2.1

# Achieving Consensus on National STD Guidelines in Haiti

In February 1995, more than 70 Haitian health care providers and officials from medical and community organizations meeting at a seminar in Port-au-Prince agreed on the need for national STD guidelines outlining a new approach to diagnosis and treatment.

Just three years earlier, many of the same medical decision makers had opposed changes in the way STD cases were managed. But in the meantime, they had learned that lack of information about STDs often resulted in ineffective treatment throughout Haiti.

Having results from local studies that supported recommendations for new STD guidelines was the key to this breakthrough, according to Dr. Eddy Génécé, then AIDSCAP resident advisor in Haiti. "The resistance was so strong at first," he said. "I think you overcome it with scientific proof."

A series of AIDSCAP-supported studies provided the information needed to change the providers' minds. The first, an assessment of STD case management at five of the primary health care centers run by the NGO Centre pour le Développement et la Santé (CDS) in Cité Soleil, revealed that more than 90 percent of the clinicians were treating urethral discharge with an ineffective drug. Another cause of urethral and vaginal discharge—chlamydial infection—was essentially ignored. Sexual partners of STD patients were seldom referred for treatment and pregnant women were rarely screened for syphilis.

As a result of these findings, CDS adopted the syndromic approach to STD management in all of its clinics. Staff received training and guidelines for providing STD care at the primary health care level. Because clinicians might not have time to focus on prevention, nurse-counselors were trained to counsel patients and their partners on safer sexual behavior and condom use.

CDS also instituted sytematic prenatal screening at its antenatal clinics. The Pan America Health Organization donated a one-year supply of drugs for treating common STDs; CDS was able to replenish its stocks by charging patients a modest sum for drugs.

But other organizations and providers still resisted change. Many providers, believing that chlamydial infection was rare among Haitians, did not think it was appropriate to treat both gonococcal and chlamydial infection in patients seeking treatment for urethritis or cervicitis, as the World Health Organization (WHO) recommends. Others were simply opposed to using the syndromic approach, even though most acknowledged that laboratory tests were not always available and laboratory results were often unreliable.

In 1993, a survey of STDs among 1,000 patients at two CDS antenatal clinics revealed that chlamydial infection was much more common than gonorrhea. This information paved the way for acceptance of the WHO syndromic approach. The next year, a coalition of 13 NGOs working on HIV/AIDS prevention in Haiti's Central Plateau began a program similar to CDS's.

Evaluations of the two programs showed that they had improved STD case management significantly. The percentage of CDS clinicians treating urethral discharge properly had increased from less than 10 percent to 69 percent. And in the newer NGO coalition program, 56 percent of the clinicians who were evaluated reported giving effective treatments for urethral discharge. Clinicians and nurse-counselors in both programs were promoting condom use.

Despite this progress, in 1995 there was still no standardized approach to STD diagnosis and treatment in Haiti. Therefore, AIDSCAP convened the February 1995 seminar to encourage Haitian organi-

zations to reach consensus STD case management. It was during this seminar that some clinicians learned for the first time that chlamydial infection was more prevalent than gonorrhea in Haiti and that most strains of gonorrhea were resistant to penicillin.

After discussing the Cité Soleil findings and their own experiences in the field, participants agreed that they should adopt a syndromic approach to managing STDs.

Representatives from local NGO and research institutions and several international organizations formed a working group to develop national guidelines for STD case management. In the fall they were joined by officials from the newly restored democratic government. The guidelines were presented and discussed at a second seminar for health professionals and medical decision makers held in collaboration with the Ministry of Health in November 1995, and a small booklet describing the guidelines was distributed to providers in 1996.

Most national health guidelines are developed by ministries of health. Because Haiti's health care system broke down during its turbulent years of military rule, development of national STD guidelines began with local institutions, which later collaborated with the Ministry of Health—a novel bottom-to-top approach. Now the groundwork has been laid, and the government and NGOs can work together to build a national STD control program. ■

Encouraging adoption of syndromic management required considerable effort at the policy level as well as research to validate and adapt WHO algorithms in different settings. AIDSCAP worked with local officials and providers to build consensus on the need for a standardized approach to STD management and to develop national guidelines for syndromic management of STDs. The success of this collaborative process laid the foundation for subsequent efforts to strengthen STD services.

AIDSCAP improved STD care at points of first encounter through technical assistance and training in syndromic management, communication and STD program management for providers, managers and pharmacists. Despite initial resistance to the syndromic approach, follow-up assessments of the STD care provided by trainees in different countries found marked increases in the percentages of clients receiving effective treatment.

Management training was critical to ensure that managers could provide the support and guidance necessary for successful implementation of syndromic management. With AIDSCAP support, managers of STD and HIV/AIDS control programs in developing countries attended international and regional training courses on STD program management. AIDSCAP also created a handbook for STD program managers—the first publication of its kind—that is being used in training courses and as a reference guide worldwide.[2]

Recognizing that failure to seek prompt STD care is often a result of stigma, lack of knowledge about STDs and providers' attitudes toward STD patients, AIDSCAP placed increasing emphasis on improving communication between providers and clients and between STD programs and communities. In 1994, the project developed a rapid ethnographic methodology for conducting qualitative studies to identify ways to make STD programs and outreach efforts more responsive to the communities they serve. The results of targeted intervention research (TIR) studies conducted in nine African countries are being used to strengthen patient-provider relations and to promote symptom recognition, accurate behavioral risk assessment, treatment-seeking, and condom use for STD prevention. Publication of the Targeted Intervention Research Manual, which was disseminated to STD programs and international organizations, will enable program managers to conduct their own TIR studies with technical assistance from local social scientists and STD specialists.[3]

# 2.2

# Targeted Intervention Research Improves STD Programs

Some Zambian women believe they will miscarry if they seek antenatal care before a pregnancy is showing—a crucial time for identifying and treating maternal syphilis. In Malawi, different stages of the same sexually transmitted disease are considered separate illnesses. And in Senegal, patients say they go straight to a pharmacist when they experience STD symptoms because the local health center has long lines and lacks confidentiality.

As these examples illustrate, patients' beliefs and perceptions have a powerful influence on when, where—and even whether—they seek care for an STD. Many people avoid formal health care systems because they do not understand the causes of their symptoms, lack confidence in health care providers' ability to treat those symptoms, or do not feel comfortable going to a local clinic.

A rapid ethnographic research tool called targeted intervention research (TIR) helps program managers improve STD programs by identifying such barriers to treatment and prevention. Developed by AIDSCAP in collaboration with researchers from Johns Hopkins University and the University of Washington, the TIR enables STD program managers to gain a better understanding of local perceptions, terminology, practices and beliefs about STDs.

A manual produced by AIDSCAP provides step-by-step guidelines for organizing a TIR study. With this manual and the help of a multidisciplinary technical advisory group of local experts, STD program managers can design, conduct and analyze the results of TIR studies in three to six months.

In Zambia, TIR research sponsored by AIDSCAP and UNICEF helped managers of a maternal syphilis project understand why women often refused to attend an antenatal clinic during the early stages of a pregnancy. The project's strategy was revised to address this barrier to early detection and treatment of maternal syphilis, which can prevent spontaneous abortion, stillbirth, prematurity and congenital syphilis. In Ethiopia, TIR findings were used to design messages and materials to address community perceptions and misconceptions about STD treatment and prevention.

Results of TIR studies are also being used to improve programs in Benin, Malawi, Morocco, the Philippines, Senegal, South Africa and Swaziland. Bridging the gap between research and practice is always a challenge. But because TIR is designed to provide rapid answers to specific programmatic questions, the prospects for effective application of findings are good. ■

While working with colleagues to strengthen STD prevention and management through existing health care and family planning facilities, AIDSCAP also explored alternative approaches to expanding access to these services. Field tests in Nepal and Thailand demonstrated that training in syndromic management can improve the advice pharmacists and drugstore personnel give their customers about STD treatment. AIDSCAP's experience with the first pilot study of the provision of prepackaged STD therapy yielded important lessons for future research to assess this approach. And the preliminary results of an AIDSCAP-sponsored study of targeted periodic presumptive treatment in South Africa showed dramatic reductions in STD prevalence among sex workers and their clients.

Program-related research on STD prevalence, antibiotic resistance, community perceptions of STDs, and partner referral strategies also contributed to efforts to improve STD prevention and management. In many cases, AIDSCAP-sponsored prevalence studies produced the only data on STDs in a country. Local data on prevalence and resistance were often the key to reversing opposition to the syndromic approach and revising essential drug lists.

Studies were conducted in more than 16 countries to advance AIDSCAP's STD strategy. AIDSCAP shared this wealth of experience with colleagues throughout the world by publishing more than 25 articles in peer-reviewed journals and presenting more than 40 abstracts at international and regional conferences.

# Lessons Learned

## Consensus and Communication

- **Building the foundation for improving care at points of first encounter requires intensive effort at the policy and program management levels.**

Engaging the commitment and resources of public health officials and STD managers and providers demands significant technical assistance and consensus building. AIDSCAP's experience in Haiti, where such efforts led to national consensus on STD guidelines and improvements in service delivery, shows that the time and resources necessary to orient and train policymakers, managers and providers are well worth the investment (Box 2.1).[4]

- **Biologic studies of STD prevalence and antibiotic susceptibility in a country are essential to building consensus on national STD treatment guidelines.**

The local data that these studies generate can help convince STD program managers and health care providers to adopt the syndromic approach to STD management. AIDSCAP found that once managers and providers understood the magnitude of the STD problem in their country and the ineffectiveness of many of the current treatment practices, they were more likely to appreciate the benefits of a simple, standardized approach that increases access to effective treatment.

- **Findings from rapid ethnographic studies of community perceptions of STDs can improve communication between provider and patient.**

AIDSCAP recognized the importance of understanding community perceptions, beliefs and practices related to STDs and developed an ethnographic tool to study them.[3] The results of AIDSCAP-sponsored targeted intervention research (TIR) are being used to improve clinic- and community-based communication with STD clinic clients and potential clients in nine countries (Box 2.2).

## Improving Access

- **Research findings from several countries confirm the impression that many people seek treatment for STDs outside the formal medical system.**

For example, AIDSCAP studies in two African countries documented a significant amount of self-treatment and treatment seeking in the informal sector. In Ethiopia, 61 percent of the men and 41 percent of the women interviewed had sought treatment at a pharmacy or from a local injector or traditional healer before consulting at a health center. In Cameroon, 50 percent of male patients with a history of acute urethritis during the previous 12 months had treated themselves with drugs bought at pharmacies or in the market. Their reasons for self-treatment were long waits at clinics, the need to wait for laboratory results before getting a prescription, the cost of lab tests, and the cost and effectiveness of the drugs prescribed by health providers.

# 2.3

# Decentralized Screening Prevents Syphilis Transmission in Jamaica

Until 1993, clients who were screened for syphilis at Jamaica's antenatal and STD clinics had to wait at least a week and typically up to six weeks for results to return from the two central government laboratories in Kingston and Montego Bay.

"By that time, patients were gone, and some women had delivered," said Frieda Behets of the University of North Carolina, an AIDSCAP consultant who provided technical assistance to Jamaica's HIV/STD control program.

Delays in diagnosis and treatment resulted in further transmission of the disease by people with symptomless syphilis and contributed to increases in the number of infants born with the disease.

One study in Jamaica showed that fetal loss, stillbirth or infant death were almost twice as likely to occur when a mother had untreated syphilis.

Jamaica's Ministry of Health and AIDSCAP tackled this problem as part of a comprehensive effort to strengthen STD diagnosis, treatment and prevention. Thousands of public health workers and private physicians were trained in STD management and informed of the most current local drug resistance data, leading to significant improvements

ARMANDO WAAK/PAHO


*A young expectant mother sits in the waiting room of a Kingston antenatal clinic. Providing syphilis screening in all Jamaican antenatal clinics eliminated long waits for lab test results that had contributed to high rates of congenital syphilis.*

in STD care. All patients were treated correctly in a 1996 study that involved direct observation of public health workers' management of gonorrhea, and the number of private physicians reporting that they had used ineffective drugs to treat gonorrhea dropped from 43 percent to 3.6 percent.

But the most dramatic improvement in STD services in Jamaica resulted from the decentralization of syphilis screening. The decentralization effort began at the Comprehensive Health Centre in Kingston and was gradually expanded to other health centers and clinics. Laboratory aides and assistants with little laboratory experience learned how to perform syphilis blood tests at the clinics.

Many people were reluctant to endorse decentralization at first because they believed syphilis tests should be conducted only by laboratory technicians. However, a quality control assessment at the national reference laboratory showed that on-site testing was accurate: more than 96 percent of the results of syphilis tests performed by laboratory aides were confirmed.

Syphilis screening is now available at 76 antenatal clinics and 17 STD clinics in Jamaica. As a result, 68 percent of those who test positive for syphilis are treated the same day and 85 percent receive treatment in less than one week. More efficient and effective diagnosis and treatment contributed to a significant decline in infectious syphilis from 1994 to 1996. ■

- **Although high levels of self-treatment and limited resources for STD control in many countries compel policymakers, medical professionals and donors to consider innovative approaches to improving access to effective treatment, opposition to providing STD management outside the clinic setting is strong.**

AIDSCAP field tested two alternatives to clinic-based treatment—training pharmacy workers in syndromic management and promoting prepackaged therapy for urethritis. Two of the pilot studies encountered resistance from the medical community, and the prepackaged therapy could not be tested as planned because of lack of support from medical professionals and public health authorities.

- **Training pharmacists and other drugstore personnel in the syndromic approach can improve the management of STDs in many patients who choose to self-medicate.**

In Nepal, training drugstore personnel to dispense antibiotics using the syndromic approach and to provide clients with preventive education and condoms markedly improved their prescription practices. The percentage of drugstore personnel suggesting effective treatment to a "mystery shopper" with urethritis symptoms increased from 0.8 to 45 percent. Trained drugstore personnel were also more likely to suggest that their customers use condoms and refer partners for treatment. However, more than half continued to advise customers to take ineffective medications, indicating a need for additional training, supervision and support.

Researchers believe that a number of factors contribute to continuing problems with the STD management practices of drugstore personnel. Even when a pharmacist or drugstore clerk is well trained and committed to providing effective treatment, he or she is unlikely to turn away business if a customer can only afford to buy a partial prescription. Moreover, it is often difficult in a public business setting to guarantee the privacy necessary for gaining a customer's trust.

- **Sales of prepackaged STD therapy in pharmacies and health facilities could increase access to effective STD care, but successful implementation requires the full support of public health officials and health care providers.**

The first pilot study of this approach, conducted by AIDSCAP in Cameroon, faltered because it lacked the necessary local support. Only 27 percent of the health care providers who had been trained to prescribe prepackaged therapy for urethritis actually did so. Without a consensus on the need for syndromic management of STDs and other alternatives to traditional STD care, it was impossible to adequately assess the effectiveness of this approach.

- **Patients may be more receptive to prepackaged STD therapy than providers.**

Follow-up interviews with patients who had received the kit of urethritis therapy in Cameroon revealed high levels of compliance and satisfaction. More than 82 percent reported taking a full course of medication, 84 percent said they had used condoms while on the medication, and 44 percent had used the cards in the kit to refer partners for STD treatment. Providers at one of the clinics reported that clients continued to ask for the kits months after the pilot study ended.

## Detecting Asymptomatic STDs

- **Current risk assessment strategies are not a valid tool for identifying STDs in women without symptoms.**

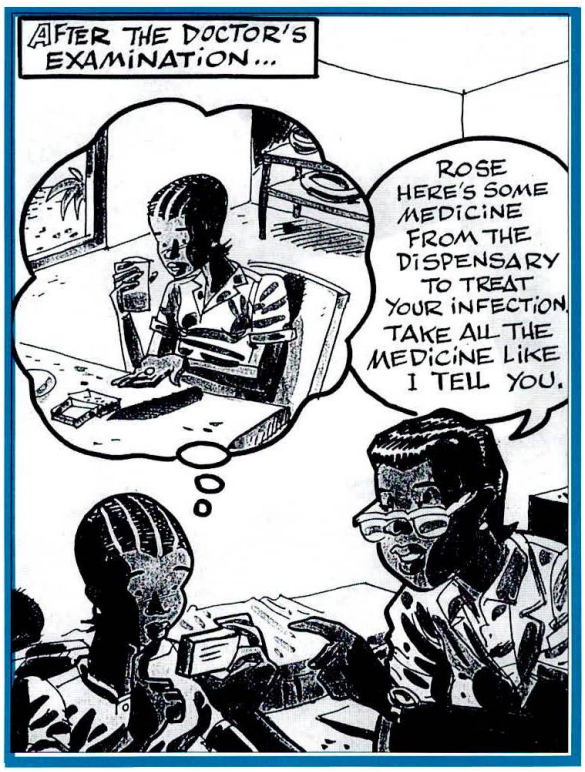
The main obstacle to managing STDs other than syphilis in asymptomatic women is the absence of valid, feasible and affordable case-finding and screening strategies, particularly for gonococcal and chlamydial infection. Results of studies conducted by AIDSCAP in Jamaica and Tanzania and by others attempting to define a risk profile for infected asymptomatic women have been disappointing.[5,6] These studies found that risk assessment scores derived from current flow charts are neither sensitive nor specific enough for widespread use. However, imperfect approaches that include risk assessment may be a better option than doing nothing at all, particularly in areas where STD prevalence is high. Moreover, risk assessment may continue to play a role in the management of STDs in asymptomatic women because risk scores could be used to determine who should be tested for a sexually transmitted infection when an appropriate test becomes available.

- **Partner referral is possible in a variety of settings.**

Reaching partners of STD patients with treatment—a long-neglected component of STD management in most countries—has great potential for improving STD control because it results in treatment of asymptomatic partners, particularly women. AIDSCAP's improved partner management systems in antenatal clinics in Haiti and primary health care facilities in Rwanda attained referral rates of 25 to 35 percent.[7,8]

- **Treating women and their partners for STDs as part of antenatal care creates opportunities to motivate men to seek treatment in order to protect the health of their children and partners.**

Luques Nisset-Raidon




*A doctor talks to a young STD patient about the importance of taking a full course of treatment in one of AIDSCAP's "Emma Says" comic books.*

An AIDSCAP pilot study found that almost half of the women attending two Haitian antenatal clinics had one or more STDs. Ninety percent of the women agreed to inform their partners, and 30 percent of the 331 men named by 384 women sought treatment. Health workers found that men were more willing to come for treatment when the problem was framed in the context of preserving fertility or ensuring healthy offspring. When men who had come to the clinic were asked why it was important to them to receive treatment, one of the most common responses was "to protect the child."[7]

- **Health workers with no laboratory experience can be trained to perform accurate syphilis blood tests, making it possible to expand syphilis screening of pregnant women.**

An effective, affordable treatment for syphilis is available, yet hundreds of thousands of undetected and untreated maternal syphilis cases lead to fetal loss, infant death or congenital abnormalities every year. Too often, logistical and managerial obstacles impede use of the rapid, simple, inexpensive syphilis diagnostic test for routine screening in antenatal clinics. In Jamaica, AIDSCAP worked with the Ministry of Health to remove some of these obstacles in a successful effort to decentralize syphilis testing (Box 2.3).[9]

- **Targeted periodic presumptive treatment of selected STDs (often referred to as "mass treatment") among epidemiologically defined "core groups" holds promise for achieving rapid decreases in communities' reservoirs of STDs.**

Mathematical models have demonstrated that core groups with high rates of sexual partner exchange disproportionately increase the spread of STDs within a population. Periodic presumptive treatment offers the advantages of achieving a decline in STDs more quickly than sexual behavior change alone and reaching asymptomatic individuals who would not otherwise seek care. But careful research is needed to ensure that this approach does not promote antibiotic resistance, disrupt individuals' normal biological resistance to sexually transmitted infection, or lead to an increase in high-risk behavior.

Preliminary results of an AIDSCAP pilot test of empiric periodic treatment among sex workers in a South African mining community confirm that this strategy can be cost effective in such a setting. By offering syndromic STD treatment to all women with multiple partners referred by peer educators, the study was able to reduce STD prevalence among women using the service by 30 percent. STDs also declined among their clients and partners: the project found a one-third decrease in urethritis and a two-thirds reduction in genital ulcers among miners. Findings from interviews with study participants and focus group discussions with peer educators, as well as limited data from miners, suggest that the women and their clients have fewer casual sex partners and use condoms more often, although high-risk behavior continues. Results of a cost-benefit analysis convinced the management of the Harmony Mine to continue the intervention and expand it to other areas of the community.[10]

# Recommendations

- **AIDSCAP proposes the following steps as a comprehensive, rational approach to establishing improved, client-centered STD service delivery.**

Many of these steps can take place simultaneously, and it is not necessary to complete studies before adopting provisional national guidelines and beginning training.

- Gather existing data or conduct studies to describe local STD prevalence, antimicrobial susceptibility patterns, and STD beliefs and practices.

- Convene local health personnel to review epidemiological data and reach consensus on national STD syndromic treatment guidelines.

- Design, conduct and evaluate training of local providers in syndromic management.

- Use TIR results to redesign services.

- Design, pretest and produce materials for patients and providers.

- Design and pretest messages and materials for community members based on TIR findings.

- Provide supportive supervision for trainees and evaluate service provision.

- Train regional, national and local managers

in program management and evaluate the results of the training.

- Work to ensure required drugs are available.

- **To improve communication between providers and clients, program managers should use rapid ethnographic studies to understand community perceptions about STDs and STD services, as well as provider attitudes toward clients.**

- **Given the high levels of self-treatment and lack of access to effective STD treatment found in many countries, STD and HIV/AIDS control programs should supplement efforts to improve traditional STD services with alternatives such as training of pharmacists in syndromic management and selling prepackaged STD therapy in pharmacies and health facilities.**

Greater emphasis on behavior change communication is also needed in both clinic-based STD services and community outreach to encourage early treatment seeking.

- **STD programs should institute partner referral in order to detect and treat asymptomatic STDs, particularly in women.**

- **All pregnant women attending antenatal clinics should be screened for syphilis and treated.**

Health care workers with no laboratory experience can be trained to use the rapid, inexpensive diagnostic test for syphilis with high levels of accuracy.

# Future Challenges

## Adding Strategies

The syndromic approach to STD management is not the complete solution to STD control. It works well for urethral discharge in men, genital ulcer disease in both men and women, and pelvic inflammatory disease, but is less than optimal for managing vaginal discharge, even with the addition of a risk assessment. Moreover, syndromic management was never designed as a tool for identifying infection in asymptomatic people. Greater support is required for additional approaches, including partner referral and treatment, services targeting high-risk populations, and comprehensive syphilis screening of antenatal women. Rapid, inexpensive, simple diagnostic tests for gonococcal and chlamydial infection are urgently needed to improve the management of STDs in symptomatic women and to identify asymptomatic infections.

## Changing Provider Behavior

In spite of efforts to improve management of STD patients through syndromic management training, many health care providers are reluctant to change their practice behaviors. Anecdotal information suggests that their reasons include prestige, profit motives and pressure from pharmaceutical companies, and the belief that certain STDs syndromes are not serious and do not warrant antibiotics. Research is needed to further understand this resistance to the syndromic approach among different groups of health care providers and to propose solutions.

## Assessing Creative Approaches

The critical constraints to effective STD treatment and prevention found in most developing countries require innovative responses. More research is needed to test approaches such as empiric periodic treatment and prevention marketing of prepackaged STD therapy. These approaches must be introduced in ways that provide sound, objective evidence of efficacy that will enable decision makers to make informed judgments on the advisability of implementing them on a wider scale.

## Tracking Antibiotic Resistance

A major obstacle to STD control is the ever-evolving development of resistance against antibiotics, particularly for gonococcal infections. Patterns of resistance to antibiotics may differ substantially by region and even from one country to the next, and a lack of reliable and representative data makes it difficult to adapt STD treatment guidelines for national and regional use. A global network of laboratories using a common methodology to conduct gonococcal surveillance would greatly facilitate efforts to develop, update and disseminate standardized guidelines for effective STD treatment.

## Improving Reproductive Health

Despite the limitations of current tools and health infrastructures, it is possible to improve women's access to STD prevention and management by integrating these services into family planning, maternal-child health (MCH) and

primary health care (PHC) programs, as AIDSCAP's experience in Nepal demonstrates (see page 84). Additional training is needed to equip the staff at these clinics to counsel clients on risk reduction and to refer symptomatic women and women with clinical signs suggestive of an STD for treatment. At some clinics, staff could also learn to provide syndromic treatment for symptomatic women and for asymptomatic women through partner referral links with clinics treating men. A smaller number of clinics could provide laboratory diagnosis and treatment. Operations research is needed to determine what levels of integration are feasible and cost effective in different settings and to establish technical guidelines and procedures for incorporating STD prevention and management into family planning, MCH and PHC services.

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# 3 Prevention Marketing: Condoms and Beyond

The use of marketing techniques and systems to promote and deliver methods of protecting public health—known as social marketing, is a key HIV/AIDS prevention strategy. The basic approach involves packaging, pricing and presenting a product or behavior to appeal to the target market and engaging the participation of wholesalers and retailers in distribution and conventional trade promotions. Mass media are often used to convey the benefits of the desired behavior for a particular target audience.

Social marketing has been applied in a wide range of public health programs, including family planning, child survival and malaria prevention. These projects commonly make use of the existing logistics systems that supply the commercial networks delivering most daily necessities. The most successful projects depend on subsidized products to ensure retail prices that are within the buying power of most people in developing countries.

The advantages of a social marketing approach to promoting condoms for HIV/AIDS prevention include the ability to make products available to people when and where they need them and to saturate geographic areas of special interest with a product. The privacy—even anonymity—of the commercial transaction between a vendor and customer is another benefit. And social marketing is a cost-effective strategy: even with a highly subsidized product, the cost of distribution, from intermediate warehousing to the actual delivery of product into the hands of the user, is borne by the purchaser, not by a donor or the public health system.

The success of condom social marketing (CSM) efforts has led to a new interest in expanding the use of marketing strategies in public health programs. Such prevention marketing can be used to encourage health-promoting behaviors, as well as other prevention "products."

## Improving Access, Increasing Sales

FHI worked with its social marketing subcontractor, Population Services International (PSI), and other organizations to make condoms accessible, affordable and attractive to millions of people. By June 30, 1997, the total number of condoms sold by social marketing projects and distributed for free by NGOs had exceeded 254 million. AIDSCAP-supported CSM projects sold 87 percent of those condoms (almost 222 million) in eight countries.

In those countries AIDSCAP strengthened existing CSM operations, providing the support needed to expand sales outlets to new areas and to target marketing efforts to reach critical audiences. In fact, each of these CSM projects enjoyed a marked increase in sales under AIDSCAP support. For example, in Ethiopia the PSI project's sales rose 141 percent, from 829,000 a month before the AIDSCAP program in that country began to 2 million a month in September 1996. AIDSCAP support also boosted monthly sales by more than 100 percent in Haiti and Nepal.

Perhaps even more important, AIDSCAP-supported CSM projects succeeded in providing reliable supplies to otherwise difficult-to-reach groups and individuals at high risk of HIV infection by adapting traditional commercial logistics systems. Innovations such as the use of nontraditional sales outlets (bars, restaurants, kiosks and other small retailers), NGO sales agents and dedicated sales forces increased sales while ensuring that condoms were available to those who needed them most.

Impressive sales figures were achieved despite formidable obstacles in almost every country. In

Ethiopia, for example, the CSM project was forced to ration condoms due to limited supplies. The internecine war in Rwanda claimed the lives of four PSI staff and forced the project to suspend sales for almost a year, prompting PSI to distribute free condoms in Rwandan refugee camps (Box 3.1). Political violence and an economic embargo in Haiti also posed safety concerns and logistical challenges to the PSI project there (Box 3.2), and Brazil was plagued by both tariff and regulatory barriers that restricted sales and complicated the administration of CSM operations.

That CSM projects were able to overcome these challenges to record such remarkable successes is testament to the resilience and pragmatism of the social marketing approach. It is also an indication of the great unmet need for condoms in many countries throughout the world. AIDSCAP's experience suggests that providing convenient access to affordable condoms is the most effective way to meet that demand.

### AIDSCAP CSM SALES

| Country | Length of Program | Total Sales |
|---|---|---|
| **Brazil** (states of São Paulo and Rio de Janeiro) | July 1993 - March 1997 | 82.0 |
| **Ethiopia** | January 1993 - Sept. 1996 | 44.0 |
| **Tanzania** | August 1993 - June 1997 | 39.0 |
| **Cameroon** | January 1993 - August 1996 | 24.0 |
| **Haiti** | September 1993 - April 1996 | 16.3 |
| **Nepal** | February 1994 - June 1997 | 12.0 |
| **Rwanda** | April 1993 - April 1994<br>March 1995 - August 1996 | 2.6 |
| **South Africa** (Welkom mining communities) | April 1995 - April 1997 | 2.0 |
| **Total** | | **221.9** |

# Lessons Learned

## Reaching Those At Risk

- **Extending condom sales beyond pharmacies, supermarkets and other large stores to nontraditional outlets such as bars, brothels, liquor stores and roadside stands makes condoms available to individuals who are likely to use them in high-risk situations.**

AIDSCAP's most significant and successful adaptation of the contraceptive social marketing model was to emphasize sales through nontraditional outlets to reach those at greatest risk of HIV infection. Sales through wholesalers and large commercial outlets are more efficient, but much less likely to provide access to condoms at the times and in the locations where people usually engage in high-risk sex. For example, pharmacies are rarely located in red-light districts, and most are not open for business late at night. By giving sales agents incentives to market condoms through nontraditional outlets, AIDSCAP provided convenient access to low-cost condoms at thousands of strategic locations.

- **NGOs can become important partners for social marketing.**

The association between NGOs and social marketing is not a natural one. Social marketing specialists operate in the commercial sector, appealing to profit motives rather than altruistic goals. NGO staff who provide assistance to the poor may object philosophically to selling anything to their clients or members. But both groups recognize the urgent need to ensure a reliable condom supply to NGO clients and members, and that common ground enabled AIDSCAP to foster productive relationships between social marketing operations and NGOs.

All social marketing operations were coordinated with the activities of other AIDSCAP partners—primarily NGOs—to ensure that target populations received comprehensive HIV/AIDS prevention services. Some NGO personnel even acted as condom sales agents. For example, Ethiopian youth and Nigerian sex workers trained by

# 3.1

# Riding the Phoenix: CSM Sales Rise as Rwanda Rebuilds

In the center of Kigali's most congested traffic circle stands a kiosk. Once a newspaper stand, this modest structure was a mute witness to one of this century's bloodiest tragedies: the 1994 slaughter of more than a half million Rwandans by their fellow citizens.

Less than a year later, the kiosk—freshly painted with a rainbow design—became one of the first small businesses to reopen. In the midday heat, many stop to buy cold drinks, but also take the opportunity to ask the nurse behind the counter about AIDS and buy packets of Prudence condoms. In its new role, the kiosk has become a bright symbol of hope in a nation desperate to renew itself.

When genocidal civil war broke out in April 1994, most foreign assistance and NGO projects in Rwanda came to an immediate halt. Despite the desperate need for HIV/AIDS interventions—before the war, 30 percent or more of the country's urban population was estimated to be HIV-positive—the AIDSCAP program was also forced to close.

Instead, AIDSCAP used country program funds to establish an innovative HIV and STD prevention and care project for some 2 million Rwandan refugees in the Ngara District refugee camps in Tanzania (see page 106). Managed by CARE International, the project included condom distribution by AIDSCAP's social marketing partner, PSI. Although the Prudence condoms that refugees remembered so well from home had to be distributed free of charge, PSI nonetheless promoted them creatively and aggressively to enhance their value and thus increase their use.

When AIDSCAP and PSI finally returned to Rwanda almost a year later, the staff who had survived the bloodshed faced the difficult and sometimes disheartening ordeal of rebuilding the program from the ground up. AIDSCAP/PSI's entire stock of condoms had disappeared from a nearby warehouse. The office was a shambles. All the computers and other office equipment and most of the files were gone, and only one vehicle from the original office fleet remained—the one staff had used to escape to Burundi.

But the real challenge was not the nuts and bolts of restocking condoms or reconstructing records destroyed in the looting. Returning staff perceived a profound change in the society around them, a population deeply affected by the bloody nightmare it had experienced.

"We soon realized that the physical destruction in Kigali was almost insignificant compared to the

PSI


*PSI staff sell Prudence condoms at a Bob Marley Festival in Kigali.*

trauma the Rwandans had lived through," said Kyle Peterson, former PSI country representative in Rwanda. "The experience of the genocide so overpowered everything else that we began to doubt that any other message might be heard at all."

Peterson and the rest of the PSI staff decided that the best way to both catch the public's attention and aid in Rwanda's long road to healing was to promote Prudence in the most positive way possible. They would use colorful, interesting advertisements and posters and create catchy, upbeat jingles for the radio that would lift spirits as they spread the Prudence brand name around the country. The new messages stressed the sweetness of life by emphasizing the benefits of taking responsibility for one's health.

The program built on the solid foundation it had established before the war to resume and expand sales throughout the country. Within months, it had succeeded in opening 1,500 new points of sale and had achieved impressive average monthly sales of more than 229,000.

Salesmen reported that Prudence's reputation had survived the war and the program's shutdown. "As survivors slowly returned to their homes, overcome with grief and loss, we were amazed to discover how many of them actually remembered Prudence and recalled their high opinion of its quality before the war broke out," said Peterson.

But the key to the astonishing success of condom social marketing in Rwanda may be more fundamental. Social marketing experts attribute the resilience of the program to society's basic instinct for survival. The marketplace has always been central to the Rwandan culture and economy, and the country's commercial infrastructure never disappeared entirely—even during the worst of the violence, even in the refugee camps of Tanzania.

"Social marketing, even during catastrophes, always make sense because the commercial sector always reappears, like a phoenix," said Peterson. "The question is, how can public health people learn to ride that phoenix?" ■

AIDSCAP as volunteer educators sold condoms to their peers.

In a number of countries, NGOs emerged as significant retailers of condoms. For example in Haiti, where government condom distribution ceased during years of political turmoil and traditional social marketing efforts were unable to reach those living in the most poverty-stricken or remote regions, the AIDSCAP-supported PSI social marketing project sold condoms at wholesale prices to NGOs, who in turn sold them to their clients at retail (Box 3.2). NGO staff learned that the (highly subsidized) retail price was bearable to their clients, experienced the superior performance of the private sector delivery system, and generated funds for their organizations through the small profits they received. Skeptical at first of the ability of NGOs to handle retail products, the social marketing managers saw NGO staff account for an increasing share of their sales, reaching 25 percent of the 540,000 condoms sold every month.

The success of this strategy led to replication in several other countries. PSI managers of AIDSCAP-sponsored programs in Tanzania, Rwanda and South Africa trained more than 2,300 NGO staff as condom sales agents.

- **A social marketing project can successfully target marketing efforts with a sales force dedicated to selling its product.**

In Brazil, AIDSCAP's social marketing partner DKT do Brasil could not rely on NGO sales agents to increase access to condoms for NGO clients because Brazilian law barred nonprofit organizations from the retail trade. Instead, AIDSCAP provided separate funds to DKT to ensure that sales efforts were particularly intense in the geographic areas served by the NGOs. Ordinarily DKT would have concentrated its resources on the most efficient (low-cost) sales, which in Brazil means large sales to chain stores and to the biggest retail outlets. With the additional resources from AIDSCAP, the social marketing operation was able to hire *promodoras* who sold to smaller outlets, ensuring adequate supplies of low-priced condoms in the areas where the NGO clients lived and worked.

A dedicated sales force also proved an effective strategy for reaching groups targeted by the AIDSCAP program in Nepal. These sales agents concentrated their efforts on the highways into the country from India—a known route for transmission of the virus—in nontraditional outlets such

as tea shops, liquor stores and roadside stands. As a result of these efforts, condom access along the highways increased dramatically (Box 3.3).

- **Without subsidies, social marketing projects cannot make condoms available to those who need them most.**

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

Social marketing operations can be self-sustaining, but at a cost. HIV/AIDS is increasingly a disease of the poor, and social marketing efforts will have less of an impact on the epidemic if condoms are not available at affordable prices.

- **Providing low-cost subsidized condoms or even free condoms does not undercut commercial condom sales.**

In fact, AIDSCAP's experience suggests that condom social marketing efforts can actually help boost for-profit sales. In Brazil, for example, the CSM project managed by PSI affiliate DKT do Brasil stimulated a stagnant commercial condom market by aggressively promoting its brand in public and by challenging barriers to imported condoms. As a result, the total number of condoms sold in a year tripled to 135 million in 1995, and the market gained at least five additional condom importers.

A similar effect was documented in Thailand, a country that distributes millions of free condoms.

DKT do Brasil


*AIDSCAP CSM projects used nontraditional sales outlets to expand access to condoms. In Brazil, such outlets included gas stations and oceanside kiosks.*

An audit by FHI partners John Snow, Inc., and PSI showed that as the number of condoms distributed in the public sector increased, the demand for commercial condoms also rose. This demand encouraged three companies to open local condom manufacturing plants. The government was able to cut back on free distribution as the private sector condom market grew, rising from about 1 million to 60 million a year from 1985 to 1995.

## Mass Media Marketing

- **As people watch their friends and relatives die of HIV/AIDS and as CSM programs relentlessly educate people through every conceivable media channel, the old barriers and stigmas attached to condoms are beginning to evaporate.**

The climate for mass media messages about HIV/AIDS and condoms has improved substantially over the past five years. The image of Bishop Desmond Tutu endorsing condom use on South African television may have shocked some viewers there, but was perhaps even more surprising to social marketers who for years had battled to gain access to mass media. As recently as 1990, the word "condom" was prohibited in advertising by the Government of Kenya, requiring a wide range of subtlety and creativity on the part of social markers. Today, more explicit advertising is permitted there and in many other parts of the world.

- **Encouraging use of condoms through mass media facilitates their adoption by marginalized groups.**

Targeted marketing has sometimes been misunderstood to mean developing brands and advertising messages that appeal directly or even exclusively to sex workers and their clients or to men who have sex with men. Such an approach associates condom use with behavior that is condemned by society and requires condom buyers to identify themselves as people who practice that behavior. Portraying condom users in the media as happy, successful, "normal" people helps those whose lack of acceptance in society has been a barrier to their obtaining condoms. When mass media conveys the message that "everybody" uses condoms, members of marginalized minorities can enter a store and

ANDY HUTCHISON


*A PSI staff member in a mobile video van uses a penis model to demonstrate how to put on a condom.*

# 3.2

# NGO Participation Boosts Condom Sales in Haiti

In the Haitian countryside, shopping for condoms once meant a two-hour hike to a distant town or rural clinic. Even in the cities, commercial sales outlets were scarce. But today, Pantè condoms, sold at bars, hotels, beauty shops, kiosks, markets and nightclubs, are accessible at all hours of the day, even in remote regions of Haiti.

Pantè (Creole for panther) is the brand name of the condom that PSI introduced in Haiti in 1990. Two years later, funding from AIDSCAP enabled PSI to create a dynamic condom social marketing (CSM) project to package, promote and sell the top-quality Pantè at a fraction of the cost of commercial condoms.

Accessibility and affordability meant extraordinary success for the project, despite the political instability and economic crisis that followed the overthrow of Haiti's elected government in 1991. Much of the nation's commercial distribution system came to a standstill, but the CSM project flourished. In less than four years, monthly sales of increased from an average of 3,000 to more than 540,000. In fact, in per capita sales, the project in Haiti ranked as one of the world's leading CSM projects.

Condom sales rose as PSI and AIDSCAP established more than 3,000 points of sale throughout the country, ultimately penetrating into all but one of Haiti's difficult-to-reach rural départements. For the first time, many of the 70 percent of Haitians who live in the countryside could find affordable condoms close to home.

This level of national coverage—unusual even for a CSM project—was the result of the unique approach that PSI and AIDSCAP took to improving distribution. In addition to working with some 100 independent and commercial vendors, the project recruited and trained 175 outreach workers from four of its partner NGOs to act as wholesale distributors and retail sales agents. Each NGO-initiated sale returned a percentage of the profit to the organization, an incentive that simultaneously built the CSM project and the financial strength of the NGOs,

These NGO partners helped the CSM project expand into rural areas where distribution simply was not profitable for commercial sales agents. And their enthusiasm and commitment carried the project through when distribution was threatened by gasoline shortages that caused the breakdown of commercial transportation.

"Many condom outlets remained stocked throughout difficult periods only because NGO sales agents collected stock themselves," said Bertrovna Grimard, a PSI consultant who worked with the Haiti project.

NGO sales agents sold almost 40 percent of all the condoms sold by the CSM project from 1991 to 1996. Their role in achieving remarkably high sales in a poverty-stricken country and in expanding condom access to remote regions can serve as a model for CSM projects throughout the world. ■

buy a condom without drawing attention to their social status.

In Tanzania, for example, one television ad showed dozens of people—well-dressed young men and women, athletes, families with young children—singing the upbeat "Salama" condom theme song. In a Haitian ad, a beautiful young woman holds a Pantè brand condom package and says, "Pantè—It's for me." Then a man puts his hand lovingly on hers and corrects her: "It's for us." Such advertising helped boost condom sales among groups targeted by HIV/AIDS programs and the general population.

# Recommendations

- **CSM projects should allocate resources to ensure that condoms are available in the nontraditional outlets most likely to reach those at greatest risk of HIV infection.**

- **CSM programs should enlist new partners to ensure that low-cost condoms are available to target audiences.**

NGO personnel proved extremely successful sales agents, expanding condom access to areas seldom reached by traditional CSM projects. Another effective way to target marketing efforts is to hire a dedicated sales force that sells to smaller outlets in neighborhoods where target audiences live and work.

- **Subsidies to CSM projects must be continued to ensure that condoms are affordable to those who need them most.**

- **HIV/AIDS prevention programs should take full advantage of the emerging greater freedom to promote condom use and other behavior changes through the public airwaves and other means of mass communication.**

- **CSM programs should design advertising messages and campaigns aimed at the general population, not groups at the margins of society.**

In countries with mature epidemics, much of the general population *is* the target audience; in others, a more inclusive approach reduces the stigma often associated with condoms and discourages the perception that HIV/AIDS affects only marginalized groups.

# Future Challenges

## Expanding Social Marketing

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

## Marketing Prevention

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

## Changing Norms

Condom social marketing has a positive impact on social norms, but the degree to which it does and mechanisms through which it operates are not well understood. From Brazil to Ethiopia to Nepal, AIDSCAP evaluations have found evidence that individual sexual behavior is changing. It is likely that condom social marketing and other HIV/AIDS prevention efforts are contributing to more long-term changes in social norms as well, but it is too early to detect such change. The experience of family planning programs in reducing fertility rates in many countries during the past 30 years, however, shows the potential for normative change through social marketing.

# 3.3

# Dedicated Sales Force Expands Condom Access in Nepal

In 1994, the Nepal Contraceptive Retail Sales (CRS) Company dispatched a sales force of three men to the country's Terai region. Part of AIDSCAP's comprehensive program in Nepal, this social marketing effort was designed to help reduce transmission of HIV and other STDs among the men who traveled through the Terai on the transport routes between Kathmandu and India and the women who were their sex partners along the way.

By improving access to affordable condoms in the nine targeted districts of the region, the salesmen aimed to increase their use. But first they had to get the condoms into the stores.

Storeowners were reluctant to stock condoms, fearing that it would turn customers away. They also pointed out that their wives and daughters usually tended shop during the day. "How can I ask my daughter to sell condoms?" was a common question.

The salesmen persevered. One by one, they convinced the owners of tea shops, grocery stores and roadside stands to take a single box of condoms. When the merchants found that the condoms sold quickly, they asked for more.

Advertising, distribution of free Dhaal calendars, signs and T-shirts and promotional events also helped reduce storeowners' resistance to selling condoms. CRS organized a contest, offering cash prizes to the storeowners who created the most creative store displays promoting CRS' Dhaal brand condoms. They went from store to store along the highway, handing out free Dhaal materials and encouraging storekeepers to participate.

Given the original reluctance to stock condoms, let alone display them prominently, the response was astonishing. Dozens of shops and

MARY O'GRADY/AIDSCAP


*Dhaaley Dai billboard along the highway in Nepal from the Indian border to Kathmandu also displays Dhaal and Panther condom logos.*

stands were adorned with red Dhaal stickers, poster and banners arrayed in every imaginable pattern. The winning entry was a small, three-dimensional house fashioned entirely of Dhaal stickers.

The contest was a turning point, according to CRS Sales Manager Depak Pyakuryal. "After the display, people really wanted to keep the condoms in their stores," he said.

Before the contest, he added, village women tended to avoid shops that displayed condoms because they didn't want people to think that they were buying the devices. When most of the grocery stores in the highway area started displaying condoms, that stigma began to disappear.

"So now the situation is changed," said Pyakuryal. "Now condoms are everywhere."

In fact, the number of sales outlets carrying Dhaal condoms in the nine districts rose from just 150 in 1994 to more than 2,500 in 1997.

During those years, CRS salesmen saw attitudes toward condoms change. Storeowners who were once afraid to ask for the condoms by name, simply muttering "I'll take one of those," now ask for four or five boxes of Dhaal without a trace of embarrassment. Participants in the workshops on salesmanship and HIV/AIDS prevention that CRS organized to enlist storekeepers in educating customers about the importance of condom use expressed their concern about the spread of HIV and STDs and their desire to help stop it.

CRS sales figures suggest that condom advertising and other AIDSCAP communication efforts are also changing the attitudes of the ultimate target audiences, the men and women who can now buy condoms in almost any commercial establishment along the highway. Annual sales in the region rose from 689,328 in 1993, when CRS sold condoms as only one of several options for family planning, to 1.3 million in 1996. ■

## Investing in Condom Supplies

Meeting the demand for condoms created by social marketing is a major challenge. For years USAID has been the only donor providing significant condom supplies for public health and family planning programs. Although additional donors (notably the European Community and the German development agency) have recently entered this area, most are reluctant to support commodity supply—particularly when the commodity is considered controversial. Governments in the developing world also shrink at the cost projections for adequate condom supplies. For example, it would cost a social marketing project U.S.$25 million to supply the country of Ethiopia alone with an adequate number of condoms. But experience to data suggests that investments in adequate condom supplies would save millions of lives. A serious effort to contain the spread of the virus will require political will and resources to provide enough condoms to everyone who needs and wants them.

# 4 Policy Development and HIV/AIDS Prevention: Creating a Supportive Environment for Behavior Change

The social and political environment of a country, community or workplace has a profound influence on efforts to reduce the spread of HIV/AIDS. The laws, rules, policies and practices of governments, religious organizations and the private sector can support or constrain prevention activities. Some policies may even inadvertently promote the transmission of HIV.

Although many governments, businesses and religious organizations have begun to adopt more appropriate HIV/AIDS policies, this progress has not kept pace with the spread of the epidemic. Few countries have responded to HIV/AIDS with comprehensive programs or have committed the resources needed to slow the epidemic. Restrictions on sex education in schools and condom advertising continue to hamper HIV/AIDS programs. And many employers and governments have adopted ad hoc discriminatory testing policies that discourage people from acknowledging their HIV status and acting to protect others from infection.

Growing recognition of the importance of supportive policies has made policy development a key strategy for HIV/AIDS prevention in the second decade of the epidemic. Early policy efforts were based on the assumption that providing accurate data to key decision makers would stimulate swift adoption of appropriate policies. Now it is clear that informing decision makers must be part of a long-term policy development process that includes analysis, strategic planning, dialogue and advocacy.

## Influencing Policy

Recognizing that policy development is a complex, gradual process that must be initiated and sustained locally, AIDSCAP focused on building capacity to inform and influence policy. Through training, technical assistance and information dissemination, AIDSCAP helped local individuals and organizations gain new skills and forge new partnerships so that they could work together to create a supportive environment for effective HIV/AIDS interventions.

AIDSCAP developed and used a range of analytic tools, such as policy assessments, computer models of the socioeconomic impact of HIV/AIDS and cost analyses, to guide policy development efforts. But these tools did not stand alone. They were used strategically in a process designed to empower local advocates and officials to develop appropriate and effective HIV/AIDS policy.

Policy assessments proved an effective tool for identifying opportunities to support HIV/AIDS prevention interventions. These qualitative reviews, which were completed in eight countries, identified existing policy responses, important HIV/AIDS issues, and structures and organizations for addressing those issues. Their findings also provided a useful baseline for evaluating the impact of policy efforts.[1-2]

Other policy tools were used to gain a better understanding of the HIV/AIDS epidemic and its social and economic impact. AIDSCAP led the way in expanding the scope of economic impact analyses to include information on households, gender and economic sectors and in integrating those analyses into policy development. Socioeconomic impact assessments conducted with AIDSCAP technical assistance in eight countries gave policymakers a clear picture of the economic implications of the epidemic, and strategic dissemination of assessment results helped influence policy.[3] In the Dominican Republic and Honduras, for example, presentations of socioeconomic data and projections to senior policymakers resulted in legal reform and increased funding for HIV/AIDS prevention.

Cost-effectiveness data were particularly useful

in convincing business owners and managers to support workplace HIV/AIDS prevention policies and programs. AIDSCAP's Private Sector AIDS Policy package, which has been used in more than ten countries, includes spreadsheets and examples to help managers calculate the potential financial impact of HIV/AIDS on their workplaces and the cost of a workplace prevention program (Box 4.3).[4] The project worked with the managers of hundreds of companies in 27 countries to establish HIV/AIDS prevention interventions for employees and encourage adoption of supportive workplace policies.

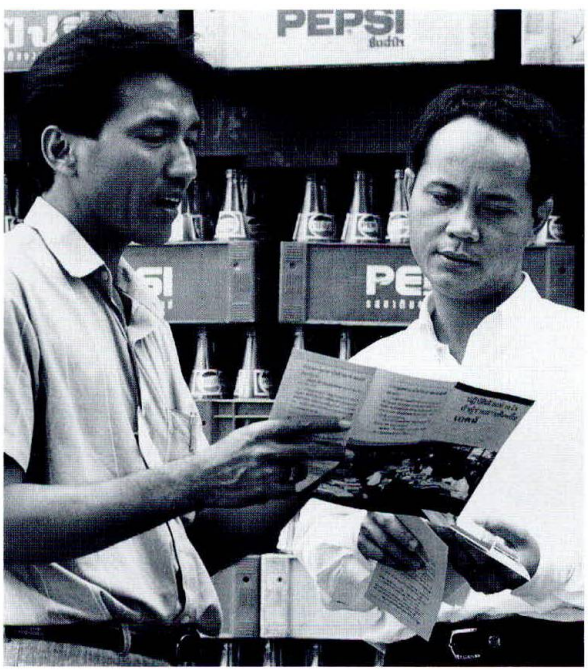
In many policy development efforts, AIDSCAP's technical role was to provide a comparative perspective, offering lessons from other countries' experiences with the epidemic. The project shared information about what has and has not worked nationally and internationally, disseminated international guidelines and policy materials that could be adapted to meet local needs, and sponsored study tours to countries with mature HIV/AIDS epidemics and programs. Study tours to Thailand, for example, gave key Indonesian policymakers opportunities to learn about the progressive policies and comprehensive programs of a country that experienced the earliest HIV/AIDS epidemic in Asia. Most of the tour participants formed an informal group that met regularly in Jakarta and helped guide the development of Indonesia's national HIV/AIDS strategic plan.

Although study tours and some other educational efforts targeted policymakers directly, AIDSCAP emphasized training of policy "influencers"—the technical and policy specialists inside and outside of government who inform and advise policymakers. Through this training, many people who had believed that policy was not their responsibility came to realize that they had important roles to play in policy development. Policy influencers who participated in AIDSCAP's training workshop in Central America were able to target and time the presentation of socioeconomic impact projections to influence the actions of policymakers (Box 4.2). In Senegal, Islamic and Catholic religious representatives recommended that assistants and spokespeople for religious leaders be engaged in initial dialogue so that they could help guide the policy response.

Whether the goal was government or religious policy change, AIDSCAP found that policy identification was a good way to create a network of committed advocates. At the national level, AIDSCAP's approach was to support local organizations in soliciting a list of key policy issues from people working on HIV/AIDS prevention at the district and provincial levels, expressing those issues as policy recommendations, and presenting the recommendations to the appropriate national authorities. The same process was used with church hierarchies and networks of religious organizations. As Kenya's experience with government, NGO and religious groups illustrates, this process can help build a constituency for longer-term policy development (Box 4.1).

AIDSCAP's experience shows that a strategic process and a focus on strengthening local capacity and collaboration can produce results and leave behind the institutional capacity to develop appropriate responses to a complex epidemic. Rigorous analysis of scientific and sociopolitical data, combined with presentations of persuasive recommendations and building constituencies for HIV/AIDS prevention, led to constructive dialogue among political and community leaders on topics such as workplace HIV/AIDS prevention, the human and civil rights of people living with HIV/AIDS, private

LANCE WOODRUFF




*A company physician discusses HIV/AIDS prevention with an employee at a Pepsi plant in Thailand. AIDSCAP worked with hundreds of companies in 27 countries to establish workplace prevention projects.*

# 4.1

# Changing HIV/AIDS Policy in Kenya

On September 24, 1997, the Kenyan Parliament approved the country's first comprehensive national policy on HIV/AIDS. This Sessional Paper on AIDS calls for a more aggressive response to the epidemic, establishes an independent National AIDS Council to ensure political commitment across government sectors, and states the government's positions on controversial issues such as HIV testing, confidentiality and human rights.

A milestone in HIV/AIDS policy development in Kenya, the Sessional Paper is the result of years of research, dialogue and consensus-building by HIV/AIDS advocates and technical specialists inside and outside of government. This process itself was remarkable, for it marked the first vigorous and inclusive public debate about the Kenyan response to the epidemic in a country where HIV/AIDS policy had long been neglected.

One of the many organizations that advised the Ministry of Health (MOH) as it drafted the Sessional Paper, a consortium of some 200 NGOs, used its own consultative process to develop specific recommendations that were incorporated into the national policy. With technical assistance from AIDSCAP, the Kenya AIDS NGOs Consortium (KANCO) held a series of district and provincial workshops in 1996 and 1997 to solicit the views and experiences of NGO personnel, religious leaders, civil servants and policymakers. Designed to build consensus among diverse groups, these workshops gave those working in HIV/AIDS prevention and care opportunities to identify common concerns and problems and to develop advocacy strategies for advancing priority issues.

Participation in policy identification workshops was an eye-opening experience for many NGO and government personnel, noted KANCO Director Alan Ragi. "Workers at the district level didn't think they had a role to play in policy development," he said.

KANCO showed them that policy was not just the province of the central government. The result was a list of 72 issues affecting HIV/AIDS prevention and care in Kenya.

Representatives of the different groups meeting at a national workshop convened by KANCO narrowed the original list to eight priority issues, which consortium staff then developed into policy recommendations. Some of these recommendations were shared with partners, such as business associations, better placed to pursue them in the policy arena. But most were conveyed, in position papers, presentations and discussions, to members of the government-appointed subcommittees drafting the Sessional Paper on AIDS.

KANCO worked closely with the various subcommittees to inform their members and to advocate for the consortium's recommendations. Ragi even represented KANCO as a member of the MOH subcommittee responsible for the strategies and interventions section of the Sessional Paper. As a result of this collaboration between the consortium and the MOH, all eight priority issues were addressed in the final document.

But passage of the Sessional Paper is hardly the culmination of KANCO's policy development efforts. Continued advocacy will be needed to ensure that the papers' guidelines are implemented and follow-up legislation is passed. And the network of KANCO chapters the consortium has built across the country will continue to identify new policy constraints and other issues for policy development and advocacy.

A similar process of policy identification, skills building and advocacy facilitated by MAP International among district and provincial clergy and church members led to a dramatic shift in the attitudes of Kenyan religious leaders. Once skeptical and sometimes even hostile to church involvement in HIV/AIDS prevention and care, the leaders of many different denominations came together in February 1996 and committed their churches to

developing policies to address 14 HIV/AIDS issues.

Their statement, later published in a daily newspaper, urged church action on providing education about family life and sexuality, developing support groups for HIV-positive people, offering premarital counseling and HIV testing, caring for orphans and those living with HIV/AIDS, and supporting the rights and needs of women. The leaders said churches should develop policies on "appropriate and acceptable methods of protection," without mentioning condoms or other specific methods. And in an unprecedented acknowledgment that clergy members do not always practice what they preach, they called for a revitalization of moral values in church leadership.

The urgency, unanimity and commitment of the religious leaders' response "was immediately and correctly perceived by local church leadership as empowerment and authorization," said Rev. Chris Mwalwa, who has served as a consultant to MAP. By giving local clergy and congregations the mandate they needed to respond to the epidemic, the policy statement strengthened the emergence of a powerful campaign among local churches and religious organizations to care for those affected by HIV/AIDS and to prevent further spread of the virus.

The experiences of MAP International and KANCO are proof that policy is not only the responsibility of central bureaucracies, and policy change is not always simply imposed from above. Changes in policy can be shaped from the grassroots by carefully executed strategies to engage people at all levels of governmental, organizational and community hierarchies in issue identification and advocacy. ■

sector support for prevention, and the organizational and financial sustainability of prevention efforts.

# Lessons Learned

## Policy Development Partners

- **The role of an outside agency such as AIDSCAP in policy development is one of advisor, not framer, of policy change.**

Outside donors can provide financial support, information, encouragement and technical assistance, but actual policies and processes for achieving policy development will come from local people and institutions.

For example, AIDSCAP provided technical assistance to help the Kenya AIDS NGOs Consortium develop HIV/AIDS policy recommendations based on the views of local constituents, which were solicited during a series of district and provincial policy workshops (4.1). AIDSCAP's role was to assist consortium staff in facilitating the policy development process, not to determine the content of the recommendations. Supporting such a process requires patience and flexibility, for donors and indigenous people might emphasize different priorities, but the policies that result will be more sustainable.

- **Working with and within coalitions is often the most effective way to advance policy goals.**

Coalitions demonstrate commitment, draw upon group expertise and provide a diversity of interests and expertise that can be focused on a single issue. AIDSCAP has worked with NGO, religious, business and government coalitions, providing technical assistance to help these groups remain focused on a defined agenda.

Similarly, a multisectoral group of technical specialists, analysts and advocates brings complementary skills, perspectives and contacts to the policy development process. This was the approach adopted by AIDSCAP in Central America, where teams of epidemiologists, economists, policy and financial analysts, and policymakers from three coun-

tries worked together to assess the socioeconomic impact of HIV/AIDS and to develop strategies for using their results to achieve policy goals (Box 4.2).

- **The best way to reach policymakers is through their advisors, constituents and already committed peers.**

In Kenya, leaders of major religious denominations committed publicly to policy adoption as a result of determined peer interest and constituent pressures demonstrated over two years of awareness raising and consensus building (Box 4.1). AIDSCAP also invited Kenyan policymakers and technical experts to co-author a book about HIV/AIDS in Kenya, which added legitimacy to its findings.[5] The country's vice president spoke at the press conference launching the book in Nairobi, where he gave the government's strongest statement to date about the epidemic in Kenya.

- **When they are respectfully engaged in the policy development process, religious leaders can play a constructive role in HIV/AIDS prevention.**

Many religious leaders are concerned that condoms are a form of birth control or that they contribute to promiscuity and youth sexual activity by reducing the risks associated with intercourse. But AIDSCAP's experience in Kenya, Indonesia, Nigeria, Senegal and Tanzania shows that when these concerns are addressed with respect, many religious leaders are willing to participate in coordinated, comprehensive prevention efforts.

AIDSCAP and MAP International's efforts to facilitate consensus on HIV/AIDS prevention within religious communities in Kenya were successful because they engaged religious leaders through the hierarchies of their churches, encouraged active discussion and networking, used persuasive results of youth sexual behavior surveys, and did not try to involve the senior hierarchy until near consensus was reached within the lower ranks (Box 4.1).

- **External organizations can support and strengthen, but not create, effective networks.**

Strong networks such as the Kenya AIDS NGOs Consortium and the National AIDS Convention

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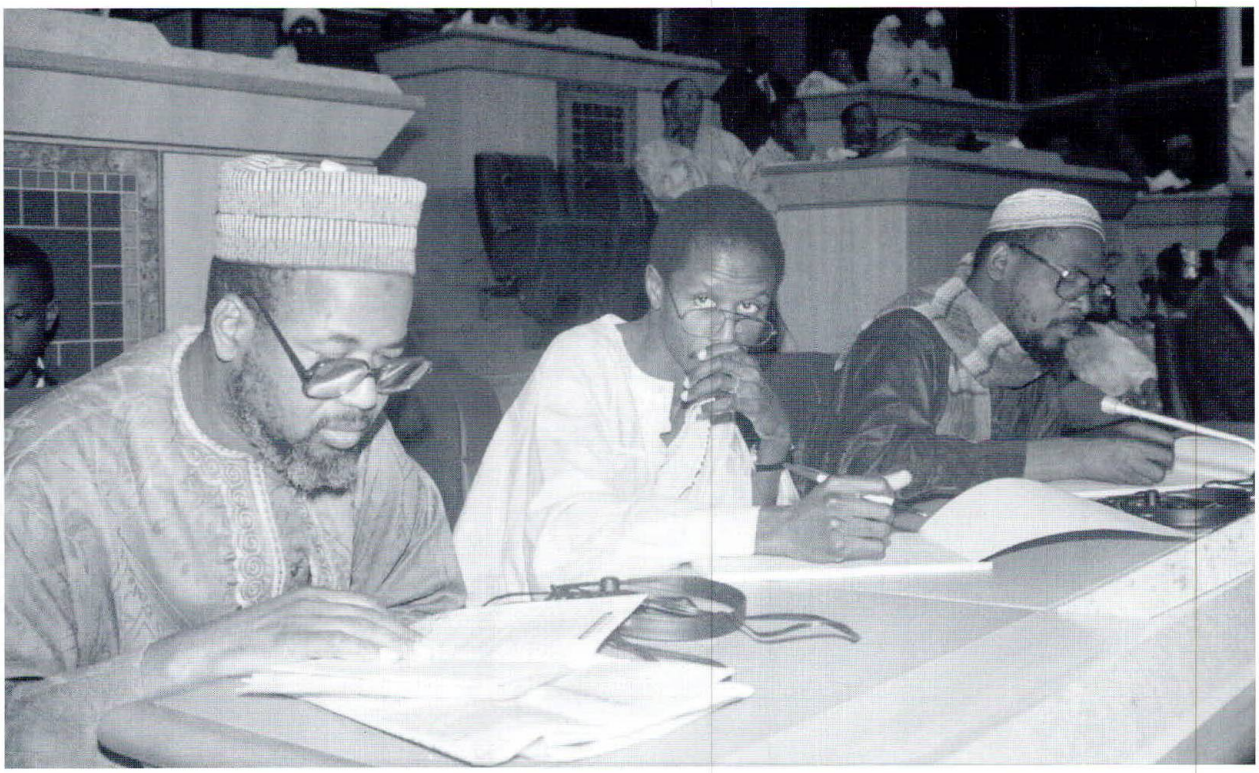


*Islamic religious leaders participate in an AIDSCAP-sponsored colloquium on "AIDS and Religion: Islam's response" in Senegal.*

of South Africa have succeeded because they serve the needs of a diverse membership, they have committed, skillful leadership, and they diversified funding sources at an early stage. These organizations came to be seen as providing a service, not only for members, but for government, and they engaged in policy and advocacy activities rather than focusing exclusively on programs and interventions.

## Policy Development Tools

- **Government and business policymakers are responsive to assessments of the potential social and economic impact of HIV/AIDS in a country or company.**

Data on the effects of HIV/AIDS on national economies and societies—particularly data generated and presented by country health officials and analysts—proved an influential advocacy tool in the 12 countries where AIDSCAP helped conduct such assessments. In El Salvador, for example, numerous presentations on the impact of HIV/AIDS on the national economy and social welfare indicators stimulated the Salvadoran Social Security Institute, which provides health care to both private and public sector employees, to work with businesses to develop HIV/AIDS programs in the workplace (Box 4.2).

- **Reports of modeling projections can be highly influential if disseminated strategically.**

For example, dissemination of a non-technical summary report of modeling projections written for the general population and the news media generated extensive coverage of the epidemic in the Dominican Republic.[6] This media coverage drew public attention to the growing HIV/AIDS problem in the country, which helped promote passage of a comprehensive AIDS law by the National Assembly.

Epidemiologic and economic impact projections can also strengthen advocates' case for laws protecting the civil rights of people living with HIV/AIDS. In the Dominican Republic, for example, a well-timed presentation of the results of a socioeconomic impact assessment was instrumental in achieving passage of a law that not only requires each ministry to fund prevention activities, but also guarantees human rights for people living with HIV/AIDS. And in Nicaragua, an advocacy NGO used the results of the assessment made during an AIDSCAP training workshop to help pass legislation protecting homosexuals and HIV-positive people (Box 4.2).

- **Policymakers are often prepared to act on recommendations for HIV/AIDS prevention when they are presented with clear, precise information.**

Specific recommendations, substantiated with convincing data and supported by advocacy, can lead to policy change. In Kenya, for example, recommendations from position papers prepared by the Kenya AIDS NGO Consortium were incorporated into the government's Sessional Paper on AIDS (Box 4.1).[7] And South Africa's minister of health adopted as national policy a comprehensive plan for a national response to HIV/AIDS drafted by local NGOs.

## Involving Employers

- **Workplace HIV/AIDS prevention activities are acceptable to business managers when the interests of the business are considered.**

By working with managers to help them understand the impact of HIV/AIDS on their businesses and to tailor interventions to meet the needs of workers and management, AIDSCAP and its partners helped establish prevention programs in hundreds of workplaces throughout the world.

AIDSCAP's Private Sector AIDS Policy (PSAP) materials encourage managers to establish constructive HIV/AIDS policies and support prevention programs in the workplace. PSAP uses rapid analysis of the potential financial impact of HIV/AIDS on a business and the expected effects of workplace HIV/AIDS prevention activities to demonstrate the benefits of prevention policies and programs (Box 4.3).

- **The greatest impact of HIV/AIDS on the financial well-being of companies occurs in the disruption of production because of absenteeism, labor turnover due to illness or death of HIV-positive employees, and the need to train new employees.**

Even in low-wage, labor-intensive industries, productivity is affected, and company profits suffer. In Thailand, for example, an AIDSCAP study of the affiliates of two multinational companies found that absenteeism due to AIDS rep-

# 4.2

# Policy Development Initiative Reaps Unexpected Benefits

In February 1996, a group of technical specialists, policy analysts and policy influencers from three Central American countries met in Guatemala City to participate in an AIDSCAP-sponsored policy development workshop. The skills and knowledge they gained there and the collaborative relationships they forged continue to have an impact on HIV/AIDS prevention in their countries to this day.

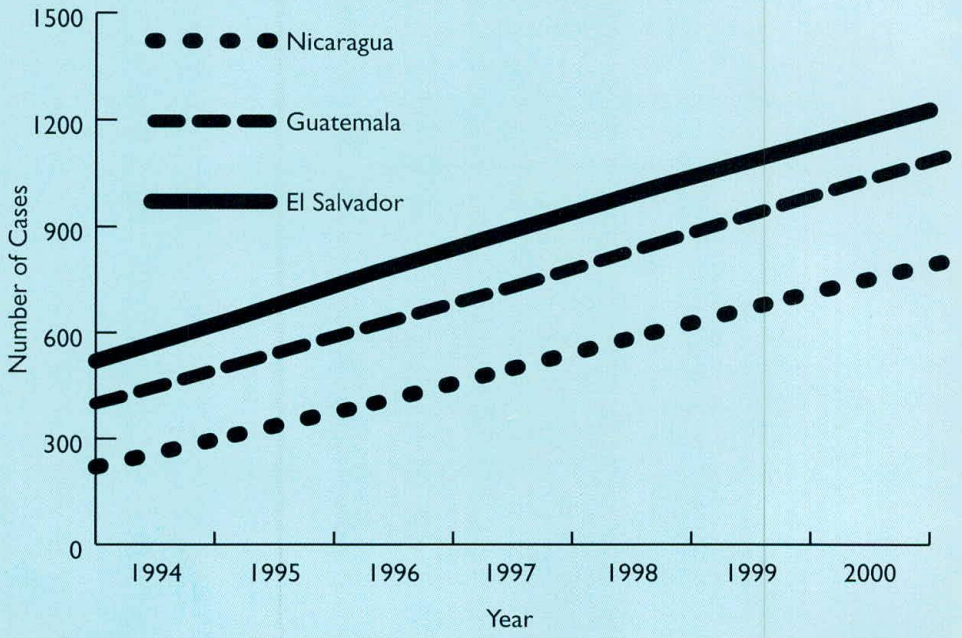
At the workshop, participants learned to estimate the potential socioeconomic impact of HIV/AIDS in their countries and to use their results to inform and guide HIV/AIDS prevention policymaking. They agreed to continue working together after the workshop to develop stronger responses to HIV/AIDS in their respective countries.

After learning how to use computer models and costing methodologies to make epidemiologic and economic projections, the three country teams developed policy recommendations and advocacy strategies to support each recommendation. Initially their action plans for presenting the results were similar, but new strategies emerged as the teams returned home and encountered different constraints and opportunities.

In El Salvador, a presentation of the team's projections at the Instituto Salvadoreño del Seguro Social (ISSS), a parastatal organization that provides health care to private and public sector employees and their families through its own hospitals and health centers, produced immediate results. The projected impact on health costs and ISSS operating expenses so concerned the institute's board of directors that it established an HIV/AIDS prevention program for its employees and initiated its own project to strengthen the HIV/AIDS prevention efforts of its private sector clients.

The legislative aides on the Salvadoran team also

**Projected Increases in AIDS Cases in Three Central American Countries**




*Projections of increases in AIDS cases, HIV infections and treatment costs were used by AIDSCAP-trained organizations to advocate for HIV/AIDS policy reform in El Salvador, Guatemala and Nicaragua.*

arranged a presentation to members of the National Assembly shortly after the workshop, which resulted in commitments by Assembly members to support passage of HIV/AIDS legislation, such as a safe blood law, being prepared for consideration in the next legislative cycle.

The Guatemalan team benefited from the participation of the chief of the military health service (Servicio de Sanidad Militar, or SSM), whose experience at the workshop made him an advocate for HIV/AIDS prevention and care in the military. After the workshop, the SSM chief quoted the team's projections in a number of media interviews and publicly called for a review of policies and practices related to HIV-positive members of the military. He continues to be involved in disseminating the study results and in HIV/AIDS policy development as the military representative on the new National HIV/AIDS Coordinating Committee.

Another benefit of the AIDSCAP workshop is the improved relationship between the national AIDS control program and the Asociación Guatemalteca para la Prevención y Control de SIDA, an HIV/AIDS service and advocacy organization, in Nicaragua. Despite prior tensions, representatives of the two groups were able to work together on the socioeconomic impact project. This collaboration bodes well for the efforts of the National HIV/AIDS Coordinating Committee, a multisectoral coalition that brings together diverse, and in some cases historically antagonistic, interests and perspectives to strengthen Guatemala's HIV/AIDS prevention and care programs.

A severe economic downturn, a series of public health crises and an upcoming national election made it difficult for the Nicaraguan team to follow through on the activities defined in its action plan. Fortunately, however, a Nicaraguan NGO that was unable to participate in the workshop but was involved in follow-up meetings and strategic planning used the team's results to work with the national AIDS control program to pass legislation protecting the rights of people living with HIV/AIDS. When this legislative effort led to the reconvening of Nicaragua's National AIDS Committee, the assessment team used the opportunity to share its results with committee members.

Success in policy development is often incremental and can take unexpected forms, as the experiences of the three Central American teams illustrate. For example, the Salvadoran team's work inspired the Social Security Institute to use socioeconomic impact analysis to sensitize other members of the private sector to HIV/AIDS. Likewise, the collaboration fostered by the workshop had unanticipated benefits in Guatemala, where it contributed to energizing the National HIV/AIDS Coordinating Committee. And in Nicaragua, Fundación Nimehautzin—an NGO that could not send a representative to the AIDSCAP workshop—linked data generated by the team with advocacy to help steer the country's legislative response to the epidemic.

The experiences of all three country teams reflect a central lesson from AIDSCAP's experience: that policy development success arises from good data, sound analysis, thorough planning and true collaboration. The way that these elements come together depends, in part, on recognition that policy development is a process. Like all good processes, it can be enhanced with strategic planning and the ability to take advantage of unexpected opportunities. ■

# 4.3

# Private Sector AIDS Policy: Helping Businesses Respond to HIV/AIDS

With a few notable exceptions, private industry worldwide has been slow to adopt policies and mount programs to protect workers from HIV/AIDS. Through its support of hundreds of workplace prevention projects in 27 countries, AIDSCAP found that many business owners and managers did not understand the threat the epidemic posed to their workforces and their businesses. Others simply did not know what to do.

AIDSCAP's *Private Sector AIDS Policy: Businesses Managing HIV/AIDS* is designed to address both problems. Known as PSAP, it helps managers gauge the potential impact of HIV/AIDS on their businesses and design appropriate workplace policies and prevention programs to respond to the epidemic.

The PSAP kit is one of the few HIV/AIDS prevention resources written specifically for private sector managers in the developing world, and it is the most comprehensive of its kind. It contains a manual to help businesses estimate the potential impact of the epidemic on their operations and profits and to plan prevention interventions, case studies of 17 African businesses' responses to HIV/AIDS, guidelines for assessing prevention needs in the workplace, and a facilitators' guide for trainers working with businesses.

The facilitators' guide helps trainers use the PSAP materials to give short presentations to sensitize business owners and managers to the need for a vigorous response to HIV/AIDS and to conduct two-day workshops on designing appropriate prevention policies and programs. But PSAP can also stand alone as a guide for private sector managers who want to develop HIV/AIDS policies and prevention programs.

Before its publication in November 1996, PSAP was pretested at business leader workshops, luncheon presentations and training-of-trainer seminars in Kenya, Nigeria and Senegal. Interviews with participants and questionnaires they completed yielded useful suggestions for improving the materials, but the response was overwhelmingly favorable. In fact, many business owners and managers said they would be willing to pay to attend additional PSAP workshops.

Ministries of health, business federations, unions, individual businesses, NGOs and international organizations in at least ten countries are using PSAP to promote greater private sector involvement in HIV/AIDS prevention. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has included the PSAP kit in its "best practices" library, and copies are available in all UNAIDS offices.

Although PSAP was originally developed for use in Africa, it is already in demand in countries throughout the world. Parts of the kit have been translated into Spanish for use in Latin America, and the entire kit will be translated into Portuguese in Brazil.

Zimbabwe's minister of industry and commerce, Herbert M. Murerwa, noted that PSAP is unique because it recognizes the needs of employers and goes beyond simply offering guidelines. "This guide provides business-based rationale for recommendations, encourages the generation of options, and offers a process for HIV/AIDS policy and program formulation," he said. ■

resented over 40 percent of the total cost of HIV/AIDS on the businesses. Labor turnover and training of new workers added up to another 30 percent of total costs. The study estimated that HIV/AIDS had cost each company $20,000 in 1994 and projected that AIDS-related expenses would rise to $100,000 per company by 2005.[8]

- **Essential management support for prevention policies and programs can be gained by identifying key allies in a company and providing data to support the need for a workplace project.**

An assessment of AIDSCAP-supported workplace programs in three African countries found that it is often most effective to approach managers in training, human resources and health departments who are familiar with the impact of the epidemic on the work force.[9]

Experience in Africa also showed that working with an industry association rather than individual companies makes "entree" and later expansion easier. In Zimbabwe, for example, regional coordinators of the Commercial Farmers Union recruit new farms to participate in the AIDSCAP-supported program and provide training in HIV/AIDS prevention education to farm employees and their families. The Organization of Tanzanian Trade Unions has also trained regional officers who approach employers in their areas. And in Eldoret, Kenya, AIDSCAP reached employers through the local branch of the Kenya Association of Manufacturers, which then decided to hold orientation workshops for business owners and managers in neighboring districts.

- **Requiring some contribution from companies from the start facilitates increased cost-sharing as workplace prevention needs and activities expand.**

Cost-sharing is introduced most effectively during negotiations with an association or company on the services to be provided. Once a program proves itself, companies may assume an even greater share of the costs. For example, two Zimbabwean companies that have collaborated with AIDSCAP to establish workplace prevention programs—the Commercial Farmers Union and Triangle Industries—now include funds for HIV/AIDS prevention in their annual budgets. In Tanzania, companies were asked to contribute 25 to 50 percent of the cost of workplace prevention.

### Evaluation

- **Changes in policies and the policy environment can be measured by using both quantitative and qualitative indicators.**

Evaluation of policy work is complex for a number of reasons, including the difficulty of attributing policy changes to specific interventions and of quantifying changes in the policy environment. In addition, because much of policy change is incremental and attitudinal, it is often hidden from evaluation efforts.

AIDSCAP overcame these limitations by using a combination of quantitative and qualitative indicators of change. Simple quantitative indicators, for example, can measure changes in the level of governmental or business funding for HIV/AIDS prevention. Assessments that include two sets of in-depth interviews with key policymakers and advocates carried out two or three years apart provide information on changes in attitudes and policies, institutional mechanisms that may affect policy, and organizational dynamics. A policy assessment in Kenya found significant changes in the policy climate, improved institutional mechanisms for facilitating policy development, and movement among major religious groups from institutional denial and occasional open opposition to HIV/AIDS prevention to a public commitment to develop appropriate denominational policies (Box 4.1).

## Recommendations

- **External agencies should limit their role in policy development to enabling local people and institutions to develop their own policy recommendations and plans for enacting them through training, technical assistance and information dissemination.**

Technical assistance should not be overly directive, and expatriates should not be put in a position to act as spokespeople to senior officials. Policies developed locally will have a stronger constituency and are more likely to be adopted and sustained.

- **HIV/AIDS programs should work with religious communities and their leaders to encourage their active participation in prevention efforts.**

Religious leaders are playing a constructive role in HIV/AIDS prevention in several countries as a result of approaches that respected their values and engaged them through the hierarchies of their churches.

- **Outcomes of technical assessments and analysis must be translated into concise, nontechnical summaries accessible to both policymakers and the media.**

- **To ensure that policymaker education results in policy initiatives, presentations of the projected social and economic impact of the epidemic should be accompanied by specific recommendations for preventing HIV/AIDS.**

These recommendations should be supported by persuasive data, including estimates of implementation costs when possible. Local advocates should follow up presentations with additional information, reminders of the proposed actions, and advocacy.

- **Workplace HIV/AIDS prevention programs should begin with a concerted effort to identify allies in a company and to provide data to support the need for such a program.**

Managers need to understand how HIV/AIDS is affecting their industries and the potential impact on labor costs and productivity if prevention efforts are not instituted.

- **HIV/AIDS programs should require an employer contribution to workplace prevention projects from the beginning to ensure further cost-sharing as prevention needs and activities expand.**

# Future Challenges

## Encouraging Early Response

Engaging the interest, concern and support of policymakers at early stages of the epidemic continues to be challenging, particularly when prevalence is low and the potential for a future problem may not be apparent. Exchanges between policymakers from countries at different stages of the epidemic have helped raise awareness of the need for early intervention in a few countries, but appropriate measures to contain early HIV/AIDS epidemics are rare. Early interventions are particularly important to offer viable protection to monogamous women and to youth.

## Leveraging Private Support

Businesses are often reluctant to dedicate resources for HIV/AIDS prevention, though most owners and managers are willing to allow such projects to operate in the workplace as long someone else pays for them. Systematic advocacy campaigns, better information about the impact of HIV/AIDS on businesses, and delivery of professional prevention services on a fee-for-services basis are needed to encourage businesses to dedicate more of their own resources to prevention.

## Understanding Impact

Although it is clear that social and economic factors contribute to HIV vulnerability and transmission of the virus, more specific data are needed to make a persuasive case. The relationship between HIV/AIDS vulnerability and poverty is assumed but has not been sufficiently described or analyzed. Socioeconomic data on specific groups of people are needed to clarify this relationship and provide a better understanding of the link between HIV/AIDS and multisectoral development.

## Improving HIV Testing Policies

As HIV testing becomes less expensive and more available, there will be a growing need to ensure that it is not used to discriminate against people living with HIV and that voluntary testing is linked with effective counseling. Policymakers need to be educated about the negative effects of discriminatory testing policies.

## Supporting Prevention and Care

The emerging availability of and options for HIV/AIDS treatment will place greater demands on medical systems and national governments to provide new, expensive drugs. Some countries may respond by moving funding allocated for HIV/AIDS programs from prevention to treatment, care, support and mitigation. Competition for scarce resources would ill serve those who need these services. Advocacy efforts are needed to convince policymakers of the importance of increasing funding for both care and prevention

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# 5 Behavioral Research: Using Results to Design Behavior Change Interventions

Understanding the behaviors that put people at risk of HIV infection is the fundamental challenge of HIV/AIDS prevention. Since the beginning of the epidemic in the early 1980s, behavioral research projects have investigated such sensitive issues as sexual behavior and drug use and have illuminated many of the cultural and social factors that influence risk behavior.

In response to rapid shifts in the epidemiology of the HIV/AIDS pandemic, strategies for conducting behavioral research have changed over the past six years. Well-designed rapid studies increasingly received priority over more long-term thematic research, and scientists moved away from repetitive studies of knowledge, attitudes, beliefs and practices toward research that provided practical information to guide interventions.

As the epidemic expanded, behavioral research also moved beyond studying the behavior of traditional "high-risk groups" to research with populations previously considered at low risk of HIV infection, such as adolescents and women. And as the number of people living with HIV increased dramatically, understanding the risk behavior of those who are HIV-positive and testing interventions to support their behavior change began to receive more attention.

## Understanding Risk Behavior

Behavioral research conducted under AIDSCAP examined issues central to both global and local prevention efforts. Research projects ranged from small, rapid, program-related studies to large-scale, multisite efficacy trials.

AIDSCAP's behavioral research was designed to expand the scientific knowledge of HIV risk behavior and to have a direct impact on the development of prevention programs. Program-related research addressed critical issues such as barriers to condom use among young women in the Dominican Republic, strategies for heterosexual couples to use in renegotiating sexual relationships to change high-risk behavior, and whether knowledge of HIV status leads to behavior change.

Behavioral research results were used to design effective interventions in many countries. In São Paulo, Brazil, for example, the success of a controlled intervention trial targeting young adults completing their primary and secondary education in night schools led to an HIV/AIDS prevention program for adolescents in 2,800 public secondary schools. A total of 300,000 manuals based on the curriculum developed for the trial were distributed to students throughout São Paulo. And in Thailand, a pilot intervention study using the Royal Thai Army's command structure and informal networks among conscripts was adapted by the military to provide HIV/AIDS prevention services for all recruits.[1]

AIDSCAP's largest intervention trial, cosponsored by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and implemented with research institutions from Kenya, Tanzania, Trinidad and the United States, was a multisite study of the efficacy of voluntary HIV counseling and testing (Box 5.1).[2] The results of this study will offer guidance to policymakers on the cost effectiveness of such services.

AIDSCAP also advanced the science of HIV/AIDS prevention by addressing emerging global issues such as the role of structural and environmental interventions in reducing HIV incidence, prevention interventions to help protect women in stable relationships, and the linkages between HIV prevention and care. A series of concept papers reviewed the research on each of these issues and defined research questions for the future.[3-5] These

questions led to research studies and pilot interventions that offer recommendations and models for the next generation of HIV/AIDS programs.

In Kenya, for example, an in-depth study of communication between men and women in stable relationships identified the best ways to encourage dialogue between partners about HIV risk and condom use. This research study showed that through counseling, couples could learn to discuss sex and HIV risk reduction within their relationships. In the Dominican Republic, formative research among sex workers and their clients, employers and steady partners was used to design a demonstration project adapting a highly successful structural and environmental intervention from Thailand (Box 5.2). And in Tanzania, one of the first studies to examine the links between care programs for HIV-positive individuals and their motivation to adopt safer sexual behavior to protect others will be used by program staff and policymakers to design HIV/AIDS support programs that include prevention activities (see page 100).

Findings from these and many other behavioral research projects were disseminated through publication of peer-reviewed articles and presentations at national and international scientific conferences. AIDSCAP's contribution to the scientific literature on HIV risk behavior and prevention includes more than 50 journal articles and more than 75 conference presentations.

In addition to guiding program interventions and addressing global research issues, AIDSCAP's behavioral research strategy emphasized capacity building. Through collaborative partnerships, training and technical assistance, the project enhanced the capacity of more than 150 social scientists and 100 institutions to conduct behavioral research for HIV/AIDS prevention. AIDSCAP also supported the Visiting Scholars Program for developing country researchers of the Center for AIDS Prevention Studies (CAPS) at the University of California at San Francisco, an FHI partner in the project's behavioral research activities (Box 5. 3).

Each of AIDSCAP's ten competitive research grants was awarded to a research team of scientists from developing and developed countries. Most of the research the project commissioned to answer important questions in HIV/AIDS prevention and all program-related studies were also conducted with host-country partners. This collaborative approach encouraged the transfer of knowledge and skills, enhanced the acceptability of research results and gave local researchers a stake in ensuring that their findings were used to improve prevention programs.

RAPHAEL TUJU/ACE COMMUNICATIONS


*The results of an HIV-antibody test were good news for this couple, who participated in AIDSCAP's counseling and testing study in Kenya.*

## Lessons Learned

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

Answering many of the most important research questions requires perspectives from such disparate fields as STD management and prevention, social marketing, medicine, counseling, psychology, epidemiology, communications and family planning.

AIDSCAP's HIV Counseling and Testing Study, implemented in Tanzania and Kenya by AIDSCAP and in Trinidad by UNAIDS, is a good example of a multidisciplinary research project.[2] A random-

# 5.1

# Study Examines Counseling and Testing for HIV/AIDS Prevention

When 22-year-old Anne Kanjiri of Nairobi found out that she had tested negative for HIV, the news was more than just an opportunity to celebrate. It was a chance to make some changes in her life.

"I used to have many sexual partners before I was counseled and tested for HIV," she said. "When I got my results, I decided to get married instead."

To researchers from the Kenya Association of Professional Counselors (KAPC), her response is as significant as the results of her test. Kanjiri* was a participant in the first randomized study of the impact of counseling and testing (C&T) on behavior change for HIV/AIDS prevention among people voluntarily seeking such services in developing countries.

Through randomized controlled trials conducted in Nairobi by the KAPC and at other centers in Tanzania, Trinidad and Indonesia, the cosponsors of the study hope to discover whether HIV testing accompanied by personalized, one-on-one counseling can influence individuals to adopt preventive behaviors and lower their risk of HIV infection. In the past, a limited number of nonrandomized studies of C&T's impact among specific populations had yielded mixed results.

Kanjiri was just one of 4,298 volunteers who participated in the study at the AIDSCAP-sponsored sites in Kenya and Tanzania and at the site in Trinidad funded by UNAIDS. Because of the breadth of the study and the size of the populations, AIDSCAP and UNAIDS expect the result to be significant for prevention programs worldwide.

An international effort, the research was conducted by the KAPC in Kenya, the Muhimbili University College of Health Sciences in Tanzania and the Queens Park Counseling Center in Trinidad, with The Center for AIDS Prevention Studies at the University of California at San Francisco serving as the coordinating center.

Study participants at the three sites were assigned randomly to one of two interventions, counseling and testing (C&T) or health information. Subjects in the C&T arm received pretest counseling and had blood taken for HIV antibody testing. After test results were available, each C&T participant received counseling. Those in the health information group—the study's control arm—were shown an informational video about HIV and STD prevention and given condoms, along with training in how to use them.

All participants were invited to return to the study center twice. At six months, participants in both groups were tested for STDs and offered the option of counseling and an HIV test. Researchers also administered a follow-up questionnaire to those in both groups at six months and again at 12 months.

During the interviews, data were collected on sexual behavior, psychological status, knowledge and attitudes about HIV/AIDS and other STDs, and care-seeking for STDs. The STD test results will supplement the self-reported behavioral data, providing a more objective measure of behavior change.

The results of the study will be available by the end of 1997. But before the data analysis had even begun, researchers had already learned a great deal from their experiences in Kenya and Tanzania. Early fears that they would not be able to recruit enough participants soon disappeared as the enthusiastic response to the study revealed a great demand for HIV counseling and testing in both Dar es Salaam and Nairobi. Even after recruitment had ended, four to ten people came to each center every day to seek counseling and testing.

People's willingness to return for the their test results was another sign of how much they valued the service. An unusually high proportion of those assigned to the C&T

arm—more than 85 percent—returned for their results one week after the test without any prompting.

Researchers at both sites did have trouble recruiting enough people to participate in the study as couples. Most people preferred to enroll alone, often bringing a partner to the center months later for counseling and testing. Counselors reported that although couple counseling was extremely challenging at the beginning of the study, they found it more effective because it gave them opportunities to assist couples in negotiating behavior change.

Economic data gathered during the study will help determine whether voluntary HIV counseling and testing is a cost-effective prevention intervention in developing countries, and whether such services can be sustained. Researchers already know that more than half the study participants would be willing to pay up to the equivalent of U.S.$2 for C&T services. Concerns about the cost of such services will undoubtedly continue, but further analysis of the data will give policymakers clear guidance on whether C&T is effective—and ultimately worth the expense. ■

**Confidentiality was strictly observed in this study. Anne Kanjiri later agreed to be interviewed by a journalist and quoted by name.*

ized, controlled trial of the impact of voluntary HIV counseling and testing on risk behavior, the study examined psychological, behavioral, epidemiologic, operations and cost-effectiveness issues (Box 5.1).

## Collaboration and Capacity Building

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

Such partnerships can offer NGOs a sustainable source of technical assistance and help strengthen local research capacity. For example, a Tanzanian NGO collaborated with a researcher from Muhimbili University on an AIDSCAP-sponsored study of how care and support services for people living with HIV/AIDS affect risk behavior (see page 100). This collaboration enabled the Tanga AIDS Working Group to continue focusing on providing HIV/AIDS services, including counseling and home-based care, while the researcher provided technical assistance in research methodology and data analysis.

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

Bringing together highly skilled and experienced people from international institutions to collaborate on research is time consuming, but it facilitates acceptance of the findings because key institutions have been involved in the research process. AIDSCAP's counseling and testing study linked host-country and international scientists through an executive committee that included the local principal investigators, AIDSCAP and CAPS scientists, and collaborators from the World Health Organization's Global Programme on AIDS and UNAIDS. The committee made decisions about the study through regular meetings and conference calls.

## Appropriate Scale

- **Large, multisite intervention trials such as AIDSCAP's HIV counseling and testing study have an important but specific role to play in HIV/AIDS prevention.**

Such projects can create opportunities to share resources, make cross-site comparisons, and sometimes even pool data to enhance statistical

# 5.2

# 100 Percent Condom Use: Adapting Thailand's Policy in the Dominican Republic

Since 1989, Thailand's government has required condom use in all the country's brothels. Enforcement of this policy through legal sanctions against brothel owners, combined with a mass media campaign, has led to dramatic increases in condom use and decreases in STD rates.

The Thai "100 percent condom policy" has been hailed as an example of the kind of structural and environmental interventions needed to reduce barriers to individual HIV risk reduction. But would the policy work in other countries?

Results of a study conducted by AIDSCAP and the NGO COIN (Centro de Orientación e Investigación Integral) suggest that in the Dominican Republic, the answer to that question may be yes. Formative research identified strong support and practical recommendations for adapting the Thai policy to the Dominican context.

Rapid ethnographic research conducted in the summer of 1996 included participant observation in five brothels and other commercial sex establishment and repeated in-depth interviews with brothel owners, clients, and sex workers and their steady partners. In just six weeks, researchers conducted more than 200 interviews.

The most surprising finding was the positive response from sex workers, brothel owners and clients to proposals to promote and monitor condom use in commercial sex establishments. Instead of considering medical check-ups of sex workers and legal sanctions oppressive, most respondents saw such policies as supportive.

Sex workers said policies requiring condom use in commercial sex would not only protect their health, but also make it easier to negotiate condom use with clients. The women reported that they spent a great deal of time and effort trying to convince clients to wear condoms. Owners and managers believed that having an STD-free establishment would increase prestige, clients and profits. Steady partners of sex workers and—for the most part—clients were also supportive, citing fears about their own health and the health of their partners and children.

The study results suggested that a program promoting condom use through both policy change and solidarity among sex workers and brothel owners was likely to be most effective in the Dominican Republic. The results also revealed the importance of addressing sex workers' risk of STD and HIV infection from steady, non-paying partners.

These findings were used to design a pilot 100 percent condom intervention that included training for brothel staff to promote group solidarity as well as promotion of a government policy on mandatory condom use. Such a policy would be enforced by sanctions (fines and brothel closings) against Dominican commercial sex establishments that did not enforce consistent condom use and certificates for those that did. Compliance would be monitored primarily through regular STD screening of sex workers.

AIDSCAP began testing some components of the pilot project in May 1997 in ten sex establishments. Brothel owners and managers, sex workers and other brothel

employees all received training in the principles, rights and responsibilities of a "collective agreement" to promote and support condom use in commercial sex. COIN held the first of a series of special workshops on communication and sexual negotiation for sex workers and their steady partners. It also organized and supervised the effort to institutionalize structural strategies such as STD screening, cards certifying that sex workers are STD-free, improved condom access, and spot checks for used condoms in brothel rooms.

Full implementation of the pilot project and eventual expansion nationwide, however, will require a formal government policy mandating condom use during all commercial sex acts and imposing legal sanctions for noncompliance. The dialogue that AIDSCAP and COIN initiated with the government continues in order to encourage the policy changes needed for effective structural interventions to support 100 percent condom use among sex workers and their clients in the Dominican Republic. ■

power. But they should only be used to test technologies and approaches that have global significance and have not already been the subject of a rigorous efficacy trial.

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

For example, results from a nine-month qualitative study of the contributing factors and motivations for risk behavior among Nicaraguan sex workers, their clients, and men who have sex with men provided information critical to the development of a national HIV/AIDS communication strategy. And in the Dominican Republic, rapid research techniques were used to assess the feasibility of adapting Thailand's "100 percent condom policy" (Box 5.2).

## Ethical Issues

- **Interventions tested in efficacy trials can be both feasible and of high quality.**

The tradeoffs involved in testing interventions in resource-poor countries are a source of continuing debate. Some argue that it is unethical to test "gold-standard" technologies or approaches in countries that cannot afford to implement them. Others contend that the only way to encourage adaptation of innovations and to attract financial support for their implementation in developing countries is to first establish their efficacy.

AIDSCAP's experience shows that ensuring the feasibility of interventions to be tested does not necessarily mean that quality must be compromised. For example, research among military recruits in Thailand assessed the impact of an intervention designed to be used at other military bases. Instead of testing an intensive, one-on-one intervention that would have been too costly to replicate, the study used the military's leadership structure and the natural social networks among the soldiers to reach recruits with education, counseling, HIV testing and peer support. When study results showed that the intervention had led to changes in behavior, the Thai military adopted it on a wider scale.

# 5.3

# Building Local Capacity in HIV/AIDS Research

Dr. Maria Eugênia Lemos Fernandes arrived at the University of California at San Francisco in the summer of 1989 with an idea. A physician and director of the HIV/AIDS prevention program in the Department of Health in the state of São Paulo, she wanted to find out more about the epidemiology of HIV-1 and HIV-2 among one of the groups most as risk of infection—women involved in commercial sex—and the factors that influenced that risk.

During the next ten weeks, she spent much of her time working with colleagues at the Center for AIDS Prevention Studies to design a study that would provide the background information needed to develop prevention interventions to reach sex workers in three cities with high HIV prevalence: São Paulo, Santos and Campinas.

Like other graduates of the CAPS Visiting Scholars Program, an intensive program designed to build the HIV/AIDS prevention research skills of scientists from developing countries, Dr. Fernandes was able to take the study protocol she developed in San Francisco, conduct the research in her own country and publish the results.[1] This research provided the baseline data for interventions implemented as part of the AIDSCAP program in Brazil and the rationale for important financial support from the World Bank for HIV/AIDS prevention in the state of São Paulo.

Eight years later, Dr. Fernandes is still working to help women and men in São Paulo and other parts of Brazil protect themselves from HIV/AIDS. As head of the NGO Associação Saúde da Família and the former resident advisor of the AIDSCAP program in Brazil, she manages an HIV/AIDS program that builds the capacity of local organizations to develop effective and sustainable prevention projects in the states of Fortaleza, Salvador, São Paulo and Rio de Janeiro.

Each year up to ten scientists participate in the CAPS program. During their time in San Francisco, they attend seminars on epidemiology, research design, data management, biostatistics, and the behavioral and psychosocial aspect of the HIV/AIDS epidemic. But the program's main emphasis is helping the scientists design HIV/AIDS prevention research projects to carry out in their own countries.

CAPS provides pilot project funding and offers continuing technical assistance to enable the scientists to implement these research protocols. A number of participants have returned to San Francisco to participate in a writing sabbatical program that gives them time to work with CAPS faculty analyzing their data and preparing manuscripts.

This collaboration between CAPS and visiting scientists has resulted in quality research projects in more than 23 countries and forged a strong international network of HIV/AIDS researchers. Alumni from the program have published a number of articles in peer-reviewed journals, including nine articles featured in a special issue of the journal *AIDS* in 1995, and many—like Dr. Fernandes—have assumed leadership positions in national and international HIV/AIDS prevention efforts.

AIDSCAP supported scientists' participation in the Visiting Scholars Program for six years. Recent behavioral research projects conducted by AIDSCAP-funded scholars include:

- a study on the impact of a peer-led educational intervention that reached Balinese youth through a network of traditional youth organizations in Bali.
- an assessment of risk behavior among male clients at a Bombay STD clinic and forma-

tive research to design an HIV prevention intervention for clients.

- a pilot study on the use of social networks to empower young, unmarried women in Senegal to negotiate for safer sex.

As these examples illustrate, one of the strengths of the CAPS program is its focus on practical research in developing countries. For a relatively modest investment of $10,000 or less for each study, the program produces quality collaborative research and develops a strong local research capacity. The visiting scientists serve as principal investigators for the studies they design, ensuring their commitment to the research and involvement in all aspects of the research process.

For Dr. Fernandes, the experience has had an enduring impact. "My participation gave me a new vision of public health that certainly influenced my professional life and consequently the quality of my work in designing and implementing programs in my country," she said. ■

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

A local committee typically offers the best perspective on local sexual and social more and practices and often has greater credibility with local scientists than committees overseas.

## Research Tools

- **Theoretical behavior change models provide useful frameworks for examining HIV risk-taking behavior in a variety of cultures and societies.**

Behavior change interventions appear to be influencing risk behavior, but without a theoretical framework, the reasons why some individuals have adopted prevention measures and others have not remain elusive. AIDSCAP's use of behavioral theories developed in the United States to study sexual behavior in a number of developing countries confirms that theory can be a flexible and valuable tool for HIV prevention worldwide.

In northern Thailand, for example, an application of the Health Belief Model and the Theory of Reasoned Action revealed that both models were useful for analyzing consistent condom use in commercial sex. The Theory of Reasoned Action, however, was more useful because of its more accurate incorporation of peer group effects on risky sexual behavior.[6]

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

Such research is particularly useful for designing programs and policies to remove or overcome structural and environmental barriers to behavior change. One example is a pilot effort to adapt Thailand's "100 percent condom policy" in the Dominican Republic, which was designed based on formative research results from intensive discussions and in-depth interviews with sex workers and their employers and clients (Box 5.2). In Haiti, the local NGO Groupe de Lutte Anti-Sida (GLAS) used participatory action research with factory workers to continually adapt and improve its workplace prevention programs.[7]

# Recommendations

- **Research for HIV/AIDS prevention should not focus exclusively on behavioral issues.**

Understanding sexual behavior and identifying ways to influence that behavior requires a multidisciplinary perspective with contributions from diverse fields such as STD management and prevention, social marketing, medicine, counseling, psychology, epidemiology, communications and family planning.

- **International organizations and donor-funded programs should foster mutually beneficial partnerships between local research institutions and the NGOs that implement HIV/AIDS interventions.**

Such collaboration builds important connections between research and interventions and offers a sustainable source of technical assistance to the NGOs.

- **Large-scale, multisite efficacy trials should be reserved for tests of interventions that have not been rigorously evaluated and that have (1) global significance, (2) important policy implications and (3) complex intervention components.**

- **HIV/AIDS programs should put more emphasis on rapid research that provides the information needed to improve interventions or to adapt successful interventions for application in different geographical areas or with new populations.**

- **Proposals for behavioral research should be reviewed and approved by an ethical review committee whose members are thoroughly familiar with the customs and traditions of the community in which the research is being conducted.**

A local review board is usually best placed to provide this perspective.

- **HIV/AIDS researchers should expand the use of formal behavioral theories of HIV risk behavior.**

Even though these theories were developed in the United States, they have also proved useful for understanding risk behavior in developing countries.

- **HIV/AIDS programs should support research that allows target audiences to propose solutions to their own problems.**

Such research is particularly useful for identifying ways to remove or overcome structural and environmental barriers to behavior change.

# Future Challenges

## Assessing Biological Data

There is growing interest in the use of biological data, such as sexually transmitted infection and HIV serostatus data, as proxy measures of risk behavior. Data on self-reported behavior may be biased as a result of poor recall and the social stigma associated with risk behaviors. But collection of biological data brings its own unique set of problems, including the social and psychological impact of receiving positive HIV and STD results, the need to provide STD treatment, misclassification bias due to the limits of STD diagnostic capacities, and the high cost of biological testing and associated counseling and treatment. Research is needed on the combined use of biologic and behavioral data to assess HIV/AIDS interventions.

## Examining Care and Support

People living with HIV/AIDS experience severe social and psychological stress, particularly soon after learning that they are infected. The results of some studies suggest that people who are infected with the virus are more likely to infect others when there are few social and psychological services available to assist them in coping with their HIV status. But as the numbers of people with HIV and AIDS increase, more research is needed to identify support services that encourage preventive behavior.

## Understanding Social Change

Most HIV/AIDS research examines sexual behavior and behavior change among individuals. While this research and the interventions it generates have demonstrated some success in changing individual behavior, there is an urgent need to focus on interventions that influence social norms and other factors beyond the individual. Developing tools to measure such change at different levels of social organization and testing those tools should be a research priority for HIV/AIDS programs.

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# 6 Evaluating HIV/AIDS Prevention Programs: Developing New Tools for Meaningful Measurement

One of the greatest challenges in HIV/AIDS prevention is determining what impact prevention efforts have had on the epidemic. Evaluators must track changes in people's most private behavior, assess program impact in environments where sexual behavior is influenced by a variety of factors, and develop evaluation measures that are reliable, valid and meaningful.

Early in the epidemic, it was assumed that biological indicators could be used to evaluate HIV/AIDS prevention programs. Many evaluation plans called for collecting data on the incidence of HIV and other sexually transmitted infections, as well as information on self-reported behavior, at the beginning and end of a program cycle. During the early 1990s, the World Health Organization's Global Programme on AIDS (WHO/GPA) developed a set of behavioral and biological prevention indicators for national AIDS control programs and standardized protocols to facilitate cross-country comparisons.[1]

Experience with HIV/AIDS prevention has demonstrated that many of the early expectations about evaluation were unrealistic. Lack of resources has resulted in inconsistent collection of biological data, and pre- and post-project measures of behavior change have provided an incomplete and imperfect understanding of the impact of prevention efforts. As the epidemic and our understanding of the complex process of behavior change have evolved, evaluators have begun to develop more feasible and sensitive evaluation methods.

## Refining Evaluation Methods

Evaluation was a key strategy for AIDSCAP from the beginning of the project in 1991. With its early emphasis on evaluation and the breadth of its experience, the project had an unprecedented opportunity to improve existing methods and test innovative approaches to evaluation.

It seems a truism that evaluation should be considered at the beginning of a project or program. In practice, however, this is not common. One of AIDSCAP's strengths was its incorporation of evaluation into the design of each country program. Each strategic and implementation plan for a country program, developed in collaboration with government and NGO partners and other stakeholders in the country, included a detailed evaluation plan that outlined the indicators to be used and how the data would be collected and disseminated. These customized evaluation plans designed for each of the 19 country programs and many of their "subprojects" were adjusted during the project as programs were revised and evaluation methods evolved.

Another unique feature of AIDSCAP evaluation strategy was its emphasis on diverse and complementary data collection methods. To an extent unusual for a large, donor-funded health program, AIDSCAP was able to complement quantitative process and behavioral data with more qualitative information from in-depth interviews, focus groups and rapid ethnographic studies. "Triangulation" of the results of quantitative and qualitative research yielded a wealth of information about the process of behavior change, the environmental factors that influence behavior, and how HIV/AIDS interventions affect knowledge, attitudes and behavior.

Tools and methodologies developed and disseminated by the project will ensure that other HIV/AIDS programs can continue to benefit from AIDSCAP's evaluation experience. These include a series of guidelines on different aspects of evalua-

tion, such as incorporating evaluation into program design and conducting effective focus group discussions. Originally developed as references for AIDSCAP staff and partners in the field, these "Evaluation Tools Modules" have been used in HIV/AIDS programs, training workshops and university courses in many parts of the world.[2]

One of AIDSCAP's most important modules offers guidelines for conducting behavioral surveillance surveys (BSS), a methodology pioneered by AIDSCAP in Bangkok. Consisting of a series of repeated behavioral surveys in key target groups, the BSS enables national programs to track trends in HIV risk behaviors and to assess the combined impact of various HIV/AIDS interventions in a country. Inspired by the success of the surveys in Thailand, national and state HIV/AIDS control programs in Cambodia, India, Indonesia, Nepal and Senegal worked with AIDSCAP to establish BSS systems. A meeting of 28 experts from ten BSS projects in eight countries, which AIDSCAP convened in August 1997, produced recommendations for conducting these surveys worldwide (Box 6.1).[3]

In another emerging area of program evaluation—capacity building assessment—AIDSCAP developed and tested a methodology that includes instruments for organizational needs assessment and determining the outcomes of capacity building efforts. Capacity building evaluations in nine countries used a collaborative approach that emphasized self-assessment and use of the results as a tool for strategic planning.

AIDSCAP also collaborated with international organizations to advance the practice of evaluation in HIV/AIDS programs and provide guidance for prevention programs. For example, project staff worked with colleagues at WHO/GPA, USAID and the Centers for Disease Control and Prevention to develop the GPA prevention indicators. More recently, they helped the USAID Office of Population design a larger set of indicators for assessing the impact of interventions to improve reproductive health.[4]

## Lessons Learned

- **Involving project implementers in evaluation throughout a project encourages the use of evaluation data to improve programs and projects.**

Deciding what information and how much data to gather in an evaluation involves difficult methodological decisions and trade-offs between the quality and utility of information. It is im-

CAROL HOOKS/PATH

*Students from the University of Calabar participate in a pretest of a questionnaire for a knowledge, attitudes, beliefs and practices survey. AIDSCAP used the results of KABP surveys and other more qualitative evaluation research to assess behavior change among target populations.*

portant to involve project staff in the evaluation process from the beginning to ensure that the research will produce data that are not only valid and reliable, but also useful for program planning.

AIDSCAP collaborated with indigenous NGOs and government ministries in the evaluation process, emphasizing the use of data to improve programs. In both Jamaica and Brazil, for example, biannual or annual evaluation meetings brought together representatives from the organizations implementing the AIDSCAP program in the country, the Ministry of Health or national AIDS control program, USAID, and the AIDSCAP office to review evaluation results. These meetings provided forums for discussing evaluation data and identifying ways to refine project or country program strategies based on the data. Frequent one-on-one meetings leading up to each review ensured that all participants were familiar with the evaluation results, and consultations between AIDSCAP's resident advisor and project staff after the meeting strengthened the recommendations and action plans adopted.

## Prioritizing Research Designs

- **Because resources for evaluation activities are limited, rigorous research designs are not feasible, or even appropriate, for every project.**

AIDSCAP's recommended practices have evolved to reflect what is appropriate and possible at the national program level and the individual project—or service-delivery—level. This multilevel approach to prioritizing the degree of rigor needed for evaluation alleviates some of the tension that arises as a result of the sometimes conflicting evaluation needs of individual projects and national programs.

- **At the service-delivery level, it is more efficient to limit evaluation activities to conducting formative research, monitoring process indicators and assessing capacity building efforts.**

From the perspective of a national or regional program, it is not practical for every individual project to assess behavior change. AIDSCAP's experience with hundreds of projects showed that such assessments are time-consuming and require technical expertise that many service-delivery organizations do not have. Even when these organizations can collect and analyze data on behavior change, without an expensive study that uses control groups it is not possible to attribute changes that have occurred to the interventions of one project.

Only in the case of a demonstration project to test a new intervention or answer a research questions would there be justification for a more rigorous research design. Otherwise, when projects deliver services based on proven prevention strategies, the focus should be on ensuring that the services are delivered as intended. This can be done by tracking process indicators such as number of people trained, number of people educated about HIV/AIDS and number of condoms distributed. Projects that work to strengthen HIV/AIDS prevention skills should also assess whether they have succeeded in building capacity.

- **In environments where many donors are supporting multiple interventions with overlapping target groups, certain types of evaluation are only appropriate at the national or regional level.**

In such environments, it is impossible to attribute any changes detected by an evaluation to the efforts of a single project or organization.

### AIDSCAP Evaluation Research

| KABP Surveys | Focus Group Discussions | Studies Using In-Depth Interviews | Capacity Building Assessments | STD Service Assessments (PIs 6 & 7) | Condom Audits |
|---|---|---|---|---|---|
| 167 | 144 | 61 | 9 | 16 | 23 |

Therefore, it is more appropriate to combine the resources of national programs and donors to monitor national or regional trends in behavior among different target groups, condom availability and sales, STD case management, policy development efforts and epidemiologic impact.

In Senegal, for example, where AIDSCAP worked with 25 organizations, various target audiences were reached by many different interventions. So instead of trying to assess the contribution of each of its projects to behavior change in Senegal, AIDSCAP helped the Senegalese Ministry of Health develop a behavioral surveillance survey to track the combined effect of all HIV/AIDS prevention efforts on sexual behavior among target audiences.

## Moving Beyond "PIs"

- **Surveillance of trends in HIV risk behavior among specific population groups is an effective tool for monitoring and evaluating HIV/AIDS prevention efforts.**

Most HIV/AIDS prevention programs measure progress toward meeting predetermined targets at the end of a project. For example, evaluators might look at whether a project has achieved a 30 percent increase in consistent condom use among youth in the project area. But setting such targets for expected behavioral outcomes requires precise estimates of baseline levels and an understanding of how much change is meaningful in each setting. And even when such targets are reached, the observed behavior change cannot be attributed to the activities of a single project.

The behavioral surveillance surveys methodology that AIDSCAP developed in Bangkok[5] and later adapted in five countries offers a practical alternative for evaluating HIV/AIDS prevention efforts. It allows evaluators to monitor trends in HIV/AIDS knowledge, attitudes and preventive behavior over time rather than taking one end-of-project reading and measuring it against a somewhat arbitrary target. And, recognizing that attribution is rarely feasible, it looks instead at the

### A Multilevel Approach to Evaluation Design

| Level | Type | Example |
|---|---|---|
| **National** | Behavioral trend analysis | Behavioral surveillance surveys (BSS) |
| | Outcomes of technical strategies | STD care provider behavior (PIS 6 & 7) |
| | Policy | AVERT model, socioeconomic impact studies |
| | Structural/socioeconomic barriers | Monitor changes in social norms |
| **Service-delivery** | Formative research | Special studies conducted when needed for program planning |
| | Process monitoring | Tracking process indicators to monitor implementation of activities |
| | Intervention-linked outcomes research | Special studies designed to respond to specific research questions |
| | Capacity building assessments | Rapid organizational assessments, capacity building inventories |

# 6.1

# Behavioral Surveillance Surveys: A Promising Tool for HIV/AIDS Evaluation and Monitoring

In August 1997, 28 epidemiologists and behavioral scientists from eight countries met in Bangkok, Thailand, to discuss what they had learned about conducting behavioral surveillance surveys for HIV/AIDS prevention. Their goal was to reach a consensus on recommendations for using this exciting new tool to monitor and guide prevention efforts.

Behavioral surveillance involves administering structured questionnaires to individuals from different target populations in specific geographic areas at regular intervals. These cross-sectional surveys are designed to collect detailed information about the sexual behaviors that increase or reduce people's risk of HIV infection and to allow managers and evaluators to track trends in those behaviors over time.

AIDSCAP designed one of the developing world's first behavioral surveillance surveys (BSS) in Thailand as part of a project administered by the Bangkok Metropolitan Administration from 1991 to 1996. Since then, the Thai Ministry of Health has begun behavioral surveillance modeled after the BSS in most of the country's provinces. AIDSCAP also helped establish behavioral surveillance surveys in Cambodia, India, Indonesia and Senegal and began work on a BSS in Nepal.

Why all this interest in behavioral surveillance? Stephen Mills, evaluation officer and epidemiologist in AIDSCAP's Asia Regional Office in Bangkok, believes that the BSS fills two critical gaps in HIV/AIDS evaluation by providing information about the short-term impact of prevention interventions and the trends in risk behaviors among vulnerable groups.

"Even though we can't separate the impact of different interventions, we are interested in whether the combined interventions are working together to change risk behaviors," Mills explained. "The BSS helps us answer that question. It can also give us an early warning of increases in risk behavior so that we can respond with timely interventions."

In Bangkok, an analysis of five rounds of BSS data collected at approximately six-month intervals from individuals in eight different socioeconomic and occupational groups helped confirm that declines in HIV incidence and prevalence were due to behavior change. Reported patronage of commercial sex by three groups of men from different socioeconomic backgrounds fell dramatically, with the overall mean proportion of men visiting sex workers decreasing by 48 percent over three years. Consistent condom use in commercial sex increased significantly, particularly in commercial encounters with "indirect" sex workers who do not work in brothels. Their use of condoms with clients, which had lagged behind that of brothel-based sex workers, rose from 56 to 89 percent during the study period.

Bangkok's BSS results from 1993 to 1996 also identified some areas for concern. Condom use by the nonpaying partners of sex workers showed no apparent increase, and sex workers were the only women in the study who reported having changed their behavior to avoid HIV infection. These findings suggest that targeted prevention efforts are needed to reduce high-risk behavior in noncommercial sexual relationships.

In the state of Tamil Nadu, India, data from the first round of the BSS in 1996 provided a baseline for future analysis of behavioral trends and

helped set the agenda for prevention research and interventions. The results point to the need to dispel widespread misconceptions about casual transmission of HIV, improve risk perception among groups reporting high levels of HIV risk behavior, and increase condom use. These baseline data, gathered from more than 6,000 respondents, represent the most comprehensive source of information about HIV/AIDS knowledge, attitudes and risk behaviors in Tamil Nadu to date.

The breadth of the data from the first round of behavioral surveillance surveys in four regions of Senegal—the first use of the BSS in Africa—was also unprecedented in that country, prompting the head of the national AIDS control program to promote expanding the BSS into all regions of the country. Among the findings that will be used to guide current prevention efforts are high levels of HIV/AIDS knowledge but a general lack of information about the signs and symptoms of STDs. Since five of the six sample groups reported low levels of HIV risk behavior, future rounds of the BSS will survey individuals from groups considered to be at higher risk of infection, such as truck drivers and market women.

Such revisions are an important part of the BSS development process. In each country, program managers, evaluators and key stakeholders must work together to ensure that the BSS provides the most relevant information for monitoring and evaluating prevention programs.

Their experiences to date informed the recommendations developed at AIDSCAP's consensus meeting in Bangkok. Key recommendations include the following:

- Groups sampled for behavioral surveillance should not necessarily be those chosen for HIV serologic surveillance. For example, antenatal clinic attenders, a frequent HIV surveillance group, are not a viable group for behavioral surveillance because pregnancy affects their sexual behavior. Other community sites are recommended for tracking the sexual behavior of married women.
- Validity and reliability studies on behavioral surveillance and other sexual behavior research indicate that reliable measurements of such behavior are feasible if strict survey quality control standards are maintained. The validity of specific point estimates is more difficult to assess, and magnitudes should be verified by other quantitative surveys.
- Complementary qualitative research is essential to help establish reliability and validity as well as to provide the contextual information necessary for understanding risk behaviors.
- Behavioral surveillance can be used to set behavioral targets for prevention interventions. However, such target-setting should be guided by realistic expectations of behavior change based on historical evidence and on the limitations of behavioral surveillance designs. These designs typically cannot (and should not, because of cost) detect behavioral changes below 10 percent. ■

combined effects of interventions on a national or regional level.

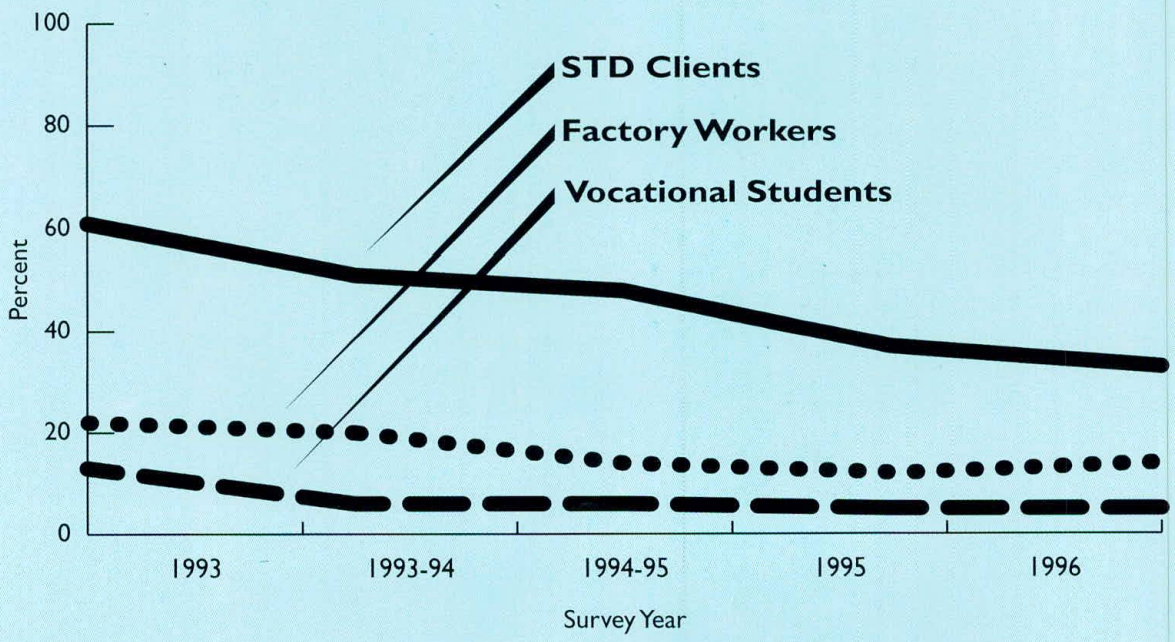
AIDSCAP found that the BSS, a series of cross-sectional surveys among different age, socioeconomic and occupational groups, is a particularly useful way of determining whether sexual behavior change is occurring in specific segments of the population. It provides more targeted information than systems that collect data only on the general population, and it ensures standardization, providing a degree of comparability that is rare when a number of different organizations are collecting evaluation data in a country or region. BSS also takes outcome evaluation to a more appropriate national or regional level, eliminating the need to collect data separately in a multitude of projects that reach the same target groups (Box 6.1).

- **"End-stage" indicators measuring adoption of a preventive behavior, such as having fewer sex partners or consistently using condoms, do not adequately reflect the intermediate stages of sexual behavior change taking place among various target groups.**

Early AIDSCAP evaluation plans called for the use of core indicators similar to those being developed by WHO/GPA to measure program impact on behavior in the general population. AIDSCAP used the basic constructs of these prevention indicators (PIs) but adapted them for specific target groups, such as youth, women, sex workers and men who have sex with men. The constructs focus on knowledge of prevention measures (an early stage of behavior change) and end-stage behavior changes such as partner fidelity and consistent condom use.

As it became evident that these indicators failed to address changes occurring in some groups, AIDSCAP added behavioral indicators that reflect intermediate stages of change along the continuum between knowledge and adoption of preventive measures. Quantitative and qualitative evaluation research in Haiti found evidence of important intermediate stages of behavior change, with less impact on end-stage behavior. For example, consistent condom use with a nonregular partner (as measured by WHO PI 5) did not increase substantially among workers who participated in a workplace education project. But the evaluation of the project did find significant increases in knowledge

**Percentage of Men Reporting Sex with a Sex Worker During the Past Year in Bangkok, Thailand, 1993-1996**



of HIV transmission and prevention methods and in the percentage of workers who felt confident discussing HIV/AIDS with their partners and negotiating condom use.

• **Using a variety of methodologies and "triangulating" their results can help evaluators overcome many of the limitations they face in assessing the impact of HIV/AIDS interventions.**

Valid assessment of the effectiveness of behavior change interventions presents numerous methodological and practical problems, including the bias inherent in self-reported data, the inability to attribute changes in behavior to specific interventions without a rigorous controlled study, and the insensitivity of HIV prevalence as an indicator of short-term behavior change.

A combination of quantitative and qualitative data is particularly helpful for assessing the complex and uneven process of sexual behavior change. Quantitative data on self-reported behavior may not provide convincing evidence of change in the short term (one to two years). Qualitative data gathered through interviews and group discussions can help evaluators detect movement in the direction of change that may not yet be discernible using the statistical techniques of knowledge, attitudes, beliefs and practices (KABP) surveys or seroprevalence studies. Qualitative data also enable evaluators to interpret the context in which behavior change occurs and helps program managers identify how to revise programs to reach and influence those who are not reducing their risk of HIV.

AIDSCAP used a variety of qualitative and quantitative methods to gain a more complete picture of the complex process of sexual behavior change. Qualitative data collected through focus group discussions, individual (key informant) interviews and rapid ethnographic studies were triangulated with quantitative data from KABP surveys or behavioral surveillance surveys. The addition of epidemiological data on HIV and other STDs, in the few cases where the appropriate data were available, enabled evaluators to compare trends in sexual behavior among target groups with trends in the epidemic among those groups (Box 6.2).

## Assessing Capacity Building

• **Progress in building the capacity of organizations can be measured using a combination of quantitative and qualitative methods.**

A lack of consensus among HIV prevention organizations and donors on the appropriate indicators for evaluating capacity building has hampered the effective measurement of organizational change in the past. In addition, many organizations overlook the importance of baseline research in capacity building, and subsequently find it difficult to measure the extent, quality and types of the capacity that have been enhanced.

AIDSCAP developed multiple, complementary methods to monitor and evaluate capacity. These methods include organizational needs assessments, detailed inventories of the project's capacity building efforts, and a rapid organizational assessment that collected quantitative information on technical skill building, organizational management skill building, systems development, networking and sustainability. Organizations have used the results from these surveys to identify lessons learned and as the basis for strategic planning.

## Measuring Potential Impact

• **Models and other innovative evaluation methods can help evaluators gain a better understanding of program impact.**

Given the difficulties and high costs associated with direct measurement of the impact of HIV prevention programs through large-scale incidence studies, evaluators are developing alternative methods of impact assessment. Their focus is establishing linkages between outcome data from program interventions and patterns of HIV prevalence and incidence. These methods fall under several categories, including application of simulation models, models to estimate HIV incidence rates and prevalence in selected populations, methodologies for linking behavioral and biological data, and tools for cost-effectiveness analysis.

AIDSCAP has created the AVERT model to estimate the impact of intervention outcomes on the number of HIV infections averted among the target population. These estimates provide a better understanding of the effect of current prevention strategies and can help program managers and other stakeholders set priorities for future HIV/AIDS programs (Box 6.3) .

# 6.2

# Triangulation: Using Multiple Evaluation Methods to Assess Progress in Cameroon

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

In six years the AIDSCAP program in Cameroon reached more than 180,000 youth, university and secondary school students, sex workers, military personnel, transport workers and owners of bars and hotels through peer education and community-based outreach. Almost 2,000 peer educators were trained to teach their families, friends, neighbors and coworkers about HIV/AIDS and to refer them for STD treatment and other prevention services. An aggressive social marketing project sold more than 35 million condoms, with monthly sales during 1996 exceeding the total number of condoms sold in 1989, and over 1 million educational materials were disseminated, including videos, radio and TV spots, and printed materials. These process data show that prevention activities did occur on a large enough scale to influence behavior.

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

One of the program's most important achievements was an increase in people seeking appropriate treatment for STDs—a serious health problem that also contributes to the HIV/AIDS epidemic in Cameroon. The percentage of those reporting they had sought STD care from a health professional rose among university students, military personnel, sex workers and their clients, with a dramatic four-year increase from 34 to 86 percent among sex workers. These results suggest that the program's emphasis on improving STD services at health care facilities and referring people to those services was successful.

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

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

Interviews and focus group discussions with sex workers and their clients provided further evidence of a dramatic shift in attitudes toward condoms. "There has certainly been a change in behavior because most of the sex workers today, you will notice that they all use condoms," said one sex worker from Yaoundé: "Ten years ago

you could not see such a thing in this country. These condoms which have been so decried, so condemned at one time, are now appreciated."

Sex workers reported significant increases in consistent condom use, from 52 percent in 1990 to 75 percent in 1996, but only with men who were not regular clients. Evaluation results suggest that the closer the relationship, the less likely women are to request condom use. About 63 percent say they use condoms consistently with regular clients, and only 13 percent report condom use with their regular, nonpaying partners.

Few biological data are available to confirm the AIDSCAP behavioral findings in Cameroon. Sentinel surveillance among women attending antenatal clinics indicates that HIV prevalence is rising in the general population. However, the results of seroprevalence studies conducted between 1992 and 1997 among one of the program's primary target groups—sex workers in the cities of Yaoundé and Douala—suggest that infection rates may be stabilizing or even decreasing among sex workers in cities where use of condoms in commercial sex is relatively high after more than seven years of comprehensive HIV/AIDS prevention campaigns. ■

# Recommendations

- Evaluators should work with project staff and local stakeholders to match research methods to the nuances of particular evaluation questions and to the time and resources available for evaluation. Project and program managers should also establish mechanisms for assessing evaluation data at regular intervals and using those data to improve interventions.

- Evaluation designs should reflect what is feasible and appropriate for a project or program to measure. AIDSCAP recommends that small individual projects concentrate on evaluating service delivery and capacity building, leaving assessment of behavior change to national or regional evaluation efforts.

- In order to detect progress toward behavior change, HIV/AIDS programs should track intermediate indicators, such as the ability to negotiate condom use with a partner or perception of risk, as well as reported condom use and other "end-stage" indicators.

- HIV/AIDS programs should consider establishing behavioral surveillance systems to track trends in knowledge, attitudes and behavior among target audiences within the overall population.

AIDSCAP's BSS methodology has proved an effective way of monitoring these trends and assessing the combined impact of various interventions.

- Because sexual behavior is an extraordinarily difficult area to assess, HIV/AIDS programs should use a variety of evaluation indicators and data collection methods.

Triangulation of qualitative and quantitative data enables evaluators to interpret intervention outcomes and offers valuable insights into how to improve future interventions.

- Capacity building needs to be measured both quantitatively and qualitatively, and staff members from participating organizations should be directly involved in the process. Plans for evaluating capacity building should be built into the original design of a project or program to ensure that baseline data are available.

# 6.3

# AIDSCAP's AVERT Model: A South African Case Study

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

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

AIDSCAP used AVERT to gain a better understanding of the impact of one of the first pilot studies of targeted periodic presumptive STD treatment in the developing world. Such treatment has been proposed as an option for reducing STDs in groups at high risk of infection—particularly in high-risk women, who often experience no STD symptoms and may not seek treatment otherwise.

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

Study results showed that this approach was effective in reducing STDs, with dramatic decreases in STD prevalence among the women using the service and their miner partners after just nine months of intervention.

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

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

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

After nine months, it was estimated that overall prevalence of genital ulcer disease (GUD) had dropped by 30 percent and nonulcerative STD rates had fallen by 32 percent. The women had reduced the number of clients they had by 20 percent, and reported condom use by the clients had increased from 13 to 29 percent. Modeling these scenarios, AVERT estimated that the intervention had averted a total of 237 new HIV infections for the year: 41 among the women and 196 among the miners.

The model was also used to project the po-

tential impact of the intervention should it continue. It showed that if the project goals of 50 percent condom use in commercial sex and an 80 percent reduction in STD rates were achieved during the next two to three years, the estimated annual cumulative incidence of HIV would decline from 52 to 12 percent among the women and from 13 to 2 percent among their miner clientele.

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

## Modeling the Impact of an Intervention in South Africa: AVERT Assumptions and Results

| **Assumptions** | **Scenario 1** | **Scenario 2** | | |
|---|---|---|---|---|
| Average annual partners (women) | 40 | 32 | | |
| Average annual contacts (women) | 10 | 10 | | |
| Average annual partners (miners) | 4 | 3.2 | | |
| Average annual contacts (miners) | 10 | 10 | | |
| GUD prevalence | 10% | 7% | | |
| Non-GUD prevalence | 25% | 17% | | |
| Condom use | 13% | 29% | | |
| **Results** | | | **Difference** | **Percent** |
| Probable HIV infections (women) | 103 | 62 | 41 | -40% |
| Probable HIV infections (miners) | 405 | 209 | 196 | -48% |

# Future Challenges

## Monitoring Sustained Change

HIV/AIDS prevention programs that have been operating for several years may find it increasingly difficult to detect changes in behavior because interventions have reinforcing rather than new effects. As a result, the potential size of changes in a target group will become smaller, and the sample sizes necessary to measure these effects will increase accordingly. Maintenance of reported behavioral change should receive greater emphasis in future evaluations.

## Improving Data Quality

Data collection systems require substantial attention and maintenance to ensure the integrity of the data they provide. Active participation of key stakeholders is probably the single most important factor in ensuring that evaluation data will be reliable, valid, relevant and timely. Besides building local capacity to collect, analyze and disseminate evaluation data, an additional challenge for prevention programs is identifying and involving implementing partners who have a vested interest in the quality of evaluation results.

## Evaluating Intervention Strategies

The Mwanza trial in Tanzania demonstrated that syndromic management of STDs in a population can reduce HIV incidence. A limited number of well-designed trials are needed to test the efficacy of other intervention strategies, particularly behavioral interventions to reduce sexual transmission of HIV and other STDs. These studies must be of sufficient size to yield clear results and should be designed to allow inferences about cause-effect relationships.

## Linking Behavioral and Biological Data

Our understanding of how different behaviors and epidemiological factors influence epidemic patterns is still incomplete. There is an emerging consensus among evaluation experts that assessing the long-term impact of multiple HIV/AIDS prevention interventions requires investigation of trends in HIV infections along with trends in behaviors that may lead to infection. Political support and resources are needed to enable programs to collect and analyze HIV/STD surveillance data in combination with behavioral, socioeconomic and sociodemographic data.

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# 7 Women, Men and HIV/AIDS: Building Gender-Sensitive Programs

One of the most significant changes in HIV/AIDS prevention during the second decade of the epidemic has been a growing appreciation of the need to reduce women's vulnerability to the virus. Once considered a disease of homosexuals, injecting drug users, sex workers and other "high-risk" groups, HIV/AIDS is now recognized as a serious threat to most sexually active women—including those who are monogamous.

Rising rates of HIV/AIDS among women and young girls throughout the world confirm that they are at increasing risk of infection. Worldwide, the proportion of adults living with HIV/AIDS who are women rose from about 25 percent in 1990 to 42 percent in 1995. By the year 2000, the annual number of AIDS cases among women will equal or exceed those among men. Today six out of ten new infections worldwide occur in women 15 to 24 years of age, and in that age group, twice as many young women are infected as young men.

Biology plays an important role in women's heightened susceptibility to HIV. In fact, sexual transmission of the virus is at least four times more efficient from men to women than from women to men. But research and experience have shown that the imbalance of power between men and women is at the root of women's vulnerability to HIV. Women's economic dependence on men and society's acceptance of different standards of sexual behavior for men and women put women at risk and make it difficult, if not impossible, for many of them to negotiate safer sex with their partners.

During the past six years, AIDSCAP and other international organizations have begun to define a more gender-sensitive approach to prevention that addresses some of the root causes of HIV's rapid spread among women. Based on a deeper understanding of the economic, legal and social factors that fuel the epidemic, this approach aims to educate policymakers about the deadly consequences of gender inequities, empower women to protect themselves from unwanted and unprotected sex, develop and test prevention methods that women can initiate and control, improve communication between the sexes, and give boys and girls positive models of mutually supportive relationships between women and men.

## Gender Initiatives

AIDSCAP advanced a gender-sensitive approach to HIV/AIDS prevention through pilot interventions, training of policymakers and grassroots leaders, research and information dissemination. Millions of women and girls acquired knowledge and skills to help them reduce their risk of HIV infection, and hundreds of policymakers, health care providers, educators and grassroots leaders—both men and women—were sensitized to the gender aspects of the epidemic.

The reach and scope of the activities and interventions described in this chapter and in previous chapters reflect the success of AIDSCAP's efforts to institutionalize a gender perspective in its own programs and those of its partners. Through its Women's Initiative, established in 1994 with support from USAID's Office of Women in Development and HIV/AIDS Division, AIDSCAP integrated a gender focus into many existing projects, expanded a number of interventions to address broader issues of gender inequality and women's social and economic empowerment, and developed dozens of new projects and activities.

With the creation of the Women's Initiative, AIDSCAP staff and their partners were challenged to take a critical look at their projects and programs to ensure that they addressed the needs of women. The results ranged from the development of regional and national gender and HIV/AIDS

strategies, such as the one developed for the Latin America and Caribbean region (Box 7.1), to incorporation of seemingly small but critical design features.

In India, for example, AIDSCAP-supported NGOs found innovative ways to reach Indian housewives who would not have been able to attend other public HIV/AIDS education events, combining outreach efforts with competitions in traditional household arts.[1] Worldwide, AIDSCAP was successful in gaining widespread acceptance among its partners of the importance of collecting and analyzing separate evaluation data on men, women, young women and young men in order to understand the true impact of their interventions on these populations.

Many of the most innovative gender initiatives were additions to projects already underway. A South African prevention project targeting sex workers and their clients and partners was broadened to address the harassment and violence that the women often face from law enforcement officers and clients (Box 7.2).[2] An Ethiopian NGO gave its young peer educators gender training and created a drop-in center where facilitators encouraged discussions between young men and women about sex and sexual risk.[3] And a Senegalese project built on an earlier intervention with market women to use their credit associations to help a particularly vulnerable group of market women and their daughters learn to access credit and protect themselves from HIV/AIDS.

AIDSCAP programs also designed new projects to address the expanding epidemic among women. Examples include training and supporting HIV-positive women to serve as outreach educators in Thailand,[4] integrating STD treatment and prevention into family planning services in Nepal (Box 7.3), creating a dynamic mass media campaign in the Dominican Republic emphasizing women's right to protect themselves from HIV infection, and training women community leaders in Honduras as advocates for better sexual health education and HIV/STD prevention services.

Financial and technical support from the project encouraged governments and other groups working in HIV/AIDS prevention to devote more resources and attention to gender-sensitive activities. In Haiti, for example, AIDSCAP sponsored a series of forums to encourage collaboration between governmental and nongovernmental organizations and to reach consensus on recommendations about women and HIV/AIDS for the National Plan of Action on HIV/AIDS. The Honduran Women's Government Office worked with AIDSCAP's office in that country to develop strategies for reaching rural women with prevention messages and activities. And in India's Tamil Nadu State, an AIDSCAP grant supported the creation of a network of influential women, including policymakers, health care providers, lawyers, journalists, educators and film stars, to advocate for legal, economic and social change to reduce women's risk of HIV infection.

Collaboration with other development organizations, particularly women's groups and networks, was a key strategy. One of the most successful col-

STEPHEN P. HUYLER

*In the traditional art of rangoli, Indian women create intricate patterns with colored powders. Sponsoring rangoli competitions on World AIDS Day helped an AIDSCAP-supported project reach women who might not feel comfortable attending other public events.*

laborations, a coalition of ten organizations spearheaded by AIDSCAP, raised awareness about HIV/AIDS in women at the United Nations Fourth World Conference on Women in Beijing in 1995 by organizing 14 panel discussions, two film festivals and three press conferences and distributing over 50,000 printed materials. In 1996, AIDSCAP and UNAIDS cosponsored a journalists' contest to encourage accurate reporting on HIV/AIDS and women that attracted almost 200 entries from 50 countries.[5] And in 1997, AIDSCAP brought together 130 scientists, policymakers, women's advocates and program managers from 19 countries to develop recommendations for increasing access to and use of the female condom.

AIDSCAP-sponsored studies on the female condom featured an innovative research design to explore introduction of the device through women's organizations. Conducted in Brazil and Kenya in 1996, the research gave women from all levels of society an opportunity to try female condoms and demonstrated the potential for women's peer support groups to sustain the use of this woman-initiated device.[6] Other AIDSCAP studies identified ways to improve communication between Kenyan mothers and their daughters, Senegalese market women and their male suppliers and partners, and young Dominican men and women.

Research results and tools developed by AIDSCAP's Women's Initiative (AWI) will continue to help other organizations and programs carry out more gender-sensitive HIV/AIDS interventions. The initiative created the first training manual developed specifically for integrating a gender perspective into HIV/AIDS policies and programs, based on training workshops held for policymakers and NGO leaders from five countries. (Box 8.2 ).[7] And a resource guide on the use of dialogue as an HIV/AIDS prevention strategy will promote more constructive communication between men and women about sex, sexuality and HIV/AIDS prevention.[8]

The Women's Initiative's most important legacy, however, may be its contribution to raising awareness about the need for a gender-focused approach to HIV/AIDS prevention. Working in close collaboration with members of its Women's Council and with other HIV/AIDS and women's organizations, AIDSCAP sought to educate policymakers and programs managers through information dissemination and advocacy. These efforts helped put women and HIV/AIDS on the agendas of international organizations, national governments and local organizations, contributing to the growing recognition that slowing the spread of the epidemic requires fundamental changes in gender power relations between women and men.

# Lessons Learned

## Gender Sensitivity

- **Although gender is a cross-cutting issue, organizations need specific mechanisms for strengthening and sustaining a focus on gender concerns.**

AIDSCAP's experience confirms that policy and resource support are essential for institutionalizing a gender perspective. By providing an explicit focus on gender and the resources needed to carry out training, research and interventions, the project's Women's Initiative made it possible to achieve a broader integration of gender concerns into AIDSCAP policies and programs. A core staff of four professionals at headquarters and designation of an AWI "point person" in each of AIDSCAP's three regional offices and many of its country offices ensured that analysis and monitoring of gender concerns occurred throughout the project. Support from USAID's Women in Development Office, USAID Missions and AIDSCAP core funding enabled resident advisors to devote more resources to identifying and addressing gender issues, empowering women, involving men in efforts to protect women and girls from HIV/AIDS, and improving communication between the sexes.

- **Training is an effective tool for making HIV/AIDS prevention programs and projects more gender-sensitive.**

Gender training workshops sponsored by AWI for project staff, implementing partners and policymakers inspired participants to initiate gender-focused programs and activities. For example, participants in a 1995 gender and AIDS training workshop AIDSCAP conducted for 41 policymakers and program managers in five eastern and southern African countries agreed that it had improved their understanding of how to recognize and analyze gender issues and integrate them into HIV/AIDS prevention policies and programs. Projects with a gender perspective were launched in each of the participating coun-

# 7.1

# LAC Regional Gender and HIV/AIDS Strategy: A Catalyst for Change

Throughout much of Latin America and the Caribbean (LAC), many people still believe that HIV/AIDS strikes only those who live at the margins of society. Yet three out of every four HIV infections in the region result from heterosexual transmission, and in many countries, HIV rates are rising faster among women than in any other group.

In this decade alone, the male-to-female ratio of reported AIDS cases throughout LAC shifted from 4.9 to 1 in 1991 to 2.8 to 1 in 1996. In the Dominican Republic, the male-to-female ratio of HIV infections went from 7 to 1 to 1.5 to 1 in eight years. And in Haiti, equal numbers of men and women are infected with the virus.

AIDSCAP responded to these alarming trends in HIV among women with a concerted effort to strengthen the capacity of HIV/AIDS programs in LAC to address the gender issues that make women so vulnerable to infection. Meetings with AIDSCAP resident advisors and their colleagues from the region led to the development of a strategy that encompassed training in gender analysis, research and pilot projects and sharing of lessons learned.

Under the regional strategy, each AIDSCAP program in the region carried out a study, training program or pilot intervention. For example, AIDSCAP's program in Brazil trained 100 government and NGO health care providers from three states to ensure that they were sensitive to gender issues that affect service delivery and to promote integration of HIV/AIDS prevention into other reproductive health services. In Honduras an AIDSCAP-supported project enhanced the leadership skills of 50 women in two municipalities, enabling them to become advocates for the reproductive health needs of women in their communities. These and other projects strengthened HIV/AIDS prevention efforts and offered models for designing gender-sensitive interventions in the future.

But the impact of the effort to develop and implement a regional gender strategy was more far-reaching than the results of the pilot projects. After AIDSCAP established its Women's Initiative in 1994, project staff reviewed all their activities in the region to determine how to reach a broader range of women and to address the needs of both women and men. This new emphasis on gender sensitivity was soon reflected in the strategies, plans and activities of AIDSCAP programs in the region—and even in the language staff used to describe them.

In Haiti, AIDSCAP worked with HIV/AIDS and women's organizations to ensure that gender concerns would be addressed in the country's future prevention strategies. In May 1995, a "Day of Reflection on Women" brought together 30 representatives from 18 organizations to develop consensus on goals and strategies for preventing the spread of HIV/AIDS among Haitian women. This dialogue was continued during the final year of AIDSCAP's program in Haiti through a series of forums in four regions of the country organized by a coalition of 34 women's organizations. The recommendations of forum participants were reported to the new Haitian National AIDS Commission for incorporation into its five-year National Plan of Action.

AIDSCAP's program in Honduras, which was launched in 1995, addressed gender issues from the beginning. Baseline survey results were analyzed to identify gender-based constraints to prevention for both men and women, and educational materials were revised to ensure they were gender-sensitive. The project also made special efforts to reach women at all levels of society. One project, designed in collaboration

with the Honduran Women's Government Office, trained peer educators to lead discussions about HIV/STD prevention in their communities. Another project linked education and discussions about HIV/AIDS, sexuality, domestic violence and women's rights with credit programs for women in rural areas. And interventions in factories with large numbers of female employees worked to prevent sexual harassment as well as HIV transmission.

In Brazil, a total of 16 new "rapid-response" grants for gender-sensitive interventions were awarded during 1996 and early 1997. One NGO distributed targeted HIV/AIDS educational materials to more than 500 newly elected councilwomen throughout the state of São Paulo to encourage them to strengthen the legislative response to the epidemic. Another NGO trained women radio broadcasters from four states in ways to present HIV/AIDS prevention on the air and helped them produce two radio spots on prevention for women. In Rio de Janeiro, a project designed to generate dialogue about HIV and STDs among women in the waiting room of a busy gynecological clinic was expanded to reach men attending other clinics at the same health care center.

And in the Dominican Republic, AIDSCAP worked with the government's department of women's affairs, the national STD control program and local NGOs to develop a strategy for preventing HIV and other STDs among young women. This strategy included a mass media campaign modeled after the program's successful campaign for adolescents (see page 8). Local and cable television stations began airing the public service announcements created for the campaign in May 1997 and continued to broadcast them after AIDSCAP activities in the country ended three months later.

AIDSCAP also sponsored numerous studies, training workshops, interventions and policy initiatives to address gender and HIV/AIDS in the Dominican Republic. Most notably, a women and HIV/AIDS plan created by AIDSCAP and the Dominican public health association, in collaboration with other governmental and nongovernmental organizations, was incorporated into the National AIDS Control Plan.

Gender training conducted in January 1997 reinforced the commitment of AIDSCAP program managers to gender-sensitive programming. It also strengthened their capacity to plan, implement and evaluate such programs as they began to make the transition from managing AIDSCAP programs to running their own indigenous HIV/AIDS NGOs (see page 93).

AIDSCAP staff had an opportunity to share what they had learned about integrating a gender perspective into HIV/AIDS programs with colleagues from other countries in the region at a workshop in April 1997. Twenty-five participants from six LAC countries met to discuss strategies for addressing gender issues in HIV/AIDS prevention and to develop mechanisms for sharing their experiences in the future. The resulting partnerships between HIV/AIDS organizations in Brazil and Bolivia and in Honduras and Nicaragua will ensure that AIDSCAP's strategy for gender and HIV/AIDS continues to influence prevention efforts throughout the LAC region. ■

# 7.2 Gender Training Produces Results

In Pietermaritzburg, South Africa, as in many parts of the world, women who trade in sex often face harassment, violence and sexual assault, not only from clients and brothel owners, but also from the police. The South African NGO Lawyers for Human Rights has collected the stories of many women who were raped by those entrusted with enforcing the laws against sexual abuse.

One woman, only 19 years old, reported being forced to have oral sex with five police officers, who left her naked on a remote road outside of town. On her way home she was raped by a drifter who demanded sex in return for a ride. Another woman was arrested for soliciting and locked in a cell for several hours by two policemen, who released her only after she agreed to have unprotected sex with each of them in the back of a police van.

In both cases—and many others—no charges were filed. Considered criminals under South African law, sex workers are easily intimidated by threats of police retaliation.

The AIDS Training, Information and Counseling Centre had been working with sex workers and their clients in Pietermaritzburg, educating them about HIV/AIDS and condom use. But in an environment where sex workers had almost no protection against physical abuse and sexual assault, "negotiating" condom use seemed a remote possibility.

Such power imbalances between women and men are often overlooked in the design of HIV/AIDS prevention projects. Driven by the urgent need for prevention education and methods and constrained by the difficulty and cost of addressing more complex issues, many projects ignore the long-term social, economic and legal problems that make people vulnerable to HIV infection.

In Pietermaritzburg, however, Lawyers for Human Rights recognized the problem early on. As participants in a regional gender training workshop organized by AIDSCAP's Women's Initiative with support from USAID's Regional Economic and Development Services Office for Eastern and Southern Africa, representatives of the NGO identified the widespread disregard for sex workers' human and legal rights as a major obstacle to HIV/AIDS prevention. The pilot project they developed during the workshop and launched in January 1996 with support from AIDSCAP included interventions to educate both sex workers and law enforcement officers about the women's legal rights, as well as national advocacy efforts to decriminalize sex work.

By April 1997, some 24 women had received training to help them understand and assert their rights and to empower their peers with this information. Lawyers for Human Rights reports that sex workers are beginning to use their new knowledge and the support they received from the NGO to do what few had dared to do before—to bring charges of rape and assault against their attackers.

Some progress was also made in sensitizing police officers, as evidenced by a decline in the number of reported incidents of police harassment and intimidation of sex workers. The project developed a training package designed to help law enforcement officers and others who work with the public confront negative and potentially dangerous attitudes toward marginalized members of society. And on the national level, it established a network of advocates to work toward the long-term goal of decriminalization.

The Pietermaritzburg project was one of five initiated as a result of AIDSCAP's gender training workshop held in Mombasa, Kenya, in October 1995. The structure of the training, which included a follow-up workshop to assess project results, and the provision of seed money made it possible for participants to put their new knowledge and skills into immediate practice.

Forty-one senior program managers from government agencies, NGOs, AIDSCAP offices and USAID Missions in Ethiopia, Kenya, South Africa, Tanzania and Zimbabwe participated in the five-day workshop, which was designed to give them the skills needed to

incorporate a gender perspective into HIV/AIDS programs. Their enthusiastic response led to plans to hold similar workshops elsewhere in Africa.

In fact, workshop participants from the AIDSCAP-supported Tanzania AIDS Project (TAP) developed their own plan to train NGO personnel in leadership skills for identifying gender issues and modifying interventions. Forty-two NGO representatives from the nine regions covered by TAP participated in a training-of-trainers workshop, then went back to their districts to hold similar workshops for a total of 239 NGO staff throughout the country. AIDSCAP's resident advisor in Tanzania reported that the impact of this gender training was reflected in the design of new projects and in the new roles men and women had assumed in prevention and care efforts.

A manual produced by AIDSCAP, *A Transformation Process: Gender Training for Top-Level Management of HIV/AIDS*, will facilitate further replication of such workshops. The first gender training manual for senior HIV/AIDS program managers, it is available in English and French and includes conceptual frameworks for gender analysis, guidance on developing gender-sensitive projects, case studies and facilitators' guidelines.

In July 1997, facilitators used the manual to conduct a regional training workshop for 26 senior program managers from five West African countries. Early reports on follow-up by the participants were encouraging. Less than two months after the workshop, for example, the executive director of the national AIDS control program in Côte d'Ivoire had already scheduled six gender and AIDS workshops for local AIDS and reproductive health coordinators, NGO personnel and private sector managers.

AIDSCAP's experience suggests that targeting senior program managers for gender training is an effective strategy, noted E. Maxine Ankrah, associate director of AIDSCAP's Women's Initiative. "Those who make or influence policy, plan and monitor programs, and provide resources are ultimately the ones who determine whether gender concerns are addressed as an integral part of HIV/AIDS programs," she concluded. ■

tries (Box 7.2) And in the Latin America and the Caribbean region, AIDSCAP resident advisors and their implementing partners used the gender analysis skills they had acquired at an AIDSCAP regional workshop to develop pilot intervention and research projects to improve HIV/STD prevention services for women across the region (Box 7.1).

## Dialogue

- **The dialogue approach to communication between men and women holds great promise for stimulating and supporting sustained behavior change to prevent transmission of HIV and other sexually transmitted infections.**

AIDSCAP promoted the use of dialogue, designed to give men and women the gender awareness and skills they need to communicate openly and honestly about sex and other issues that affect their sexual health, at the interpersonal, community and policy levels. Representatives from 27 countries who helped field test the methodology in a satellite meeting at the XIth International Conference on AIDS in Vancouver responded enthusiastically, calling this initiative "long overdue." One woman noted that dialogue is "the only way that women can approach men in my culture. We cannot 'negotiate' with our men." After the meeting, groups from around the world requested assistance in replicating the dialogue among policymakers, communities and couples.

Most participants in the first operations research project to test the dialogue process—a series of facilitated sessions with truck drivers and their spouses conducted in Jaipur, India, in 1997—reported that the experience made them feel comfortable discussing sexual matters with spouses and friends. Many of the truck drivers said they had started to use condoms with their spouses for the first time. These encouraging results convinced the John D. and Catherine T. MacArthur Foundation to fund a two-year pilot intervention using the dialogue process with Indian truck drivers and their wives.

- **Although the ultimate goal of dialogue for HIV/AIDS prevention is to improve communication between men and women, it may be necessary to first build sexual communication skills in single-sex groups.**

In Zimbabwe, for example, the Women and AIDS Support Network found that initially it was better to separate boys and girls for school-based HIV/AIDS education sessions, giving the girls opportunities to ask questions without feeling inhibited. Once the girls gained confidence in their ability to discuss sexual issues, they asked that the boys be included in future sessions. And in the operational study of the dialogue process with Indian truck drivers and their spouses, only one of the five facilitated sessions involved a mixed-sex group. The researchers found that they had to convene single-sex groups for the other rounds of dialogue because of cultural constraints against unacquainted women and men discussing sexual issues. Nevertheless, participation in these groups helped truck drivers and their wives talk to each other about sex and sexual health. Policymakers and policy influencers meeting at a national conference organized by AIDSCAP in New Delhi in May 1997 recommended same-sex approaches as a means of initiating dialogue between women and men on HIV/AIDS programs and policies as well as personal protection.

## Men as Prevention Partners

- **Although it is critical to empower women so that they are better able to protect themselves from HIV, prevention interventions for women must also address men's behavior and communication between the sexes.**

Research data from around the world consistently demonstrate that many women's risk of HIV stems from their partners' unsafe behavior, not their own. In most societies, men still have greater control over sexual decision making than their female partners, and are in a better position to act on messages that focus on individual behavior change.

Moreover, AIDSCAP found that strategies for empowering women were most successful when they involved men as well. In Nigeria, for example, several AWI projects reached out to include men after the women they were working with said that it would be easier to use their new skills if their male partners were also aware of the importance of prevention. In Brazil, the NGO Grupo Pela Vida expanded a project that offered education and facilitated discussion about HIV/STD risk reduction in the waiting room of a large gynecological clinic to reach the primarily male clientele of a tuberculosis and pneumonia clinic at the same health center and to encourage discussion about HIV/AIDS among male and female clients.

- **HIV/AIDS prevention programs should address men not only as sexual beings, but in their roles as fathers, husbands, workers and community members.**

For example, gender-sensitivity training for drivers of Kenyan *matatus* (vans that serve as informal public transport) succeeded in convincing the young men to be more courteous to female passengers by appealing to them to treat all women as they would like their mothers, sisters, wives and daughters to be treated. They were also encouraged to extend the same courtesy to their partners. A study at two Haitian clinics revealed that the most important motivations for men to seek STD treatment were preserving fertility and ensuring healthy offspring (see page 27).

## Woman-Initiated Methods

- **Peer support can help women who are vulnerable to HIV/AIDS and other STDs convince their partners to use female condoms.**

AIDSCAP's research in Kenya and Brazil, as well as UNAIDS-sponsored studies in Costa Rica, Indonesia, Mexico and Senegal, found that group discussions with peers helped women overcome obstacles to using the female condom, including unfamiliarity with the device and the need to communicate with one's partner about its use. During the sessions, women encouraged each other and shared strategies for introducing female condoms into a relationship.

- **The female condom is an acceptable alternative to male condoms for some couples.**

In AIDSCAP's studies in Brazil and Kenya, 70 percent of the Kenyan women and 97 percent of the Brazilian women said that they would like to continue using female condoms after the research ended. The majority of their male partners also wanted to continue using the new condoms. While none of the women were able or willing to buy male condoms regularly, most said they would be willing to pay for female condoms if they were available.

Results from acceptability and intervention research discussed at a conference on the female

condom AIDSCAP convened in suburban Washington, D.C., in May 1997 support these findings. For example, successful pilot projects in Bolivia, Guinea, Haiti, South Africa and Zambia demonstrated that women and men will buy female condoms at prices about twice as high as male condoms.

## Women's Organizations

• **Women's organizations are effective partners for empowering women to protect themselves from HIV/AIDS and integrating HIV/AIDS prevention into other health and development programs.**

More than 70 percent of the projects funded under AWI were carried out by women's groups, which provided the access and structure needed to reach women and built on the formal and informal support networks women themselves had established. Through these groups, AIDSCAP helped influential women become spokespeople and advocates for HIV/AIDS prevention and other women's health and development issues in their communities.

In Nigeria, for example, working with five established women's organizations enabled AIDSCAP to institutionalize discussion of HIV/AIDS prevention and other health issues among groups that reached hundreds of women and girls and their families and friends. Now these issues are on the agenda for each regular meeting of the Federation of Muslim Women's Associations Nigeria (FOMWAN) in Jigawa State and of several branches of the NGO Women in Nigeria (WIN). Women trained by WIN/Cross River State started grassroots women's health clubs to continue to disseminate information and promote health-seeking behavior, while the market women's daughters trained by WIN/Lagos formed peer leader groups to help them continue educating other youth in the market.

Working with women's organizations that addressed other health and development issues also encouraged a more integrated approach to HIV/AIDS prevention. In Senegal, for example, HIV/AIDS interventions for market women were carried out by an organization that also provides credit and literacy programs, establishing a link between prevention education and practical measures to empower the women. And in Honduras, the Association for the Development of Youth and Rural Women integrated HIV/AIDS and STD prevention with credit programs and other efforts to improve the lives of rural women by training 20 women leaders from communal banks and solidarity groups. These women became facilitators for discussions about HIV/AIDS, sexuality, domestic violence and women's rights in their communities.

• **Some women's groups may be reluctant to become involved in HIV/AIDS prevention work.**

Although AIDSCAP found many women's organizations that were eager to implement prevention interventions and others that had already begun to do so, some groups did not want to address HIV/AIDS. Leaders of some development and family planning organizations thought that such work would dilute their mission, while others feared it would stigmatize their organizations. Fear of stigma was most common in countries or regions with less advanced epidemics. Education and advocacy are needed to sensitize women's leaders to the threat HIV/AIDS poses to all women and to promote an understanding of how HIV/AIDS organizations and women's groups can work together to achieve shared goals.

JEMIMAH MWAKISHA

*Participants in AIDSCAP's female condom study in Kenya listen as a woman describes her experience with the device.*

# 7.3

# Integrated Services Improve Women's Access to STD Treatment in Nepal

A woman comes to the Chitwan State Clinic in the Nepalese city of Bharatpur seeking contraceptives. While discussing her family planning needs with a provider, she mentions that she has been experiencing pain in her lower abdomen. The provider carefully explains that this symptom could be a sign of a sexually transmitted disease, and suggests that the woman see the clinic's physician.

The doctor talks to the woman about her symptoms, does a pelvic examination and asks her some questions to assess her risk of sexually transmitted infection. Then he tells the woman that she probably has an STD and explains the importance of taking all the prescribed medicine, even if she feels better after a few days. He advises the woman on how to prevent further infection, and the assisting staff nurse gives her a wallet of condoms and a referral card for her husband. The nurse also provides tips on how to convince the husband to seek treatment.

The nurse asks the woman to stop in the clinics' health education room on her way out. There she meets with a woman health educator who demonstrates how to use a condom and gives her a simple brochure about STDs and HIV/AIDS. Before leaving the clinic, the woman sits for a few minutes to watch a short, entertaining videodrama about condom use and HIV/AIDS prevention.

This woman and hundreds like her received STD treatment from a trusted source—the providers at their local family planning and maternal-child health clinics—as a result of an AIDSCAP-supported pilot project implemented by the Family Planning Association of Nepal (FPAN). Although the goal of integrated reproductive health services remains elusive in much of the world, it has become a reality in the FPAN clinics in the Central Region districts of Chitwan, Makawanpur and Dhanusha.

The clinics offer prompt, effective STD diagnosis and treatment and HIV/STD prevention counseling and education along with family planning and maternal-child health services. Prevention of STDs, including HIV, has also been integrated into the work of the clinics' outreach staff and volunteers, who distribute condoms, talk to community members about STDs, and refer people to the clinic for STD services.

Just a few years ago, FPAN provided no STD services, and most providers were reluctant to talk to their clients about STD prevention. Outreach workers distributed condoms, but only for family planning.

That all changed when Dr. Bijaya Neupane, the physician at the FPAN clinic in Chitwan, attended an AIDSCAP-sponsored training session on STD case management conducted by the Nepal Medical Association. Believing that FPAN had an important role to play in improving women's access to STD treatment, he proposed that AIDSCAP support a pilot project to test an integrated reproductive health model in Chitwan district.

Beginning in January 1996, FPAN's Chitwan branch recruited additional nursing and health education staff, upgraded the clinic's facilities and extended its hours. All staff received an orientation in the basics of HIV/STD prevention. Then targeted training sessions in STD syndromic management, risk assessment, prevention counseling and laboratory support prepared medical, counseling and laboratory staff to provide quality STD services.

Outreach staff and volunteers also received training to help them make the shift from family planning alone to integrated reproductive health. They learned to promote condoms for disease prevention as well as contraception, and to help people assess their risk of contracting an STD. Outreach workers not only referred women whom they believed to be at risk for STDs, but accompanied them to the

FPAN clinic to ensure proper follow-up.

A revolving drug fund begun with U.S.$1,700 in seed money from FPAN enabled the clinic to supply STD drugs to clients at a cost about 15 percent below the retail price. When patients cannot afford to buy the prescribed drugs even at discounted prices, FPAN staff tries to supply them free from sources such as physicians' samples or contributions from drug wholesalers.

Impressed with what FPAN had accomplished in Chitwan, AIDSCAP provided funding in December 1996 to expand STD services to the FPAN clinics in the cities of Hetauda and Janakpur. During the first four months, more than 100 people sought STD diagnosis and treatment at each of these clinics.

FPAN's experience in the three clinics represents one of a few successful attempts to integrate STD diagnosis, prevention and treatment into family planning and maternal-child health services. In just 15 months, 1,275 patients—both men and women—were treated for STDs at FPAN clinics and outreach sites in the three districts. More than 87 percent of those patients were women, evidence that the project had achieved its goal of improving women's access to STD services.

Much to the surprise of the family planning workers who had feared any association with the stigma of STDs, the new STD services actually enhanced FPAN's reputation for providing high-quality, client-centered services. For Chitwan, offering STD services had a dramatic impact on the demand for all reproductive health services. For example, the number of clients requesting sterilization services climbed by 65 percent from 1995 to 1996.

These results impressed Nepali family planning managers and policymakers attending a lessons learned workshop in April 1997, and they recommended further integration of STD services into family planning and maternal-child health programs. FPAN and Family Health International plan to begin this expansion in Nepal's Eastern and Western regions. ■

MARY O'GRADY/AIDSCAP

*Nepali women wait to see the doctor on a Saturday afternoon at a reproductive health outreach clinic organized by FPAN and a local NGO in the village of Malekhu.*

# Recommendations

- Gender orientation of policies and programs should be an explicit policy of an organization from its inception. HIV/AIDS prevention programs should build in specific structures and mechanisms, such as gender training of staff, point people in field offices and earmarked funding, to integrate a gender perspective into projects and monitor all activities for gender sensitivity.

- Additional operations research should be conducted to explore the use of dialogue as a strategy and tool for improving sexual communication between men and women and promoting HIV risk reduction.

- HIV/AIDS interventions should not target just women or men, but should focus on improving understanding and communication between them. Men should be addressed in their roles as fathers, husbands, workers and community members, and not merely as sexual beings.

- HIV/AIDS programs should work together to make the female condom more available and affordable to women and men in developing countries. Efforts to increase availability should begin with large-scale introduction in a few countries; efforts to improve affordability should include expediting research on whether the female condom can be used more than once and providing incentives for alternative, less expensive product designs.

- HIV/AIDS organizations should collaborate with women's groups, particularly those that address other health and development issues, to empower women and promote a more integrated approach to prevention. They should also continue to promote a better understanding among these organizations of the threat that HIV poses to health and development efforts and of the need to work together for women's empowerment and gender equity.

JEREMY HARTLEY/PANOS PICTURES

*Women sell second-hand clothes in a market in Dakar, Senegal. AIDSCAP worked with an NGO that offers credit and literacy programs to empower Senegalese market women and their daughters to protect themselves against HIV/AIDS.*

# Future Challenges

## Understanding Stable Relationships

Few studies have explored the dynamics of sexual communication and control between couples. More research is needed to understand how to help couples develop safe, respectful, mutually satisfactory sexual relationships.

## Increasing Women's Options

The enthusiastic response to the female condom in studies and pilot projects throughout the developing world confirms the urgent need for HIV/STD methods that women can initiate and control. Female condoms are a promising option, but their cost has limited their availability to all but a handful of countries. Research to develop microbicides that protect women against HIV and other STDs and simultaneous efforts to improve access to affordable female condoms must be a top priority for prevention programs.

## Integrating Reproductive Health

The promise of integrating family planning, HIV and STD prevention, and STD treatment services to reach millions of women through family planning, maternal-child health and primary health care clinics has yet to be realized. Obstacles include inadequate resources, providers' reluctance, a lack of clear technical guidance on how to provide integrated services in different settings, and an emphasis on treating and counseling women rather than couples. Operations research is needed to address these constraints to achieving a truly integrated approach to reproductive health.

## Empowering Women

In many developing countries, women's vulnerability to HIV/AIDS will continue without fundamental changes in their social, economic and legal status. Income-generating activities linked with HIV/AIDS prevention can empower some women to protect themselves from infection, but the scope of such activities is far too small to have a significant impact on the status of women in society as a whole or on the spread of the epidemic among women. Political commitment, human and financial resources, and true collaboration among health and development agencies and organizations are required to empower women through legal reform, education and greater access to employment and credit.

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# 8 Managing HIV/AIDS Programs and Building Capacity to Sustain Prevention Efforts

Sound technical strategies and state-of-the-art technical skills are essential for HIV/AIDS prevention, but they do not guarantee the success of a prevention program. Planning, management and monitoring create the infrastructure that makes it possible to deliver effective technical services to those at risk of or affected by HIV. During the past decade, government agencies and nongovernmental organizations have strengthened their management skills and systems as well as their technical skills to meet the challenges posed by the epidemic.

NGOs have played an important role in the response to HIV/AIDS and remain one of the most effective channels for reaching and influencing target audiences. Once wary of NGO involvement in HIV/AIDS prevention, most governments now recognize the value of NGOs' contributions and accept them as partners.

Some of these NGO partners were established to respond to the epidemic, while others added HIV/AIDS prevention to their other health and development objectives. The new organizations often lack basic institutional and financial capability, and many NGOs—new and established—lack technical expertise in HIV/AIDS prevention. Governments, on the other hand, have longer experience in managing HIV prevention efforts, but face daunting new management challenges. Erstwhile strong, centralized programs bolstered with international technical and financial support now struggle with the complexities of decentralizing planning and management to regional and district health authorities and with the need to expand care and support services to people infected and affected by HIV/AIDS as financial resources diminish.

Strengthening the capacity of developing country NGOs and government agencies to plan, manage and evaluate HIV/AIDS programs has become an even great priority during this second decade of the epidemic with the explosive growth in the number of HIV infections in developing countries and the realization that a cure or vaccine is still a long way off. The crisis mentality of the early years, when governments, donors and NGOs moved to mount an emergency response to AIDS, has been replaced by an understanding that the epidemic is a long-term development problem requiring a long-term multisectoral response.

## Managing Programs Worldwide

One of the largest donor-funded health programs ever mounted, with some 584 projects and activities in more than 40 countries and more than 500 implementing partners, the AIDSCAP Project offered a unique opportunity to develop innovative management systems for international HIV/AIDS programs and to build the capacity of local partners to sustain such programs.

From 1991 to 1997, AIDSCAP worked with local partners to design, manage and evaluate comprehensive, multiyear programs in 19 countries throughout the world. These ranged from a primarily grassroots, nongovernmental program to address prevention, care and orphan support in Tanzania (Box 8.1) to a program housed in and directly supportive of the government's national HIV/STD control program in Jamaica. AIDSCAP also provided targeted expertise to national and regional efforts in more than 20 countries. Examples include strengthening Zambia's national STD service, infusing state-of-the art HIV prevention expertise into the design and implementation of a reproductive health project in West Africa, training epidemiologists and social scientists to

conduct socioeconomic impact studies in Central America, and evaluating non-AIDSCAP HIV/AIDS prevention projects in Uganda.

Two AIDSCAP grant programs offered special opportunities for strengthening community-based responses to the epidemic. A competitive grants program that paired U.S. private voluntary organizations with host-country NGOs awarded nine three-year, $400,000 grants to support innovative projects that were integrated into existing AIDSCAP programs. And by providing more than 200 "Rapid-Response Fund" grants of U.S.$900 to $5,000, AIDSCAP was able to expand the number and type of community-based organizations delivering client-centered HIV/AIDS prevention services in countries around the world (Box 8.2).

Other initiatives were designed to address emerging needs and opportunities. AIDS care and management grants enabled organizations in selected countries to test interventions to link and strengthen prevention and care efforts at the community level. A "Domestic Areas of Affinity" pilot project encouraged networking and sharing of experiences between Dominican and Haitian programs and U.S.-based programs that serve similar populations. And the lessons from a demonstration project providing HIV prevention and STD services to Rwandan refugees in camps in Tanzania—the first to test the viability of integrating such services into primary health services in a refugee setting—have been used by the United Nations High Commission on Refugees and others to shape subsequent programs for refugees.

Systems and tools developed for managing these initiatives and the AIDSCAP Project as a whole may serve as useful models for future international HIV/AIDS programs. These include a program management manual to guide field implementation, processes for increasing local participation in project design (Box 8.3), and database management tools for indexing and tracking projects, research studies, BCC materials and program documents.

Strengthening the capacity of local organizations to design, implement, manage and evaluate HIV/AIDS programs was a key objective of the AIDSCAP Project. The vast majority of its projects and field activities were carried out by host-country NGOs, community-based organizations, government agencies and universities, with technical assistance and management support from AIDSCAP staff and consultants.

During the first half of the project, capacity building efforts emphasized project design and technical skills. Strengthening financial, management and networking skills became increasingly important during the second half of the project as AIDSCAP prepared its implementing partners to continue and sustain HIV/AIDS prevention programs. The project developed new tools for assessing, monitoring and evaluating capacity, including an instrument to help organizations identify their own strengths and weaknesses and a strategic planning manual, and trained all its resident advisors to use these tools to integrate comprehensive capacity building efforts into the programs they managed.

AIDSCAP's commitment to building local capacity was apparent in its 20 field offices, where 80

EVARISTO FÁ/REVISTA CARA


*Sales of this T-shirt displayed by Brazilian First Lady Ruth Cardoso (right) will support the HIV/AIDS prevention work of the Asociação Saúde da Família in Brazil. This NGO is one of seven that AIDSCAP helped establish through its NGO Partnership Initiative.*

# 8.1.

# NGO "Clusters": A Coordinated Approach to HIV/AIDS Prevention and Care

One of the few lawyers in Tanzania who advises people living with HIV/AIDS and their families, Nuru Mazora meets half of her clients through referrals from local NGOs.

"Before they found out about my work, these NGOs had nowhere to refer people living with AIDS who had legal problems," she said, explaining that clients usually come to her with questions about discrimination, inheritance laws, writing wills and protections against rape and domestic violence.

The NGOs learned about the legal aid services provided by Mazora's employer, Comprehensive Community Rehabilitation in Tanzania, when they joined the Dar es Salaam HIV/AIDS "cluster." Their experience illustrates one of the advantages of the cluster strategy employed by the Tanzania AIDS Project (TAP), which brings together the NGOs working in HIV/AIDS prevention, care and support in a city or region to coordinate activities, share resources and information, and avoid duplication of effort.

The USAID-funded TAP, which was implemented by AIDSCAP from 1994 to 1997, organized these clusters in the nine regions of the country most affected by HIV/AIDS. In each region, TAP-facilitated workshops enabled representatives of participating NGOs to understand the individual and collective strengths and weaknesses of their organizations, and this understanding allowed them to rapidly design joint plans for a comprehensive, region-wide HIV/AIDS prevention, care and support program. Together they developed project goals and strategies and mapped out which target populations and technical areas each NGO would cover.

In each cluster, an "anchor" organization selected by the participating NGOs is responsible for hiring staff to manage the cluster, holding monthly meetings, dispersing funds, overseeing financial management of activities and submitting reports. TAP facilitates meetings among the clusters and provides technical assistance and training to help cluster members strengthen their technical, management, planning and evaluation skills.

Formal coordination mechanisms within the clusters include monthly meetings of a cluster steering committee of five to six NGO representatives to review the progress of their joint program and quarterly or semiannual meetings of a subcommittee consisting of two representatives from each NGO in the cluster. But informal communication among cluster members is much more frequent, as people from the different NGOs confer to plan joint events, seek advice and assistance, make referrals or just give other each some much-needed encouragement.

"I find that people who work in the same field as I do, we share our problems," Mazora said. "This is what happens in a cluster. Sometimes you're so depressed you regret you took the job, and you have somebody to boost your morale."

For Margaret Mshana, director of a grassroots women's organization called KIWAKKUKI in the town of Moshi, the greatest benefit of cluster participation is the training provided by TAP. Participation in training-of-trainers workshops TAP held for members of the Kilimanjaro cluster equipped KIWAKKUKI's volunteers to go out into the villages and train others as HIV/AIDS peer educators and community-based counselors.

Such training opportunities are rare for groups as small as hers, explained Mshana, whose organization has about 450 members but a staff of only three.

Mazora agrees that the training available to small organizations as members of a larger cluster is an important advantage. As

an example she cites the training she received in counseling, which helped her cope with the hardest part of her job—knowing what to say to a client who is distraught, angry, depressed or even suicidal.

"When I started working, I never knew anything about counseling," she said. "So I would say, 'I can provide legal service, but I cannot *talk* to them.' I've been able to attend some seminars on counseling and have greater skill and knowledge."

Like Mazora and Mshana, cluster participants believe that the experience has been a positive one. Although inevitable disagreements, misunderstandings and rivalries arise as cluster members struggle to cooperate, the benefits of their collaboration—and the urgency of their shared goals—help them overcome these difficulties. The results have been more efficient division of responsibilities, less unhealthy competition for support, strong collaborative relationships among NGOs and, ultimately, more effective HIV/AIDS prevention, care and support services. ■

MARGARET DADIAN/AIDSCAP

*Tanzanian NGO leader Margaret Mshana makes a point at an HIV/AIDS workshop for policymakers in the Kilimanjaro cluster.*

# 8.2

# Promoting a Rapid Community Response to HIV/AIDS

In Lagos, the largest city in Nigeria, traffic jams are an inescapable part of daily life. Many people spend as long as four hours a day traveling to and from their jobs.

But for the Nigerian NGO Health Matters Inc., a traffic jam is an opportunity, not an annoyance. Taking advantage of the large captive audience mired in Lagos traffic each day, Health Matters' mobile health educators weave their way through lines of cars and buses, stopping to talk to commuters and pedestrians about HIV/AIDS prevention and to distribute condoms and educational materials.

With U.S.$3,000 from AIDSCAP's Rapid-Response Program, a flexible funding mechanism for supporting small, innovative interventions, Health Matters was able to reach 32,000 people in just 12 weeks. The NGO's six mobile health educators also distributed 1,500 posters, 8,000 pamphlets, 7,540 bumper stickers and 21,600 condoms in the three most congested areas of Lagos.

AIDSCAP's resident advisor in Nigeria was impressed with what Health Matters had accomplished with a small amount of money and with the NGO's ability to manage the grant funds. As a result, AIDSCAP contracted with Health Matters to expand the traffic jam intervention to ten additional sites and to train 20 more mobile health educators.

Health Matters Inc. is one of 214 local organizations that benefited from the AIDSCAP Project's rapid-response grants. The grants enabled these NGOs to respond to community needs while developing their own organizational capacity to manage HIV/AIDS activities, learning from the experience before taking on larger projects.

AIDSCAP worked with its resident advisors in each country to streamline application and reporting procedures. Applicants were asked to fill out a simple form, providing brief statements on what an activity would accomplish, why it was needed, how it would be implemented and evaluated, and a short description of the applying organization. A typical application consisted of six to seven paragraphs. These applications were reviewed by the country's AIDSCAP resident advisor, who awarded grants ranging from $900 to $5,000. At the end of an activity, the grantee submitted a two- to three-page narrative report and

AIDSCAP/Senegal

*Community members exchange ideas during a meeting sponsored by ARLS.*

a one-page financial report.

With these simple application and reporting procedures, the Rapid-Response Program made it possible for AIDSCAP to respond quickly to community interest in HIV/AIDS prevention without overburdening the developing infrastructures of new community-based organizations. It also gave AIDSCAP programs the flexibility to fund creative projects that were not envisioned when country strategies were designed.

Rapid-response grantees developed educational materials, organized special events, and trained outreach workers and volunteers. ARLS (the Senegalese Association Rurale de Lutte Contre le SIDA), a group of mostly women farmers, used an AIDSCAP grant to build a rural network of volunteer HIV/AIDS educators that works with *marabouts* (Islamic teachers) and other community institutions. In Ethiopia, the NGO Beza Lewegen trained deaf leaders and sign language professionals to educate the country's 200,000 deaf adults about prevention and developed and distributed posters and other printed materials on HIV/AIDS in sign language. And in India, the Media Foundation established a resource center that gives local NGOs access to international sources of HIV/AIDS information, helps them identify sources of technical assistance and educational materials, and provides AIDS counseling services.

AIDSCAP's Rapid-Response Program funded more than 230 such activities from 1993 to 1997. With modest amounts of money, organizations such as Health Matters, ARLS, Beza Lewegen and the Media Foundation were able to reach more than a million people worldwide with life-saving information about preventing HIV/AIDS. ■

percent of country programs were directed by resident advisors from the host country or neighboring countries and almost all other field staff were host-country nationals. Their contacts and understanding of the local situation made it possible to begin programs more rapidly, resulted in stronger relationships and better communication with AIDSCAP's partners in each country, and enhanced local ownership of the programs.

Recognizing that the skills and experience of the staff of these field offices represented a valuable resource in each of the host countries, AIDSCAP launched an NGO Partnership Initiative in 1996 to help this newly developed capacity continue beyond the AIDSCAP Project. Through this initiative, AIDSCAP and FHI assisted seven of its offices in establishing indigenous NGOs and provided training in business planning, fund raising, proposal writing and financial management. These skills have enabled the new NGOs in Brazil, Cameroon, the Dominican Republic, Ethiopia, Haiti, Honduras and Zimbabwe to raise funds from a variety of sources so that they can continue to provide technical and financial support to other local organizations working to prevent the spread of HIV/AIDS.

# Lessons Learned

## Planning and Monitoring

- **A systematic planning process articulates a clear vision for a program, provides a framework for implementation and makes it easier to assess program progress.**

In each of its 19 major country programs, AIDSCAP worked with representatives of the host-country government, USAID Mission, NGOs, community leaders, potential target audiences, influential stakeholders, other donors and technical experts to conduct needs assessment and develop detailed, multiyear strategic and implementation plans. This process ensured that programs were responsive to local needs, gave long-term direction to program efforts and enhanced donor coordination.

- **Joint planning by all of the organizations that will be involved in implementing a country program results in stronger individual projects and encourages valuable collaboration among the organizations.**

# 8.3

# Collaborative Design Process Creates Integrated Prevention Programs

When representatives of ten Honduran organizations met in Tegucigalpa in July 1995 to design a national HIV/AIDS prevention project, many of them had never worked together before.

"It's the first time that a project of this magnitude has been developed where the MOH (Ministry of Health) and local organizations have worked together to define strategies for intervention," explained María Luisa Gonzales of the Centro de Orientación y Capacitación en SIDA, a participant in the planning process.

AIDSCAP brought the ten public and private organizations together for two weeks shortly after an intensive one-week course in project planning. The goal was to use these new skills to develop a comprehensive HIV/AIDS prevention program consisting of complementary projects. And at the end of the two weeks, 10 projects had been created, the contracts between AIDSCAP and the participating organizations had been signed, and those organizations had received the initial funding for project implementation.

AIDSCAP used a similar process for its programs in Tanzania and Indonesia, holding project development workshops after initial assessments conducted with the individual organizations and training sessions in project design. This process gave participants an opportunity to receive technical assistance in project design, proposal development, financial planning and computer technology as they applied these new skills.

"Participants didn't just learn the theory of effective AIDS program design," said Gail Goodridge, AIDSCAP associate director for country programs and one of the facilitators at the Tanzania workshop. "They really had a chance to put it into immediate practice."

The workshops were also a "very effective team-building tool," Goodridge said. Designing their projects together gave participants a clear understanding of each organization's role in the comprehensive program and of how they could collaborate to achieve the overall objectives of the program.

At the Honduras workshop, for example, the Ministry of Health designed a subproject to strengthen its STD services. Other participating organizations then added an STD referral component to their projects to ensure that project staff and volunteers would encourage members of the target audiences to use these improved services.

Participants in all three countries appreciated the opportunity to learn from each other. "The interaction among all the institutions involved generated a search for better responses and strategies," said Juan Ramón Gradelhy of Comunicación y Vida, a Honduran HIV/AIDS prevention project sponsored by the municipality of San Pedro Sula. "All of those involved in this common effort shared experiences and helped each other."

This collaborative spirit served the organizations well as they carried out the projects they had designed. In Indonesia, Tanzania and Honduras, participants said that it strengthened their ability to coordinate their activities and to work together to achieve common goals. ■

AIDSCAP's experience in Tanzania, Honduras and Indonesia provides a model for such team building, with an intensive design process that brings together all the implementing agencies in a country to develop complementary projects (Box 8.3).

- **Effective project monitoring requires intensive on-site support but can be facilitated with appropriate, easy-to-understand tools.**

Frequent site visits by program managers provide the best vehicle for monitoring activities in the field; however, such visits are not always possible given staffing limitations, geographic distance, travel costs and other constraints. One strategy is to complement visits to project sites with the use of process indicator monitoring forms that require implementing agencies to report monthly progress toward achieving previously agreed-upon project targets, such as condoms distributed, individuals reached through interpersonal communication, materials distributed and training sessions conducted. Monitoring such process indicators can help managers identify when it is necessary to modify the project approach (and budget) to ensure achievement of project objectives.

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

AIDSCAP found that requests by implementing partners to modify or augment project designs were often a demonstration of active, attentive program management and commitment to improving the effectiveness of activities.

Large national or regional programs can also benefit from periodic internal assessment and review. Reviews by senior managers of each of AIDSCAP's major country programs allowed program managers to make mid-course corrections to program strategies or management structures, incorporate innovative technologies and strategies from other programs, expand successful interventions and boost staff morale by recognizing program accomplishments.

In Jamaica, for example, the AIDSCAP program was expanded to reach people in the high-prevalence areas of western Jamaica as a result of a program review conducted in 1994. The geographic coverage of AIDSCAP's STD activities in Senegal was also broadened at the recommendation of a review team, and several full-time consultants were hired to meet the increasing technical and management needs of the program. The participation of senior program managers and representatives of the donor in these reviews allowed for rapid joint decision making.

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

AIDSCAP maintained communication with its target audiences through formative research and qualitative evaluation and by encouraging their participation as peer educators and project staff. The project found that peer education was not only a good way to reach target audiences, but also provided a regular source of valuable feedback about clients' needs and perceptions of prevention activities and services.

## Forging Partnerships

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

In Ethiopia, for example, AIDSCAP brought together NGO, community and industry representatives and federal and local government officials to coordinate HIV/AIDS prevention activities in four regions that were project "focus sites." Members of these "focus site intervention teams" carried out their own interventions, but met monthly to ensure that their individual projects fit within the larger regional HIV strategy, that the designated target groups were being reached and that efforts were not unintentionally duplicated. They also shared resources and planned joint events. Team members said that this collaboration and coordination enabled their organizations to accomplish much more than they could have done alone and built stronger, more productive relationships between the public and private sectors in the four regions.

Another effective mechanism for encouraging collaborative partnerships among organizations working in HIV/AIDS is the "cluster" approach AIDSCAP established in Tanzania (Box 8.1).

- **Programs can be structured to ensure collaboration between governmental and nongovernmental organizations.**

A number of AIDSCAP country programs built such collaboration into their program designs and into their grant agreements with local organizations. In Honduras, for example, the project helped four regional health administrations of the Secretariat of Public Health strengthen STD services and created a referral system supported by the local NGO implementing partners. Similarly, AIDSCAP strengthened STD services at select district health clinics in Ethiopia and included STD prevention and referral in its agreements with NGOs working in those districts.

- **Linkages between international and domestic HIV/AIDS organizations can be mutually beneficial, particularly when the organizations work with similar populations.**

AIDSCAP sponsored a number of exchanges between U.S. and developing country NGOs, including a project that paired NGOs from the Dominican Republic with U.S. NGOs that work with Dominican immigrants. NGOs from both countries were able to share intervention methodologies and materials developed for working with Dominican populations. They also identified opportunities for further cross-country collaboration. Participants in this exchange decided to form a coalition to work on issues of common concern, including providing referrals to support services for HIV-positive people who travel frequently between the two countries.

## Mobilizing Communities

- **Working with existing organizations is generally more effective and sustainable than setting up new ones.**

AIDSCAP found that organizations with established links to their communities—even NGOs with no HIV/AIDS experience—were generally better able to respond to changing community needs for HIV/AIDS prevention and care than new NGOs created in response to the epidemic. These organizations can mobilize quickly, possess a ready infrastructure into which they can incorporate HIV prevention and AIDS care, often have a shorter learning curve and are able to maintain their efforts with little technical assistance. Organizations that have deep roots in a community, such as the Family Guidance Association of Ethiopia and the Community Development Association in Thailand, are also in a better position to sustain recently integrated HIV/AIDS services.

- **Community-based groups with little or no previous HIV/AIDS experience can be mobilized to support HIV/AIDS prevention in their communities if the process is kept simple.**

Donors must be careful not to overwhelm community-based groups with overly bureaucratic application, monitoring and reporting requirements. AIDSCAP found that small grants with streamlined application and reporting procedures are a good way to encourage innovative community-based approaches to prevention and to help community-based groups develop skills in HIV prevention and program management (Box 8.2).

## Sustainability

- **The tension that often exists between achieving direct program results and building long-term capacity can be resolved, but only when capacity building objectives have been clearly stated and all the stakeholders have agreed that capacity building is a priority.**

Better methods of defining needs and measuring improvements in capacity, such as the collaborative self-assessment and strategic planning process developed by AIDSCAP, could make it easier to strike an appropriate balance. Funding should be allocated specifically to achieve capacity building objectives.

- **Effective management of donor-funded national or regional programs requires a critical mass of local staff.**

The initial design of the AIDSCAP Project called for a minimal country office staff of management (resident advisor) and administrative (finance officer and secretary) personnel. Local consultants or AIDSCAP regional and headquarters staff were expected to provide additional support. But senior managers soon recognized that AIDSCAP resident advisors needed additional long-term, on-site capacity to help them provide the necessary technical and program

support to local organizations implementing AIDSCAP country programs.

All the country programs increased the size of their program management staff and some added full-time technical experts. Such investments made it possible to manage programs more efficiently and provide more responsive oversight and support. And by supporting and strengthening the capacity of local program management and technical staff, AIDSCAP contributed to the sustainability of HIV/AIDS prevention efforts in the host countries.

# Recommendations

- **To ensure that programs are responsive to local needs and to enhance collaboration and sustainability, international HIV/AIDS programs should involve government and community leaders, influential stakeholders, other donors and technical experts, and all implementing partners in a systematic joint planning process.**

- **Periodic opportunities to review and revise objectives, strategies and activities should be built into programs and projects.**

- **International HIV/AIDS prevention programs should seek to work with existing organizations that already have strong links to their communities—even groups with no HIV/AIDS experience—rather than establishing new community-based organizations.**

- **HIV/AIDS programs should consider creating formal collaborative relationships among all the organizations working on HIV/AIDS in a region to strengthen prevention efforts and reduce duplication of effort. Donors can use contractual agreements with government agencies and local organizations to encourage coordination of the HIV/AIDS services provided by the private and public sectors.**

- **Donors, contractors, implementing agencies and beneficiaries should clearly articulate reasonable benchmarks and schedules for achieving both direct program results and long-term capacity building.**

# Future Challenges

## Maintaining Momentum

With the realization that the epidemic is not a short-term crisis comes the challenge of maintaining the enthusiasm, energy and commitment that drove early HIV/AIDS prevention efforts. Program managers need to find ways to reduce "burnout" among staff whose work is difficult and often discouraging and to document slow but real progress in prevention to convince governments and donors of the importance of continued support.

## Overcoming Adversity

The constraints caused by war, civil strife and natural disasters make it more difficult to manage effective programs. Yet the populations affected by these calamities are particularly vulnerable to HIV/AIDS due to displacement, disruption of families and lack of access to services. Program managers need to identify and document strategies for overcoming such constraints and implementing effective prevention programs.

## Linking Prevention and Development

Building stronger linkages between HIV/AIDS programs and other development programs would make HIV/AIDS interventions more sustainable and enable them to address many of the social, structural, environmental and economic factors that influence sexual risk behavior. Governments, NGO coalitions, donors and other international organizations need to establish formal mechanisms for encouraging collaboration among people and organizations working in various development sectors.

## Sustaining Prevention and Care

Perhaps the greatest challenge facing those who manage and support HIV/AIDS programs is sustainability. Stronger partnerships between donors, governments, NGOs and the private sector are needed to help sustain HIV/AIDS programs. Fostering greater community ownership of programs would also increase their sustainability by reducing dependence on outside donors.

# 9 Prevention and Care: Mutually Reinforcing Approaches

With no cure or vaccine available, the global strategy against HIV/AIDS has focused on prevention. However, as the number of people becoming infected continues to rise at an alarming rate and millions of HIV-positive people fall ill, there is an increasing need for care and support services for people living with HIV/AIDS.

In this second decade of the pandemic, there is also a growing recognition of the contribution care can make to prevention efforts. People living with HIV/AIDS are valuable partners in prevention, giving the epidemic a human face and bringing the weight of their experience to prevention messages. And with no vaccine on the horizon, sustained behavior change over time remains the only way those infected can prevent HIV infection in others. However, if people living with HIV/AIDS feel abandoned by care services, they are less likely to acknowledge their status or to be motivated to protect others.

Communities throughout the world are searching for affordable models of prevention and care that meet their needs. Providers are expanding services from the traditional hospital crisis intervention model to develop community-based strategies for improving the quality of life for people living with HIV/AIDS and supporting their families and loved ones.

## Exploring Models of Care and Prevention

In AIDSCAP's work with communities affected by the epidemic, we found that it can be difficult to separate prevention from care, and that doing so may reduce the potential effectiveness of a prevention program. Although AIDSCAP's mandate was primarily to build local capacity for prevention, the project was able to conduct short-term pilot interventions of community-based HIV/AIDS care and support in a few countries.

A small grants program for AIDS care and management enabled AIDSCAP to respond quickly to support innovative, community-based initiatives for the care and management of people with HIV/AIDS. In Haiti, for example, AIDSCAP's care and management grants helped several hospitals to change the focus of care from the hospital to community-based prevention and home-based management of people living with HIV/AIDS. Through these projects, community members became directly involved in training, home care, developing educational materials, and prevention education.

AIDSCAP successfully integrated care and prevention into community-based structures and services in a number of countries. In Kenya , MAP International won over a skeptical clergy to the cause of HIV/AIDS prevention and support, creating a powerful grassroots campaign based in the churches and the communities they serve. Surveys conducted in 1996 showed that the churches in the MAP areas were more likely to provide home care for people living with HIV/AIDS, develop peer counseling programs, and counsel couples on risk reduction. In Jamaica, the Community Outreach Program expanded the support services provided by both governmental and NGO organizations by sensitizing health service providers to the needs of people living with HIV/AIDS and developing a referral resource manual. And in Tanzania, strengthening NGOs and other community-based groups to provide both prevention and care forms the cornerstone of the country program, resulting in integrated community-based services.

To meet the growing demand for practical tools to help those working in prevention respond to the increased demand for care, AIDSCAP developed a manual on HIV/AIDS care and support projects. A

concise guide to designing, implementing and evaluating such projects, the manual helps health and development organizations integrate HIV/AIDS care and support into their other activities in communities.[1] Three other AIDSCAP publications, part of the "Emma Says" comic book series, help communities, families and individuals affected by HIV/AIDS learn how they can come together to end stigma and improve care (Box 2.3, page 24).[2]

Several studies, mainly from developed countries, suggest that care and support in the form of counseling and testing can play an important role in encouraging preventive behavior.[3,4] AIDSCAP counseling and testing study at centers in Kenya and Tanzania and at a third UNAIDS-supported site in Trinidad assessed the efficacy of this intervention in developing countries (Box 5.1, page 54). Another study sponsored by AIDSCAP in Tanzania was one of the first to examine whether care and support for people newly diagnosed with HIV can encourage preventive behavior change over time (Box 9.1).

## Lessons Learned

- **Providing care and support for HIV-positive people in a community promotes acceptance of HIV/AIDS as a community problem and reduces stigmatization of people living with the virus.**

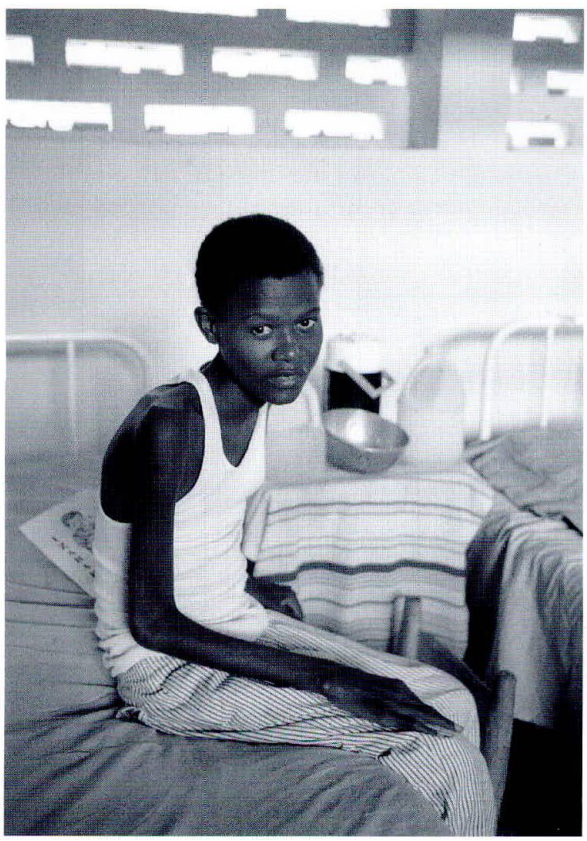
In the isolated mountain communities served by Hôpital de Fermathe in Haiti, involvement in care and support helped community members understand that HIV/AIDS is not the result of a supernatural curse. Acceptance of HIV/AIDS as an illness led to less stigmatization of people with HIV/AIDS and greater willingness to speak openly about preventing its transmission. Another AIDSCAP-supported project in Haiti resulted in a dramatic shift in the attitudes of staff at the Grace Children's Hospital, who had been reluctant to care for people with HIV/AIDS. At the request of hospital staff and other caregivers, the hospital expanded a support group for people living with HIV/AIDS to include family members, other community members, and hospital staff and patients, fostering a sense of solidarity among all these groups.

- **Care and prevention efforts are more likely to be sustained if they are integrated into existing community-based structures and services.**

The USAID-funded Tanzania AIDS Project managed by AIDSCAP, which brought together NGOs working on HIV/AIDS in a region to strengthen prevention and care, illustrates the benefits of building on community resources. Ownership and control of these programs, implemented by a "cluster" of NGOs in each of nine regions, remain in the hands of the community institutions.

The Tanga AIDS Working Group, for example, is an association of physicians, nurses and public health workers who coordinate cluster activities in and around the Tanzanian town of Tanga. Their involvement has made care an integral part of prevention activities in the cluster and has encouraged greater public sector support for HIV/AIDS programs. Government support for cluster activities, which includes providing office space, furniture and some transport costs and paying the salaries of

SEAN SPRAGUE/PANOS PICTURES



*A young patient fights tuberculosis and HIV/AIDS in a hospital in Léogâne, Haiti.*

# 9.1

# Study Explores Link Between Prevention and Care

Passersby barely notice the large shipping container that stands at the edge of the hospital grounds in a small Tanzanian market town. But others—mostly young men and women—stop and go inside.

Some enter hesitantly, dreading the news that may await them. Others hurry inside, seeking reassurance. For the container serves as the Muheza office of the Tanga AIDS Working Group, a community-based association of health workers that provides HIV pre- and post-test counseling, HIV/AIDS prevention services and continued counseling and support for people living with HIV/AIDS.

The makeshift office was also one of the sites for a unique research study, one of the first to assess how providing such care for people living with HIV/AIDS affects their sexual behavior. Experiences like those of the Tanga AIDS Working Group suggest that HIV/AIDS care and prevention are complementary, but only a handful of studies—mainly in developed countries—have examined the role of care and support in reducing risk behavior.

AIDSCAP's study in the Tanga district was designed to detect differences in risk reduction among HIV-positive people who received enhanced support and those who received post-test counseling only. Members of the experimental group participated in regular counseling sessions and some requested home visits.

These home visits were for support rather than medical care, explained Dr. Joan MacNeil, AIDSCAP's associate director of behavioral research. "During a visit, a counselor talked to family members about what it means to be HIV-positive and how they could work together."

Principal investigator Dr. Gad Kilonzo started recruiting participants at three sites in the Tanga district in November 1996. People were asked to enroll voluntarily in the study after the second of two post-test counseling sessions. A total of 157 people, ages 22 to 35,

JOAN MACNEIL/AIDSCAP

*Tanga AIDS Working Group staff confer outside the converted shipping container that serves as their office in Muheza.*

chose to participate.

Members of both groups were interviewed at enrollment, after three months and at the end of the six-month study period. Researchers collected information about illnesses, hospital and clinic visits, episodes of sexually transmitted disease and, for women, pregnancy. They asked about risk behavior, condom use and other prevention strategies, discussing HIV with partners, and relationship histories. Participants also discussed their thoughts about their condition, the reactions of their families and communities, and the impact of their HIV status on decisions about having more children.

All of this information is expected to shed light on how people make decisions during the first months after they learn that they are HIV-positive and on the kinds of support that encourage them to adopt preventive behaviors. Preliminary findings revealed that most participants cited abstinence as their main prevention strategy, yet they also said they wished to have children or additional children. In addition, ongoing care and support encouraged those who were positive and healthy to be more open about their status and led to the creation of the first HIV-positive support group in Tanga. Final results will be available by the end of 1997 and will be shared with policymakers, donors, program managers and health care providers.

"The results can be used to develop strategies for supporting behavior change over time among people living with HIV/AIDS," Dr. MacNeil said. "This is one small study, but it will give us a better understanding of one of the most critical issues in this second decade of the pandemic." ■

public health workers who devote as much as 40 percent of their time to HIV/AIDS interventions, has laid the foundation for a sustainable program.

- **HIV/STD prevention programs in the workplace lead to a more tolerant and accepting attitude among workers toward HIV-positive employees, resulting in a positive effect on morale and productivity.**

Studies conducted by AIDSCAP on the impact of HIV/AIDS on 17 sub-Saharan businesses found that managers of organizations with HIV/AIDS prevention programs believe their workplace activities are increasing tolerance and productivity as well as reducing employee risk behavior, health costs and other business costs. Many noted that greater acceptance of people living with HIV/AIDS reduces the potential for work stoppages, which have occurred at other companies because employees were afraid to work with HIV-positive coworkers.[5]

- **There is a high demand for HIV counseling and testing services in many developing countries.**

HIV counseling and testing centers established in Tanzania and Kenya as part of a study sponsored by AIDSCAP and UNAIDS had no trouble recruiting study participants. In fact, people kept coming to the centers for counseling and testing even after recruitment efforts ended. At the request of community members, this valued service was continued when the study concluded.

- **Provision of care can be an entry point for discussions about behavior change and can provide opportunities for personalized prevention messages in traditional and nontraditional settings.**

In Haiti, for example, religious leaders trained as community-based caregivers by Hôpital de Fermathe provided counseling to people living with HIV/AIDS in their homes, taught their families how to provide basic care and nutrition, and helped them access other support services. The caregivers also used these home visits to talk to HIV-positive people and their families about prevention. In Tanzania, providing care and support has enabled TAP to involve people living with HIV/AIDS in educating their families, neighbors and friends about prevention.

• **Peer educators and others working in communities to prevent HIV transmission are increasingly called upon to provide care and support to people living with HIV/AIDS and their families.**

A study of peer education in 21 AIDSCAP projects found that in many countries, people are looking to community-based prevention educators for HIV/AIDS counseling, care and support.[6] In Zimbabwe, several AIDSCAP-sponsored projects responded to changing community needs by teaching trainers basic home care techniques to pass on to peer educators. And in Nigeria, AIDSCAP expanded its peer education training curriculum to include support for people living with HIV/AIDS.

• **An educational approach is useful for introducing the concept of peer support groups for people living with HIV/AIDS.**

Peer support groups can reduce fear, decrease isolation and encourage HIV-positive people to educate others about HIV/AIDS. But participating in a support group can be difficult for people in cultures where such group processes are a new idea. The NGO Jamaica AIDS Support found that it was more effective to start groups with an educational focus, inviting people to meetings to learn about how to live with HIV/AIDS. After a number of meetings, these gatherings often developed into true support groups.

## Recommendations

Many questions remain about how to best provide care and support for people living with HIV/AIDS and about the relationship between care and prevention. Operations research is needed to:

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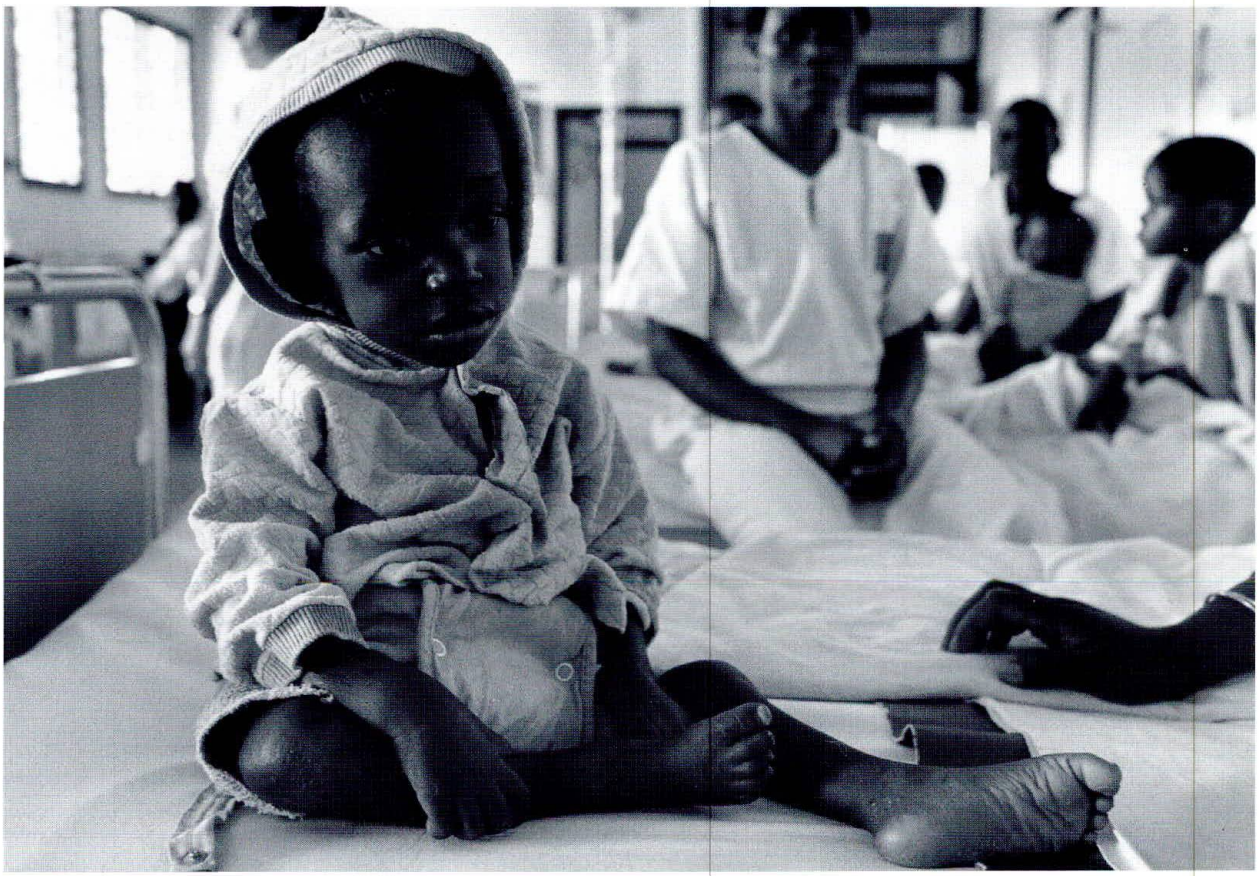

*A young Tanzanian AIDS patient. AIDSCAP worked with local NGOs in Tanzania to integrate HIV/AIDS care and support with prevention efforts.*

- Gain a better understanding of the types of social, psychological and economic support required to mitigate the virus's impact on families. In particular, studies should examine the role of care in reducing social vulnerability to HIV in at-risk populations such as women and children.

- Identify models of care and support for people with HIV/AIDS and their partners that can influence HIV risk behavior.

- Examine the effects of integrating HIV/AIDS prevention with care at sexually transmitted disease, family planning, tuberculosis, maternal-child health and other health clinics.

- Explore the relationship between HIV and productivity. Thus far, primarily anecdotal reports suggest that if people with HIV are provided care in a humane and non-discriminatory way, they are more likely to resume a productive life. The costs of labor lost due to illness and absenteeism have been documented, but increasing attention needs to be paid to HIV and the workplace.

# Future Challenges

## Improving Cost Effectiveness

Determining how to make care and prevention services more cost effective by improving accessibility, affordability and acceptability represents the major challenge for the future. To cope with this challenge, health care planners must improve health care delivery and develop new models of prevention and care.

## Developing New Models

Developing new models of prevention and care will require a shift in thinking from the notion of individual risk to a new understanding of social vulnerability and structural evolution. For pre-

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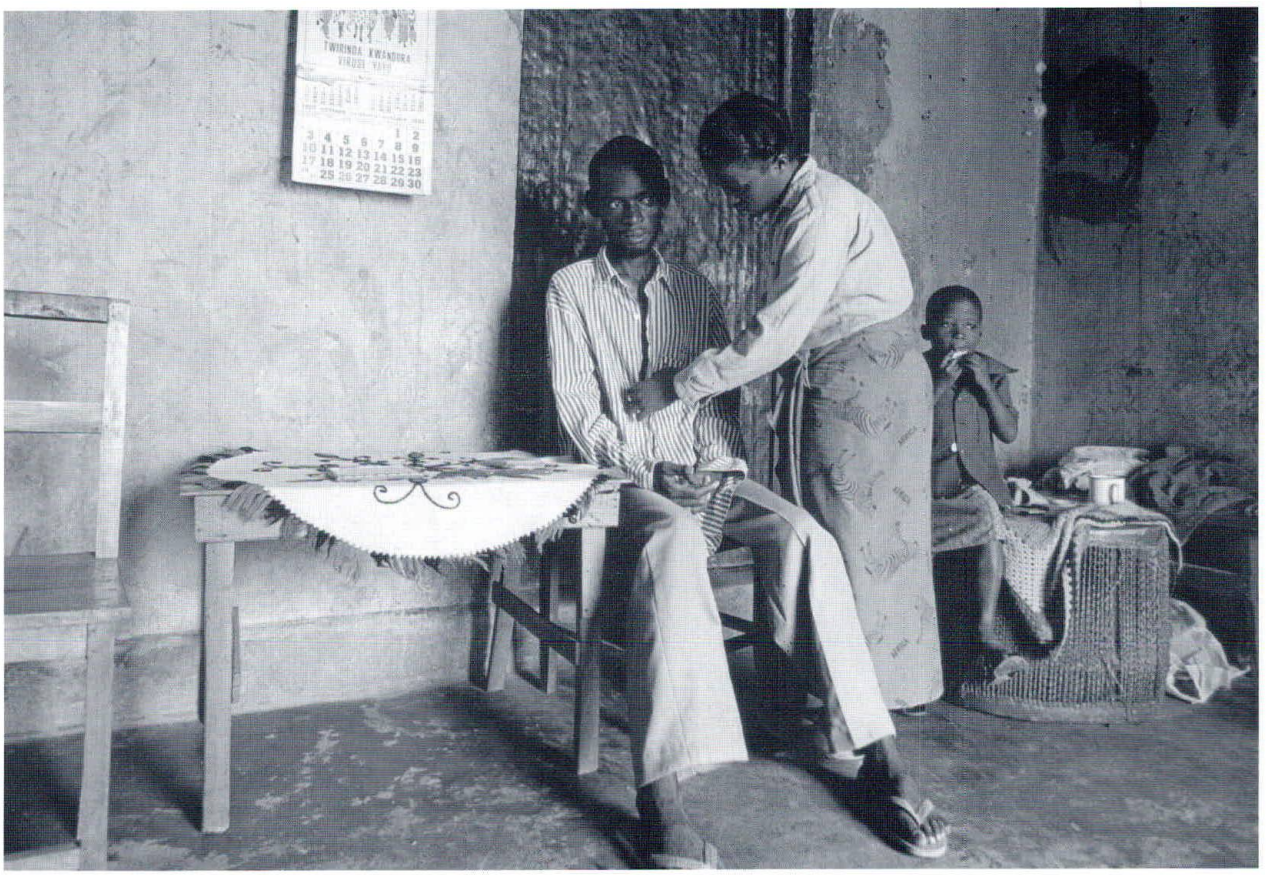

*An HIV-positive woman cares for her husband, who suffers from AIDS-related illnesses, in their home in Kigali, Rwanda.*

vention, we need to explore more multidimensional models of collective empowerment and community mobilization. For care, we need to build confidence in levels of care closer to home and to encourage the development of alternate providers and settings. At the same time, services must become more responsive to the diverse needs of people living with HIV/AIDS.

## Reaching Youth

Young people under 25 now account for half of all new HIV infections, with the most rapid growth among women 15 to 24 years old. This age group also has the highest rates of other sexually transmitted diseases. To help reduce young people's vulnerability to infection, research is needed to identify the best ways to link STD/HIV prevention with care services for adolescents and youth.

## Adopting Long-Term Strategies

As earlier and more accessible testing and improved treatments make it possible for people to live longer with HIV/AIDS, they need support and must engage in prevention for longer periods of time. More long-term strategies must be developed for providing care and support and for encouraging sustained behavior change.

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# 10 Crossing Borders: Reaching Mobile Populations at Risk

Most HIV/AIDS prevention efforts are defined by geography: they are designed, funded and implemented country by country or in regions within countries. But the epidemiologic and behavioral factors that drive the epidemic know no borders. In fact, mobile populations—and those affected by transient traffic in the areas where they live—are often at increased risk of HIV/AIDS. These mobile populations, in turn, can bring the epidemic from cities and towns to more rural regions when they return to their spouses and other sexual partners at home.

Mobile populations at risk of HIV infection include transport workers, miners and other migrant workers, military troops, refugees and women who trade sex in tourist and transient areas. Their risk stems from the experiences they share: separation from families and communities, language barriers, limited entertainment options, and easy access to alcohol, drugs and commercial sex.

Reaching mobile populations with consistent HIV/AIDS prevention messages and interventions is a formidable challenge. Cross-border and transient areas tend to have less developed health care infrastructures, including facilities for STD diagnosis and treatment, and mobile populations often do not know where or how to access the services that are available. The remote locations of most transient towns, the cultural and language differences among the populations who pass through them, and the generally higher crime levels and security risks encountered in cross-border environments make it difficult to carry out successful HIV/AIDS prevention programs.

## Leading the Way

During the late 1980s the AIDSTECH Project (also funded by USAID and implemented by FHI) pioneered interventions with mobile populations in Tanzania, where it carried out a successful HIV/AIDS prevention project targeting truck drivers and their assistants and sex partners along the country's major transportation routes. AIDSCAP used the lessons from this experience in Tanzania to design interventions with transport workers in a number of African and Asian countries, including Zimbabwe, Ethiopia, India and Nepal.

Beginning in 1994, AIDSCAP expanded this early focus on drivers and truck routes to understanding sexual risk behavior among other mobile populations and developing effective interventions for them. A series of ethnographic studies supported by USAID's Asia and the Near East Bureau produced a wealth of information about the factors that promote the spread of HIV in border towns and port cities in Asia and the Pacific,[1-6] leading to the design of some of the world's first cross-border prevention projects.

In Indonesia, in a pilot prevention project that could serve as a model for other Asian port cities, a shipping company's management endorsed a comprehensive HIV/AIDS intervention, enabling outreach teams to work with Thai fishermen and their Indonesian sex partners in the city of Merauke. In the Lao People's Democratic Republic, AIDSCAP and CARE International used local festivals and other innovative communication strategies to raise awareness of HIV and increase condom use along the border with Thailand. In the Philippines, the Center for Multidisciplinary Studies on Health Development reached thousands of fishermen and their partners through interactive group sessions. And assessments along Nepali and Indian trucking routes led to successful collaboration between projects on both sides of the India-Nepal border (Box 10.1).

AIDSCAP interventions targeting refugees, miners and military troops have also yielded useful lessons about how to reach and influence mobile populations and their sexual partners. In Rwandan refugee camps in Tanzania, AIDSCAP sponsored the first large-scale early intervention against HIV and other STDs among refugees.[7] In South Africa, where mining companies are beginning to develop prevention activities for employees who often travel across the country or from neighboring countries to work in the mines, AIDSCAP and Population Services International built upon the prevention efforts of the management of South Africa's large Welkom area mines to establish a condom social marketing project for miners and the community around the mines. Annual condom sales exceeded 249,000 in 1996 and had already reached 213,000 in the first four months of 1997.

In its work with the armed forces in Thailand, Cameroon and Zimbabwe, AIDSCAP found that the military hierarchy and its traditional role in educating young men offer ideal opportunities for HIV/AIDS prevention education. An intensive intervention that used Thailand's military structure and the prevailing social networks among soldiers was so successful in reducing risk behavior that it was adapted for use throughout the Thai military. In Zimbabwe, a local NGO called CONNECT worked with the Air Force and Army to conduct workshops on HIV/AIDS issues for commanding officers, train military personnel and their spouses as peer educators, and develop appropriate communication materials. And the AIDSCAP-sponsored Civil-Military Project on HIV/AIDS worked with civilian and military populations worldwide through the Civil-Military Alliance to promote collaborative HIV/AIDS prevention strategies.

AIDSCAP was also able to reach the female partners—both commercial and casual—of mobile men. For example, a study conducted by the African Medical Research and Education Foundation identified the most acceptable and cost effective ways to provide confidential STD services

BHORUKA AIDS PREVENTION PROJECT

*An outreach worker discusses HIV/AIDS prevention with truck drivers at the border checkpoint in Raxaul, India.*

to women living along the Tanzania-Zambia truck route.[8,9] In South Africa, in conjunction with the national AIDS program, the project reached out to the sexual partners of miners with education and a condom social marketing project in the mining communities. AIDSCAP also supported pilot efforts to help the wives and other steady partners of mobile men protect themselves from infection—a difficult challenge because these women often live far from the original intervention sites .

But perhaps AIDSCAP's greatest contribution to strengthening HIV/AIDS prevention for mobile populations has been its role in raising awareness of the magnitude of the problem and in advocating for interventions that cross borders, particularly in Asia. The results of AIDSCAP's assessments of HIV risk among mobile populations and the experiences from subsequent interventions were disseminated through position papers and other publications, presentations at international and regional meetings, and smaller workshops and meetings. As a result of these efforts, several international organizations and donors, including UNAIDS and the British and Australian aid agencies, have agreed to support AIDSCAP cross-border projects once the project ends or have used AIDSCAP findings to design new projects. And government officials who participated in meetings that AIDSCAP organized to encourage support for cross-border activities are beginning to recognize the importance of facilitating such cooperation to slow the spread of HIV/AIDS.

# Lessons Learned

## Cross-Border Interventions

- **Mobile populations encounter increased opportunities for HIV-risk behavior in border towns and port cities.**

Formative research conducted by AIDSCAP in nine countries revealed that border towns and port cities offer individuals greater access to inexpensive commercial sex and alcohol than other urban and trade areas.[1-6] The remote locations of border towns also isolates individuals from their regular social networks, which typically regulate individual behavior. As a result, mobile populations in cross-border environments, where men greatly outnumber women, have more opportunities to engage in risk-taking behavior.

- **Consistent and complementary prevention strategies and messages, implemented on both sides of a border, can greatly enhance the effectiveness of HIV prevention programs.**

AIDSCAP's experience working with NGOs in neighboring border towns in Nepal and India shows that consistency and collaboration are the keys to implementing an effective cross-border project (Box 10.1).

Similarly, community-based organizations implementing AIDSCAP-supported projects in Haiti and the Dominican Republic exchanged ideas, shared resources and established networks with counterpart groups working with Haitians and Dominicans in New York, Florida and Massachusetts. A brochure listing referral services in both countries is just one of the ways in which the organizations from the Dominican Republic and New York plan to reinforce HIV prevention messages and provide services to a mobile Dominican population that frequently travels between the two countries.

- **Intergovernmental authorization and support are preferable, but not required, for assessments and HIV/AIDS prevention interventions across borders.**

Blanket authorizations from all countries involved would, of course, be most desirable, but require long-term policy dialogue. In the meantime, prevention activities can proceed while program managers and sponsors simultaneously seek broader support for cross-border action.

The AIDSCAP-sponsored cross-border activity in Nepal and India, for example, began in 1995 through the collaborative efforts of two NGOs (Box 10.1). In 1996, AIDSCAP convened a three-day workshop for representatives of governments, NGOs and private industry from India, Nepal and Bangladesh to share lessons learned from the project and to encourage further collaboration among prevention projects in border zones. UNAIDS is providing funding for a series of workshops to continue this dialogue, as well as support for the India-Nepal border project after the AIDSCAP Project ends. And Family Health International is planning additional cross-border interventions in India, Nepal and Bangladesh.

# 10.1

# The India-Nepal Partnership: A Model Cross-Border Intervention

Dhaaley Dai, a cartoon condom figure, wards off HIV with a shield in the border town of Birgunj, Nepal. "Wear condoms. Drive away AIDS," reads the message on billboards and posters. Just a few hundred meters away in Raxaul, India, another condom figure spreads a similar message in Hindi.

The use of a slightly modified Dhaaley Dai in India (pretests revealed that members of target audiences there did not identify with the traditional Nepali shield and did not like the condom's muscular limbs) is just one example of the close collaboration between two AIDSCAP-sponsored organizations on opposite sides of the India-Nepal border. By adopting similar strategies, methods and materials, the Nepali NGO General Welfare Pratisthan and the Bhoruka AIDS Prevention (BAP) Project in India were able to create complementary HIV/AIDS prevention programs for transient border populations.

This collaboration grew out of AIDSCAP's research on HIV risk behavior along trucking routes in India and Nepal and the Transport Corporation of India's (TCI's) interest in protecting its workers from HIV/AIDS. Through its Bhoruka Public Welfare Trust, TCI had already opened a network of 15 STD clinics throughout India. In 1995, with technical assistance from AIDSCAP, the Trust opened a similar clinic in Raxaul and began linking it to GWP's prevention activities across the border.

Raxaul was chosen as the site for the cross-border intervention because it is the most important entry point into Nepal from India and because of its proximity to GWP's activities in Birgunj. Both border towns are located at "zero points" where a number of major highways converge. About 2,000 truck drivers pass through these points daily, often stopping to load and unload trucks and to rest before continuing their drive.

MICHAEL BUJA/AIDSCAP


*AIDSCAP Nepal's "Dhaaley Dai" logo*


*The Indian version of the popular cartoon character*

At every stage of the project, the Indian and Nepali staff of the two projects worked together to ensure that project goals, strategies, evaluation indicators, messages and services were consistent on both sides of the border. And because the projects had adopted similar approaches, outreach workers from India and Nepal found it easy to coordinate their activities. Staff from BAP, GWP and AIDSCAP reviewed communication strategies, materials, training curricula and condom social marketing strategies developed for the Nepal program and adapted them for the BAP Project in Raxaul.

Frequent visits and communication among field staff were also important to successful collaboration. The GWP team in Birgunj and BAP staff visited each other regularly, and BAP personnel participated in staff training activities at GWP's Hetauda field office, just an hour's drive north of the border.

BAP Project Manager Atanu Majumder noted that his staff had learned a great deal from GWP's outreach workers. "We didn't have the experience of how to work with sex workers, so we are grateful to GWP," he said. "Our staff has gone there and worked with them. They have taken us to the field and showed us how to interact with sex workers."

The two teams also organized several joint events, including a World AIDS Day Rally at the border. But the most important part of the collaboration was the joint STD referral system. Because people were often reluctant to visit the highly visible and well-known STD clinic in Birgunj, GWP staff used bilingual referral cards to direct men and women in need of STD services to BAP's general clinic just across the bridge.

Such visible cooperation helped both groups gain credibility and support within their communities. It also meant that the target audiences of the transport workers and their sex partners received the same messages on both sides of the border—a successful way of reinforcing the idea that HIV knows no boundaries and ensuring access to consistent prevention options. ■

## Women

• **Reaching the spouses and regular partners of migrant workers, business travelers and military personnel with HIV prevention activities is possible and essential in order to slow the spread of HIV.**

It is difficult, but not impossible, to reach the regular partners of mobile men when they do not live at the men's place of employment or along the transportation routes. For example, AIDSCAP-supported research conducted by the Indian Institute of Health Management Research in the Jaipur region of India successfully engaged truck drivers and their wives in a dialogue about HIV/AIDS and other STDs, which resulted in a greater awareness about the epidemic and an increased willingness among participants to discuss sexual matters with their spouses. The study results will be used to design an education and counseling intervention that will target both groups.

In Zimbabwe, AIDSCAP's intervention with the National Army and Air Force trained not only the military men but also their spouses as peer educators. Women's involvement ensured that both members of a relationship received the same messages and were aware of the same risks, which was particularly important because men in the Zimbabwe National Army are not permitted to live with their spouses.

## Refugees

• **Effective HIV/AIDS prevention interventions are possible in refugee camps.**

Refugees are vulnerable to high-risk sexual behavior that can lead to HIV infection because of family disintegration, general trauma and stress, rape and violence, lack of access to condoms, the breakdown of HIV/AIDS prevention interventions, and increased impoverishment of women, whose only option may be to exchange sex for money or food. But to people who have been displaced by war, civil strife or natural disasters, HIV/AIDS may seem a distant threat as they struggle to survive. Therefore, when AIDSCAP launched the first large-scale early HIV/AIDS and STD intervention in a refugee camp, no one knew whether project staff could engage camp residents in efforts to protect their long-term health.

The pilot project, managed for AIDSCAP by Care International in the Benaco camp for Rwandan refugees in Tanzania, proved that HIV/AIDS prevention programs can be effective in a refugee setting. Using a comprehensive strategy that included peer education, educational entertainment, condom distribution and promotion, and STD services, the project trained thousands of peer educators, reached hundreds of thousands of refugees with prevention messages, motivated thousands of them to seek counseling and STD treatment, distributed 1.5 million condoms in less than a year, and reduced the number of people who reported having more than one sex partner (Box 10.2).

- **Income-generation projects can help reduce the risk of HIV infection among women and young girls in refugee camps.**

Relief agencies usually avoid creating income-generating activities for refugees because they fear that such activities would encourage people to stay in camps indefinitely. Their objective is to provide temporary relief to displaced people until they can be repatriated or resettled. But in

HOWARD DAVIES/PANOS PICTURES

*Rwandan refugees arrive at the Benaco camp in Tanzania, where AIDSCAP launched the first large-scale, early HIV/AIDS prevention program in a refugee setting.*

refugee camps where single women and girls are at high risk of acquiring HIV infection because many must exchange sex for food and other basic commodities, income-generating projects are essential for HIV/AIDS prevention, giving participants a means of supporting themselves without threatening their health. In Benaco, women benefited from income-generating activities such as produce-growing cooperatives sponsored by other NGOs working in the camp.

- **Structural changes in the environment of a refugee camp can play an important role in HIV/AIDS prevention.**

Environmental changes may be easier to make in these temporary settlements than in more settled communities, and they can help prevent HIV transmission as well as improve the quality of life. For example, in the Benaco camp in Tanzania, relief officials learned that rapes often occurred in the large communal latrines, which were located a short distance from the camp and shielded with pieces of plastic. Replacing the latrines with smaller, four-family structures close to people's tents helped protect women and girls from sexual assault and HIV/AIDS. Another environmental change—construction of a community sports complex with a soccer field and basketball court—helped combat the boredom that often led to high-risk behavior. It also provided a venue for creative HIV/AIDS prevention activities (Box 10.2).

# Recommendations

- **HIV/AIDS prevention activities should not only target individuals passing through border towns and port cities, but should also address the factors that make cross-border sites such high-risk environments.**

Examples of such interventions include policies requiring consistent condom use in brothels, presumptive STD treatment of key groups, provision of free condoms in hotels and brothels, and mass media messages warning of the heightened risk of contracting HIV in border towns and port cities.

- **Linkages need to be established between organizations implementing HIV prevention activities on both sides of an international border.**

By agreeing on common goals, strategies and evaluation indicators, these groups can address cultural differences and language barriers to provide consistent, complementary and effective HIV prevention messages and programs to the populations they serve.

- **The lack of bilateral treaties or memoranda of understanding between governments should not deter projects from establishing the cross-border linkages needed for effective HIV/AIDS prevention among mobile populations. Project directors and managers can create successful linkages on their own while seeking wider support from national and regional governments.**

- **Refugee programs should incorporate HIV prevention activities into reproductive health services as early as possible and should address environmental issues as refugee settlements emerge, such as the placement of latrines and creation of sports fields. They should also consider organizing income-generation activities to give women alternatives to trading in sex.**

# Challenges for the Future

## Building Trust

Inspiring trust in target populations is one of the keys to convincing them to change behaviors. But establishing such relationships takes time and repeated contacts, which are very difficult to achieve with mobile populations. Programs need to use a variety of methods to convey consistent messages to mobile populations at different destinations and to design structural interventions that make the environments mobile populations encounter in their travels less hospitable for high-risk sex.

## Increasing Support

Many international donors and national and regional governments do not seem to have the flexibility to fund projects that cross borders. The interest generated by the growing body of knowledge about HIV/AIDS among mobile populations needs to be converted into greater financial support for cross-border interventions. These interventions could also be integrated into more established cross-border initiatives in other sectors, such as transnational environmental projects.

# 10.2

# Rwandan Refugees Mobilize to Prevent HIV/AIDS

In 1992, a staggering 30 percent or more of Rwanda's urban population was infected with the virus that causes AIDS. When genocidal civil war sent hundreds of thousands of people fleeing the country two years later, HIV inevitably followed them into hastily constructed refugee camps in neighboring Tanzania and Zaire.

With families separated and communities torn apart, the daily hardships confronting refugees living in overcrowded camps often overshadow the threat of HIV. But those same day-to-day struggles put refugees at increased risk of contracting HIV/AIDS and other STDs. Commercial sex is common, alcohol consumption is high, and condoms are rarely available. Women and youth—particularly those separated from their families—are at risk of rape, other forms of violence, and HIV.

The Benaco camp in Tanzania became the site of the first early HIV/AIDS intervention for refugees in August 1994, when AIDSCAP and CARE launched prevention activities that were gradually expanded to three other refugee camps. An assessment conducted for the project by John Snow, Inc., found that more than half the respondents perceived themselves to be at risk of HIV infection.

The project began by training about 100 volunteers as community health educators to teach camp residents about HIV/AIDS prevention, distribute condoms and encourage them to seek treatment for STDs. PSI, which managed condom distribution for the project, also trained special condom promotion teams and peer educators. And CARE trained counselors to conduct health education sessions about HIV/AIDS and STDs for patients awaiting treatment at outpatient clinics run by the African Medical Research and Education Foundation. The remarkable degree of collaboration that occurred among these and other organizations working in the camps was the key to the project's success.

In response to needs identified by the community, the project expanded. For example, a home-based care component was added for those already sick, "Adolescent Health Days" were held to acquaint teens with the health services available to them, and a women's crisis team was created to provide social, legal and medical support to those who experienced sexual violence.

Empowerment—taking control of one's own health—proved a powerful message in an environment riddled with uncertainty. Refugees also responded to messages urging them to seek STD care to ensure future fertility.

Sports events were perhaps the most effective medium for reaching youth with HIV/AIDS prevention messages. Weekly events at the community sports complex drew thousands. During half-time, performers conveyed HIV/AIDS messages through traditional dance and music, and PSI and CARE staff distributed condoms.

The AIDSCAP/CARE project in the Tanzanian camps proved that it is possible to involve refugees in HIV/AIDS prevention, training 2,173 peer educators and reaching more than 700,000 people. A survey conducted after the first year of the project found that the number of people who reported having more than one sex partner had dropped. About 80,000 people had sought counseling and STD treatment as a result of project efforts. But with continuing unrest throughout the world and the growing international threat of the HIV/AIDS epidemic, the pilot project's most valuable legacy may be a greater understanding of how to help refugees prevent HIV transmission. ■

## Reaching Women

Women whose husbands or boyfriends have mobile lifestyles are at significantly greater risk of HIV and other STDs than the average spouse because their partners are more likely to acquire HIV than a husband who returns home every night. Reaching these women is difficult because they do not necessarily live or congregate in one place, and their homes are usually far from the sites of interventions for mobile populations. Empowering them to protect themselves from infection is even more difficult because of cultural expectations that wives submit unquestioningly to their husbands and because of their economic dependence on their male partners. More aggressive efforts are needed to help these women protect themselves without antagonizing their partners. HIV/AIDS prevention programs need to develop more realistic prevention options for these women as well as better ways to reach them.

## Testing Alternative Strategies

Because many border areas lack the infrastructure needed to support traditional prevention efforts, including health facilities for STD treatment and a staff of outreach workers to educate and counsel members of the target audience, there is an urgent need to explore alternative strategies such as prevention marketing and periodic presumptive STD treatment of key groups. Pilot studies are needed to test prevention marketing approaches to HIV/AIDS among mobile populations, using existing commercial outlets to sell subsidized condoms and prepackaged STD therapy and employing the mass media available to target populations to promote healthy sexual behavior.

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