SYNOPSIS

HIV/AIDS PREVENTION AND CONTROL SERIES

Regional Accomplishments and Lessons Learned

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Family Health International (FHI) is a non-governmental organization that works to improve reproductive health around the world, with an emphasis on developing nations. Since 1991, FHI has implemented the AIDS Control and Prevention (AIDSCAP) Project, which is funded by the United States Agency for International Development (USAID). FHI/AIDSCAP has conducted HIV/AIDS prevention programs in more than 40 countries, and the Latin America and Caribbean Regional Office (LACRO) has implemented interventions in 14 countries within the region.

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The HIV/AIDS Prevention and Control SYNOPSIS Series

REGIONAL ACCOMPLISHMENTS AND LESSONS LEARNED

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TABLE OF CONTENTS

Acronyms ii

Acknowledgements iii

Prologue v

Dedication ix

Introduction 1

Behavior Change Communication 5

STI Prevention and Control 23

Condom Programming 35

Policy Development 43

Behavioral Research 51

Evaluation 57

Capacity Building and Sustainability 63

Other Strategies 69
- Gender-Sensitive Initiatives 69
- Civil-Military Collaboration 73
- Religious-Based Initiatives 76

The HIV/AIDS Multidimensional Model: Advocating a Holistic Approach 81

References 88

ACRONYMS

AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
BCC	behavior change communication
CBD	community-based distribution
CBO	community-based organization
CMC	civil-military collaboration
CSW	commercial sex worker
FHI	Family Health International
FTZ	free trade zone
GSI	gender sensitive initiative
GUD	genital ulcer disease
HIV	human immunodeficiency virus
IDU	injecting drug use
JSI	John Snow, Inc.
LAC	Latin America and the Caribbean
LACRO	Latin America and Caribbean Regional Office
MOH	Ministry of Health
MWM	men who have sex with men
NACP	National AIDS Control Program
NGO	non-governmental organization
PAHO	Pan American Health Organization
PSA	public service announcement
PSI	Population Services International
PVO	private voluntary organization
RBI	religious-based initiative
STI	sexually transmitted infection
USAID	United States Agency for International Development
WHO	World Health Organization

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PROLOGUE

The HIV/AIDS Prevention and Control SYNOPSIS Series is a summary of the lessons learned by the Latin America and Caribbean Regional Office (LACRO) of the AIDS Control and Prevention (AIDSCAP) Project. AIDSCAP is implemented by Family Health International (FHI) and funded by the United States Agency for International Development (USAID). The series is a program activity of the LACRO Information Dissemination Initiative and was created with several goals in mind:

- to highlight the lessons learned regarding program design, implementation, management and evaluation based on five years of HIV/AIDS prevention and control experience in LAC countries
- to serve as a brief theoretical and practical reference regarding prevention interventions for HIV/AIDS and other sexually transmitted infections (STIs) for program managers, government officials and community leaders, non-governmental organizations (NGOs), private voluntary organizations (PVOs), policy and decision makers, opinion leaders, and members of the donor community
- to provide expert information and guidance regarding current technical strategies and best practices, including a discussion of other critical issues surrounding HIV/AIDS/STI programming
- to share lessons learned within the region for adaptation or replication in other countries or regions
- to advance new technical strategies that must be taken into consideration in order to design and implement more effective prevention and control interventions
- to advocate a holistic and multidimensional approach to HIV/AIDS prevention and control as the only way to effectively stem the tide and impact of the pandemic

AIDSCAP (1991-1997) was originally designed to apply the lessons learned from previous successful small-scale prevention projects (1987-1991) to develop comprehensive programs to reduce the sexual transmission of HIV, the primary mode of transmission of the virus. AIDSCAP applied three primary strategies — Behavior Change Communication (BCC), STI Prevention and Control, and Condom Programming — along with supporting strategies of Behavioral Research, Policy Development and Evaluation.

The success of this approach, based on the combination of strategies and targeted interventions, has been widely documented. The AIDSCAP Project, in fact, has been recognized as among the best and most powerful international HIV/AIDS prevention programs to date.[1] AIDSCAP has worked with over 500 NGOs, government agencies, community groups and universities in more than 40 countries; trained more than 180,000 people; produced and disseminated some 5.8 million printed materials, videos, dramas, television and radio programs, and advertisements; reached almost 19 million people; and distributed more than 254 million condoms.[2]

However, the pandemic continues to escalate at a rate that outpaces our successes. Thus, we need to build upon these successes, learn from our experiences, and determine what has worked and what is missing in order to respond with added effect in the future. The magnitude and severity of the HIV/AIDS pandemic calls for boldness, flexibility, wisdom and openness. The world cannot afford to continue to fight HIV/AIDS only with current thinking and tools. We must look toward new thinking and strategies that complement and carry the current state-of-the-art approaches forward in the fight against HIV infection.

Therefore, LACRO endorses, promotes and elevates *Gender Sensitive Initiatives* (GSIs), *Civil-Military Collaboration* (CMC), *Religious-Based Initiatives* (RBIs), and *Care & Management* (C&M) as the new prototype of technical strategies that must be incorporated on par with the strategies that have been implemented to date. Walls, barriers and biases have to come down in

order to unlock the strengths, benefits, potential, synergy and/or resources of GSIs, CMC, RBIs and C&M.

More importantly, approaches that compartmentalize strategies can no longer be justified. Despite the efforts to integrate and coordinate amongst and between technical strategies and different sectors of society, prevention programming is barely scratching the surface of what a real comprehensive effort should be. One of the most important lessons learned about HIV/AIDS is that it is not only a medical problem, nor is it exclusively a public health problem. Rather, the pandemic is in addition a socioeconomic problem and, as such, threatens the sustainable development of developing countries and challenges the ethical foundations of the developed world. HIV/AIDS has become a challenge to health, development and humanity.

For lasting success, a genuine multidimensional approach is urgently needed. One that demands new forms of wealth distribution, educational opportunities and development; attempts to resolve the inequalities in gender and power; acknowledges the individual, environmental, structural and superstructural causes of and solutions for the pandemic; and aims to balance the disparity between the "haves" and the "have-nots," resulting in more sustainable, equitable, effective and compassionate efforts.

Therefore, the SYNOPSIS Series reaffirms that current HIV/AIDS prevention and control strategies work, and contends that new technical strategies are needed and can be effective and complementary. The Series also strongly advocates for, and will discuss in a separate issue, the Multidimensional Model (MM) for the prevention and control of the pandemic. This model must guide national, regional and international planning and programming in order to achieve measurable and significant gains that can truly effect changes at the individual, societal, environmental and structural levels.

We trust the reader will be open to our futuristic thinking and will contribute to the further development of the strategies presented here as well as others. We hope the SYNOPSIS Series will

stimulate discussion and reflection, propel continued dialogue, and encourage the pioneering of new combinations of innovative approaches.

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DEDICATION

Teri Ann was 25 when her life fell apart. She was diagnosed with AIDS. Her husband, who had infected her, deserted the family. Her young son was sent to live with relatives in New York. Fearing violence and ostracism in her home community, she moved to Kingston and sought the help of the Jamaican AIDS Support (JAS), a non-profit organization offering prevention services and hospice care for people with AIDS. A beautiful woman, with a model's cheekbones and a dazzling smile, Teri became a gentle crusader, the first to publicly discuss her illness. She wanted to help others, to reach other Jamaicans with her story. With the supportive encouragement of JAS, Teri chronicled her last six months with the hope that her message of prevention and protection could save lives. Her other most fervent wish, which she spoke of passionately on tape, was to see her son one last time. JAS Executive Director, Ian McKnight, recalls the power of this story, "People could relate to Teri Ann. It impacted everyone, especially women. It was a real wake-up call!" Teri Ann died in September 1994 at the age of 28. She never did see her son.

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

Source: "Teri Ann" the video and interview with Ian McKnight, JAS Executive Director

It is for Teri Ann and the millions like her that we have worked these six years. We strove to share their voices, their messages and their struggle, so that fewer in the world would have to live with HIV/AIDS, and so that those who do, will have the compassion of others.

INTRODUCTION

As of September 1997, the Latin America and Caribbean (LAC) region had reported over 200,000 cases of AIDS, 13 percent of the total number of cases reported worldwide. In addition, it is estimated that between 1.6 and 2 million people in the region are infected with HIV. This region encompasses 44 countries and territories with an estimated total population of 470 million people, notable for its tremendous diversity in culture, ethnicity, language, geography, climate, and economic activity.

Between 1991 and 1997, the AIDSCAP LAC Regional Office (LACRO) established priority programs and fully staffed country offices in Brazil, the Dominican Republic, Haiti, Honduras, and Jamaica. AIDSCAP collaborated with other countries as well, on a smaller scale, including Bolivia, Ecuador, Peru, Colombia, Costa Rica, El Salvador, Guatemala, Nicaragua and Mexico. The level of prevention and control conducted in these latter countries was determined by the local USAID Missions, ranging from a single activity to comprehensive national campaigns integrating non-governmental organizations (NGOs), the Ministries of Health (MOH), and the private sector. Over the six-year life of the project, AIDSCAP/LACRO supported 175 projects and over 100 small grants in fourteen countries.

The AIDS epidemic began in Latin America and the Caribbean in the late 1970s and early 1980s, with most infections occurring among homosexually active men. Heterosexual transmission has since increased substantially, principally among bisexually active men, their female partners, female commercial sex workers and their clients. Injecting drug use (IDU) has also come to play a significant role in transmission in the Southern Cone (Argentina, Chile, Paraguay and Uruguay), accounting for 29.3 percent of reported AIDS cases in the subregion and 25.7 percent in Brazil. IDU is an increasing concern in Central American and Caribbean countries as well, principally Honduras, Nicaragua and Jamaica. Nonetheless, sexual transmission is the

predominant mode of transmission in the region, accounting for 81 percent of AIDS cases overall.

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

The region's demographic, economic and commercial characteristics also favor the rapid spread of HIV infection. Migration, both among countries and to and from rural and urban areas, contributes to the spread of HIV/AIDS. International highways, such as the Pan American Highway, and seaports service increasing levels of commercial traffic. Epidemiological evidence signals a rapid shift of new infections to younger age groups, particularly toward individuals between 15 and 24 years old and primarily women. Declining economic conditions, particularly in the Caribbean, have caused many women to become even more dependent upon their male partners. Women's economic vulnerability has resulted in increased multi-partnerism and transactional sex.

During the six years of the AIDSCAP project, achievements in Latin America and the Caribbean have been exciting and encouraging. In the region as a whole, where AIDS was once perceived as a "homosexual" disease and a disease of foreigners, governments are increasingly recognizing the gravity and potentially devastating impact of the epidemic and the importance of taking preventive action to avoid the type of crises faced in other regions. AIDSCAP, through its many local implementing agencies,

has been largely responsible for this shift. AIDSCAP country programs also resulted in an award-winning advertising campaign in the Dominican Republic, a national "Red Ribbon" postage stamp in Brazil, a world-touring theater troupe in Jamaica, promulgation of AIDS/Human Rights laws in Nicaragua and the Dominican Republic, and recognition for continuing work during political upheaval in Haiti. In Honduras, AIDSCAP/LACRO created a significant partnership among the Ministry of Health, the Social Security Institute, the Municipality of San Pedro Sula and the NGO sector, wherein planning and implementation were shared to ensure complementary efforts. This milestone earned presidential recognition of the program.

In addition to its high-profile achievements, there were numerous other successes. The program conducted high-quality mass media campaigns for a wide range of target audiences. It promoted the syndromic management of STIs in the public and private sectors. In collaboration with subcontractors, AIDSCAP country offices in Brazil, Haiti and the Dominican Republic initiated condom social marketing for HIV/AIDS/STI prevention. A goal was set to implement gender-sensitive initiatives in all LAC countries in order to respond to the shift of the pandemic to higher rates of infection among women. AIDSCAP in Latin America effectively worked with the public and private sectors to affect policy changes, presenting socioeconomic and epidemiologic impact analyses, mobilizing commitment and leveraging resources. AIDSCAP designed a rapid program implementation protocol for Honduras that set a precedent for "jump starting" national programs. On a more limited scale, AIDSCAP supported activities focusing on civil-military collaboration and cooperation with religious institutions.

The experience of these six years has taught AIDSCAP/LACRO many valuable lessons related to strategy design and implementation, evaluation, program management and capacity building. One overriding lesson has been that HIV/AIDS prevention cannot take place in a vacuum. The complexities of human politics, economic pressures, gender inequality, cultural context and structural issues are all part of the problem. The solution lies in a holistic approach to the person and society as a whole, incorporating a

combination of strategies, joint efforts on the part of all sectors and institutions, and implementation of a multidimensional model for prevention and care.

This booklet is a synthesis of the accomplishments and lessons drawn from each of the project's strategies and areas of interest in the region. It compiles a summary of the lessons AIDSCAP/LACRO felt would be most useful to future or current program designers, strategic planners and project managers working in HIV/AIDS. These lessons have come from the field as well as the regional level; they have been gleaned at different stages of the project and by programs at various levels of maturity. The accomplishments and lessons learned are organized by technical strategy with the final section presenting a holistic approach for the future — a multi-dimensional model AIDSCAP/LACRO hopes to see guiding future HIV/AIDS programming.

BEHAVIOR CHANGE COMMUNICATION

Context and Accomplishments

AIDSCAP/LAC programs have targeted a diverse array of populations including male and female commercial sex workers (CSWs), men who have sex with men (MWM), hotel workers, sexually transmitted infection (STI) clinic attendees, residents of impoverished and marginalized communities, adolescents, factory and agricultural workers, college students, women, and general population adults. In every population, increased knowledge of HIV/AIDS transmission and prevention methods has been recorded. Additionally, some measure of protective behaviors, increased condom use or decreased number of partners, has been noted.

Knowledge of two or more methods of HIV transmission and prevention in both high and low risk target populations in many of AIDSCAP's priority countries has become nearly universal:

Country	Target Population	Knowledge of two or more HIV/AIDS prevention methods	
		Baseline	Follow-up
Brazil	CSWs	74% (1991)	93% (1996)
	MWM	71% (1993)	91% (1995)
DR	Youth (15-19)	45% (1993)	100% (1996)
	MWM	94% (1992)	100% (1996)
	CSWs	91% (1992)	100% (1996)
Haiti	General Population	71% (1990)	97% (1995)
Jamaica	General Population	91% (1994)	95% (1996)
	Youth (12-14)	70% (1994)	95% (1996)
	MWM	85% (1993)	95% (1996)

BEHAVIOR CHANGE COMMUNICATION

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

In addition to improved knowledge, condom use has increased in every AIDSCAP/LAC country. While condom use has been only moderately accepted among men and women over the age of 30 and in the context of "regular" relationships, 100 percent condom use is becoming a norm among female CSWs and, to a lesser degree, MWM in many settings as the following table illustrates.

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

The high level of condom use in these populations reflects the success of AIDSCAP's peer education efforts and the impact of condom social marketing programs on improving the availability and accessibility of condoms. CSWs and MWM now universally cite accessible low cost condoms available in a myriad of traditional outlets, including pharmacies and supermarkets, as well as non-traditional outlets, such as bars, hotels, kiosks, and beauty salons.

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

Country	Target Population	Condom Use (during last sexual intercourse with a non-regular partner)			
		Baseline (Male/Female)		Follow-up (Male/Female)	
Brazil	Youth (18 - 25)	4% * (1994)		2% * (1995)	
DR	Youth (15 - 19)	24% (1992)	10%	47% (1996)	17%
Haiti	Youth (15 - 19)	—	—	40% (1996)	21%
	General Population	16%** (1990)	6%**	32%** (1995)	12%**
Jamaica	Youth (12 - 14)	16%*** (1994)	21%***	29%*** (1996)	35%***

* Use of condoms with casual partner, last 6 months
** Ever use of condoms
*** Consistent (every time) condom use, last 12 months

The lower levels of behavior change in terms of condom use among general populations may be due to their lower perception of, and real, risk for HIV infection. Another explanation may be that more intensive interventions targeted high risk populations than general populations.

One exception to low general population condom use rates is in Jamaica, where HIV prevention campaigns have benefited from long-running family planning campaigns. Seventy-five percent of men in the general population reported condom use during their previous sexual intercourse with non-regular partners. This high figure was unchanged between 1992 and 1996.

Throughout the region, a high percentage of men in the general population report having changed their behavior to reduce their risk of HIV infection. The most common specific steps taken are having "fewer partners," "avoiding commercial sex" or being more "selective" of sexual partners. The following table details by country the steps men and women have taken. The extent to which these changes have occurred, as well as the protective effect of this incremental behavior modification, is difficult to assess but undoubtedly provides some degree of reduced exposure and risk for HIV infection. A smaller percentage of women generally report "changed behavior," due to their lower rates of high risk behaviors and/or their lack of power or control in critical areas of their lives that keep them from being able to negotiate protective sex with their partners.

Country	General Population	Behavior change to reduce HIV infection risk (1995-6)	
		Change	Specific strategies cited
DR	male	85%	Have one partner (29%) Avoid sex with CSWs (26%) Reduce number of partners (25%) Use condoms (23%)
	female	26%	Have a steady partner (23%) Have one sex partner (11%) Abstain (4%)
Haiti	male	68%	Have one partner/be faithful (48%) Avoid occasional partners (36%) Avoid CSWs (35%) Use condoms (25%)
	female	31%	Have only one partner/be faithful (71%) Use condoms (11%)
Jamaica	male	59%	N/A
	female	47%	N/A

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

The Lessons

Research, Target Populations and Messages

In order for behavior change communication (BCC) to be effective, it must be supported by on-going research related to the HIV/AIDS epidemic. With the findings of this research, BCC strategists and planners may shift the focus of messages to appropriate target groups and tailor the content to address identified gaps, respond to newly updated information or sustain behavior change over time. For example, increasingly affected by HIV/AIDS, youth and women are emerging as new target populations. Additionally, future BCC campaigns should emphasize accurate risk assessment, the linkages between STI and HIV, and persistent misconceptions about modes of HIV transmission. At the same time, programs should not lose sight of the "high-risk" populations who have changed their behaviors. New strategies should include methods to sustain these changes.

There is a need to recognize that many individuals in high risk populations are no longer in fact at "high risk" because of their adoption of risk reduction strategies. Therefore, emphasis should be put on resistant members within these groups who continue to practice "high risk behaviors," including low-income, occasional CSWs; subsets of MWM such as transvestites; migrant workers and others. Additionally, emphasis should be placed on improving the environmental and structural conditions that will sustain behavior change among those in high risk populations who have adopted lower risk behaviors.

The HIV/AIDS pandemic can be understood as a series of overlapping epidemics involving different populations at different times. Intensive efforts aimed at target populations where the epidemic is most rapidly spreading are most cost-effective and efficient over the long term for slowing the overall epidemic. However, these also initially require more costly formative research and labor intensive intervention strategies. At the same time, broad general population campaigns can increase general awareness of HIV, social acceptance of people living with HIV/AIDS, and support for resources for HIV prevention. General

population programs also reach individuals who do not self-identify as members of the target populations, including partners of those being targeted.

Specific Lessons from LACRO Country Programs

- Adolescents represent an increasing percentage of HIV infections in the LAC region. As new "waves" of adolescents become sexually active, educational interventions must be available to address their concerns. These interventions should be designed to ensure collaboration and acceptance across societal, cultural and religious views. Reaching adolescents requires substantial support from a wide range of gatekeepers (parents, school teachers, religious officials, and so forth) and frank recognition that ignoring adolescent sexuality is a deadly proposition.

- BCC interventions with youth need a clear and practical approach. HIV/AIDS prevention programs targeting youth and young adults need tailored approaches that provide honest, direct messages with clear guidance. Although behavior modification is more successful at an earlier age, messages of mutual fidelity and monogamy are often inappropriate and can be confusing to this group. These can conflict with approaches encouraging abstinence and delay of sexual initiation. Gatekeepers, such as parents and teachers, need to be targeted to reinforce the messages youth receive. Youth and young adults can be effectively reached by the mass media.

- High-quality, professional media spots are not only more likely to be accepted by youth, but also are a good investment. Attractive, catchy spots are likely to receive private media support and, thus, be aired more frequently.

- While BCC campaigns effectively increase knowledge of HIV transmission and prevention in the general population, certain messages were more difficult to convey, and certain target audiences were more difficult to reach.

  In the region, most of the adult population could cite two means of HIV prevention. Nonetheless, significant numbers of the population also believed in inaccurate modes of transmission, such as mosquito bites, public toilets, or social contact. Although most youth were able to cite two prevention methods, many were unaware that individuals with HIV may be asymptomatic. These contradictions indicate that individuals acquire new, preventive, information more easily than they reject previously acquired myth, rumor, and bias.

  Certain target populations, which are more geographically, economically, or socially isolated (including youth), require more carefully crafted BCC campaigns with active participation of target population members and collaboration with gatekeepers. These contacts improve the project's potential access, legitimacy and visibility.

- Individual risk prevention strategies adopted by men were closely tied to age cohort. BCC campaigns must recognize these differences and adopt appropriate strategies and messages to each audience.

  AIDSCAP's BCC campaigns in Jamaica influenced different age groups differently. Among the youngest group, 12-14 year old boys, a marked delay in sexual initiation and a reduction in sexual activity were noted. Among boys aged 15-19, fewer casual partners were reported. Among men older than 20, fewer multiple regular partnerships were found. By understanding these different adaptations to risk prevention campaigns, program managers can assess the follow-on messages needed and how to shape them to the appropriate age cohort.

You Get What You Pay For — Mass Media Campaigns

In Latin America and the Caribbean, it is imperative to produce professional quality messages in order to reach audiences who have wider exposure to mass media than in other regions. Polished productions are also more accepted by television and radio stations and are likely to generate donated air time at more highly visible times of the day.

- In the Latin America and Caribbean region, sophisticated, high-quality media are an effective means of reaching the general population, where most people have access to television, radio and a variety of print media. AIDSCAP programs in Haiti, Jamaica, Brazil and the Dominican Republic disseminated behavior change messages by making creative use of their respective mass media channels. In Haiti, the jingle for Panther condoms was heard recited in the streets. The Jamaican program contracted with a local public relations firm and succeeded in raising awareness and putting HIV/AIDS on the country's social agenda. The Brazilian magazine, "Claudia," with a circulation of almost 700,000 copies a month, teamed with AIDSCAP to educate its readership on HIV/AIDS through articles in each monthly issue.

- Working with a Dominican advertising company, AIDSCAP crafted an award-winning ad campaign for adolescents. Not only did these campaigns reach a vast audience, but they created linkages with the private sector which resulted in millions of dollars worth of free air time and print space.

Dominican Republic: Solamente Una Vez (Just Once)

Lyrics from the popular and traditional Mexican ballad, "Solamente Una Vez," were the backdrop of the third installment in a three-part mass media campaign in the Dominican Republic that won international acclaim. This high-quality production of TV and radio spots aimed at Dominican youth was launched in September 1995. Since then, the young actors have become minor celebrities, being approached frequently with questions about HIV/AIDS. "Just Once" is transformed from a heartfelt declaration of love to a warning for youth to protect themselves from HIV infection. "Young people live in their own world," said Mr. Freddy Ginebra, President of the Dominican advertising company, Cumbre, that worked with AIDSCAP on the campaign. "They don't have fear; they take more risks; they're adventurous and rebellious. They don't think death exists, so we looked for a 'code' to challenge them and make them think." In three separate phases, the messages urged adolescents to learn about HIV/AIDS and to protect themselves. It exhorted parents to discuss STIs and HIV/AIDS with their children. This campaign garnered extraordinary support from the media itself, with donated airtime for the advertisements valued at over US $9 million.

Source: AIDScaptions June 1997/W. Black

- A public relations component benefits a public health campaign, particularly in leveraging support from the private sector for their activities.

By incorporating public relations into its BCC strategy from the beginning, the Jamaica program had greater access to and influence on media, corporate and community contacts. Prior to program implementation, news coverage about the epidemic was limited and actually served to reinforce the stigma surrounding HIV/AIDS. Consequently, the local public relations firm, Berl Francis & Co., met with editors of newspapers and program directors of radio stations

to present the findings of a survey that outlined how they reported on HIV/AIDS and the effects of this reporting on the knowledge and attitudes of the public. By humanizing the problem and presenting it as a development issue, the media realized it had a role to play in the prevention and control of HIV/AIDS. Thus, over the course of two years, more than 400 articles appeared in print and over 60 radio and television programs aired on HIV/AIDS topics. Over the same period, the public relations campaign generated cash or in-kind contributions totalling more than US $1 million that benefited program activities and covered the cost of widely broadcast prevention messages.

- Negotiation of free media on HIV/AIDS prevention is feasible and should be encouraged.

  AIDSCAP/Brazil was able to leverage more than US$6.8 million worth of donated print space to publish articles on HIV/AIDS prevention. Although the cost of mass media campaigns can be extremely high, it is feasible to leverage donated air time and space from radio, television, newspapers and magazines. Future programs should consider the negotiation of free time with large communication companies. Furthermore, media are an important vehicle for dissemination of best practices on HIV/AIDS prevention.

Participation and collaboration

It is important to integrate all institutions, both governmental and non-governmental, from the outset in the development, planning and implementation of a behavior change communication strategy. This coordination creates a homogeneous team and a spirit of cooperation and collaboration that assures consistency and enhances the effectiveness of the campaigns. Of equal importance is that participation increases institutional capacity and allows the participants to take ownership of the strategy, both of which improve prospects for sustainability. Working as a team can also eliminate competition and duplication of efforts, thereby increasing cost-effectiveness.

- Participative planning of BCC interventions must constantly reflect and accommodate the changing target population.

  Ensuring target population involvement in project development, a key to program success, is a challenge with mobile target populations and youth. As youth "age into" the target population, mobile target population members move and staff/volunteers turn over, projects must "reinvent" themselves and assure again the active participation of target populations in project design. Likewise, the participation of gatekeepers must be continuously renewed. Another consideration is the need to retarget efforts to segments of target populations which are less responsive to prevention methods. This effort may run counter to the involvement of target population members who have been actively involved in, and shaped, the focus of the project up to that point.

- In addition to the participation of the intended target audiences and community members, BCC messages are best developed by multidisciplinary teams, including professional health educators, media and public relations specialists, evaluators, and psychologists.

  A collaborative approach in the development of BCC messages was utilized successfully in Jamaica. A group consisting of project managers, professional health educators, individuals from the Communications Team of the Ministry of Health's Epidemiology Unit and the public relations and evaluation agencies, and a psychologist worked closely with the communities and target audiences. It met frequently to review and discuss current and new messages for the specific target audiences and the results of pretesting and validation in the communities. This participation resulted in messages that clearly demonstrated an in-depth understanding of the target populations from all aspects — psychological, sociological, economic and cultural. Thus, this coordinated approach resulted in BCC messages that were appropriate for and relevant to the target audiences, technically sound, and culturally sensitive.

- Culturally-sensitive public health campaigns have the greatest effect on target populations. Understanding the culture and society in which one is working is vital to a program's success.

  Jamaica is an oral culture, and understanding this aspect enabled the program to design and implement strategies to fit within this culture. Dancehall disc jockeys, for example, wield tremendous influence on Jamaican society as their lyrics both reflect social attitudes and influence ideas and behaviors. Their influence is islandwide. Although they command attention from middle-class teenagers and young adults, they have the greatest impact in low-income urban areas from which the artists originate. The Jamaican program was able to tap into this cultural aspect and use it to spread BCC messages. Prominent DJs donated their time to record public service announcements encouraging condom use.

- Youth need to be supported in designing and conducting their own behavior change activities.

  In Haiti, AIDSCAP (known as Aba SIDA) supported a number of projects that emphasized youth motivating other youth to reduce their sexual risk. Through this peer-to-peer approach, AIDSCAP learned it is critical that youths' own experiences, concerns, curiosities, and solutions for reducing sexual risk provide the essential content of behavior change materials and activities. The potential for controversy is always present, especially if youth-determined communication materials are of an explicit nature. Projects should, nevertheless, encourage and support youth innovations for STI/AIDS prevention, implying a substantial degree of adult detachment — other than assistance in technical areas and ensuring accuracy of messages — from an essentially youth-driven process. In many settings, youth peer education has shown to be effective for increasing knowledge and influencing attitudes and behaviors regarding STI and AIDS. To maximize benefits of these strategies, young people themselves must be involved in the definition of terms and approaches to peer-to-peer education.

- Several communication strategies using participatory approaches, such as role play, theater presentations, use of mazes or fortunetellers, were implemented in Brazil with significant results. The increased use of participatory approaches in which the individuals and the groups participate actively in the process is highly recommended as a strategy for behavior change communication.

Lessons on BCC Approaches

AIDSCAP has implemented a wide variety of strategies and approaches in the region. The global lesson learned was that effective strategies and approaches are difficult to generalize and extrapolate due to the range of settings in the region. Interventions must be designed to be specific to each country, society, culture and population.

- Peer education, while effective among some groups, was found to be ineffective and impractical among street-based CSWs in Honduras and youth groups in Jamaica.

  Due to the transient nature of street-based CSWs, training them as peer educators was not an efficient use of resources. Turnover was high and monitoring was difficult. Additionally, other CSWs resisted the counseling and education provided by their peers. They were suspicious of the advice given and feared losing customers if they followed it. These CSWs responded better to the interventions by professionals. Similarly, youth groups in Jamaica reported feeling more confident in the messages and education provided by professionals rather than their peers.

- Constraints in conducting BCC campaigns in clinic settings can be overcome through small group and individual counseling approaches.

  Some clinic-based subprojects initially conducted educational and counseling activities in waiting rooms and other group settings. Due to the sensitive nature of the material,

these projects found a much improved dialogue and openness when they began presenting material and giving counseling in a more private setting.

- Workplace educational interventions need management's support in order to be effective.

  Education regarding the economic impact of HIV/AIDS on local businesses may be the catalyst needed to elicit support for HIV prevention projects in the workplace. However, continued support requires close collaboration with management, as well as strong monitoring and evaluation to demonstrate the project's benefits to the company.

- The sharing and exchange of information, ideas, and BCC materials between country offices is a current practice that has proven to be very beneficial to some country programs.

  For example, the AIDSCAP/BCC headquarters office forwarded materials from Tanzania to Haiti. A poster advocating the use of condoms was adapted to fit the Haitian cultural context. In Nicaragua, several NGOs reprinted quality materials produced by fellow organizations. The ad campaign for youth developed in the Dominican Republic was shared with other countries at a regional workshop. The AIDSCAP/FHI STD Handbook, *Control of Sexually Transmitted Diseases: A Handbook for the Design and Management of Programs,* was translated into Spanish and Portuguese for wider distribution and has received an overwhelming response from health professionals. Such cross fertilization practices should not only be encouraged but expanded.

Expansion of BCC

Educational interventions that address individual behavior must be complemented with strategies to change structural and environmental factors which contribute to risky behavior. Knowledge of HIV transmission and prevention, and intent to change behavior, are clearly not enough to protect individuals from HIV infection. BCC is not just about individual change. It should be used to help create a protective environment and a social climate conducive to and supportive of low-risk behavior. Factors that create or encourage greater risk behaviors, including poverty, illiteracy, the inferior status of women, alcohol and drug use, high rates of unemployment, low wages, sex tourism, limited availability and access to condoms, must be addressed in association with increasing knowledge of HIV to ensure the success of HIV prevention efforts.

- BCC must play an advocacy role.

  Information on HIV/AIDS must be presented as a public health issue—not a morality issue. It must confront denial and complacency among political and religious leaders as well as the general public. BCC should be used to counter stigmatization and discrimination. To combat AIDS effectively, societies must function on sound public health principles and not succumb to scapegoating, stigmatizing or discriminating against HIV-infected persons in the vain hope of curtailing the pandemic.

- Anecdotal evidence can be used as progress indicators for BCC.

  Such indicators are able to detect movement in the direction of "influencing individual behaviors and the social context in which they occur." Examples of intermediate indicators might be: increased grassroots participation in campaign activities; increased discussion of HIV/AIDS policy issues in legislative bodies; increased press coverage of ethical and legal issues dealing with HIV/AIDS issues; more religious leaders and/or business leaders speaking out about HIV/AIDS issues; fewer complaints about media openness;

and increase in self-reported ability to recognize STI symptoms in women.

Evaluation of BCC

- Evaluation of BCC materials and approaches enables programs and projects to expand upon successes and improve weaknesses.

  During the AIDSCAP project, a wide variety of BCC materials were produced for different target groups. There is a need to evaluate the quality of these materials. It is as important to register what is not working in behavior change communication for the prevention of HIV/AIDS as what is working. Future programs and projects should not start from zero or repeat mistakes. If existing materials have been evaluated, findings should be used in planning new BCC strategies. If evaluations have not been done, they should be. An annotated compilation of existing high quality materials should be made available to avoid duplication of efforts.

- The international HIV/AIDS community should develop a stronger system for sharing successes and failures among country programs.

  There is a need for large-scale, international donor driven programs to implement ongoing feedback mechanisms that enable the community to share accomplishments, best practises and lessons learned.

STI PREVENTION AND CONTROL

"The results of a clinical trial published in August 1995 provide perhaps the clearest evidence so far that other STIs have a significant impact on HIV transmission. Researchers documented a 42 percent reduction in new HIV infections in communities where improved STI services were provided...There appears to be a synergistic relationship between HIV and STIs. HIV increases the duration of some STIs, and STIs appear to enhance the transmission of HIV infection. Prevention and treatment of STIs are clearly critical strategies for HIV prevention."

Source: AIDSCaptions May 1996, Quote from Gina Dallabetta, Associate Director, STI Unit, AIDSCAP.

Context and Accomplishments

The AIDSCAP programs in Latin America and the Caribbean strove to strengthen and improve the diagnosis and treatment of sexually transmitted infections (STI). Interventions focused on training of health care providers, testing of treatment algorithms, upgrading laboratory diagnostic capabilities, conducting research and working with Ministries of Health to establish national STI guidelines. Programs also aimed to educate target populations on the link between STI and HIV transmission.

The introduction of syndromic management was a major achievement related to this strategy. Using World Health Organization (WHO) guidelines for syndromic management, AIDSCAP focused on field testing and adapting these to local situations. As a result, new national guidelines were established in several LAC priority countries. Subsequently, public and private sector medical professionals in these countries received training in syndromic management. The medical establishment's acceptance of syndromic management over etiologic management has been mixed, but important first steps have been taken.

Haiti

AIDSCAP-supported studies were the foundation for presenting the case for introducing the syndromic management of STIs in Haiti. As a result of the findings of these studies, the NGO, Centre pour le Développment et la Santé (CDS), adopted the syndromic approach to STI management in each of its clinics. Subsequently, a coalition of thirteen NGOs working on HIV/AIDS prevention in Haiti's Central Plateau began a program similar to CDS's. In the absence of a functioning public sector at that time, the NGOs assumed the advocacy role, pushing for the adoption of this approach. A subsequent evaluation of the success of the approach showed that STI case management had improved significantly. It found the percentage of CDS clinicians treating urethral discharge properly had increased from less than 10 percent to 69 percent. In the newer NGO coalition program, 56 percent of the clinicians who were evaluated provided effective treatment for urethral discharge. Clinicians and nurse-counselors in both programs were more effectively promoting condom use. The next step was to standardize this approach to STI diagnosis and treatment.

The three main STI programs achieved consensus on standardized protocols that were adopted by the MOH for national use. These national guidelines were disseminated to service providers in 1996. Since Haiti's health care system collapsed during its turbulent years of military rule, the development of STI national guidelines began with local institutions that later collaborated with the MOH — a novel bottom-to-top approach.

Additionally, AIDSCAP funding to the Haitian Study Group for Kaposi Sarcoma and Opportunistic Infections (GHESKIO) supported the training of some 440 medical professionals in STI management.

Jamaica

From the inception of the project, Jamaica had a strong and visionary public STI control program within the Ministry of Health whose top management agreed with the philosophy of syndromic STI management. The Jamaican STI control program, acting as a leader for STI control issues in the Caribbean basin, independently developed STI treatment guidelines and management tools based on WHO algorithms. These guidelines and STI management booklets were produced with the support of the Pan American Health Organization (PAHO) and distributed to appropriate public sector clinics.

In Jamaica, syndromic management training was provided through the Ministry of Health's Epidemiology Unit and through the Medical Association of Jamaica and the Nurse Practitioner Association of Jamaica. Over 1,700 medical professionals and students received training to strengthen STI services. In addition, the MOH produced and distributed over 2,000 copies of the manual developed on STI case management and counseling.

Brazil

Brazil has one of the most organized public health systems in the Americas, with a network of polyclinics serving its population. An assessment of STI case management revealed the syndromic approach for the diagnosis and treatment of STIs was rarely used by health care workers, despite national endorsement of this protocol. In a cooperative effort between the Ministry of Health, local NGOs and AIDSCAP, the project attempted to integrate STI syndromic management into this health care system. The MOH had previously approved and printed national guidelines for the syndromic management of STI, based on WHO guidelines and algorithms, and these were distributed to all polyclinics and health care workers.

During the life of the project 12 training courses on syndromic management were given to over 1,000 health care workers from 90 health centers. However, some health care practitioners (HCPs) were resistant to accept the syndromic approach. Most

HCPs were trained during medical school and residency to diagnose STIs based on the etiologic approach and considered the syndromic approach inferior. In response to studies indicating pharmacists were selling drugs that were either ineffective or inadequate for the treatment of STIs, 31 private and public sector pharmacists were trained in the syndromic management of STIs.

An evaluation to assess the quality of STI care in Brazil indicated recently trained health care professionals used the syndromic approach in 50 percent of male cases but only in 2.6 percent of female cases. While 90 percent of the male patients reported receiving messages regarding partner treatment, just 34 percent of the female patients reported receiving these messages. Although the use of the syndromic approach increased, the increase was not substantially higher due to several factors. These include the overestimation of the validity of clinical signs for an etiologic approach, the resistance of STD specialists and university professors to the syndromic approach and their continued teaching of the classical etiologic approach, and the influence of pharmaceutical companies on the prescription patterns of the physicians. Therefore, additional and refresher training were recommended, with particular focus on STI management in women.

Dominican Republic

In the Dominican Republic (DR), STI services were improved by upgrading clinic facilities, improving STI drug logistics and developing a STD syndromic management manual for practitioners. In the development of their flowcharts, the DR effectively designed changes in the WHO templates for their country-specific needs. Because of the high prevalence of STIs in the DR, it was thought the syndromic algorithms should emphasize sensitivity over specificity. This was done by emphasizing demographic risk factors, such as young age and single marital status.

AIDSCAP, in collaboration with local institutions, trained 854 health professionals, including physicians, nurses, social workers and health educators. Both clinicians and non-clinicians were required to attend refresher courses six months after the initial

training workshop. Pre and post tests were conducted for all workshop participants. STI treatment manuals and treatment algorithms were distributed to health educators and providers. A study to validate the syndromic treatment algorithm was conducted and a reporting and referral system was developed to incorporate syndromic management into epidemiologic surveillance efforts.

Honduras

Honduras began its efforts to improve STI case management with the introduction of syndromic management in 1995. A close relationship developed between AIDSCAP and the Ministry of Health which allowed the project to respond to the needs of the National STI Control Program. The strategy for syndromic management was implemented in the four health regions reporting the greatest number of STI and AIDS cases. This strategy was initiated with the creation of four Units for Integrated Management of STIs (UMIETS), one in each region. In order to improve service delivery, AIDSCAP supported the remodeling and upgrading of the facilities and provided training to clinic staff. The NGOs supported by AIDSCAP worked to increase utilization of UMIETS by creating a referral system for suspected STI cases to treatment services.

The MOH, with technical assistance from AIDSCAP, prepared the National Manual of STD Syndromic Management. This manual advocates the syndromic approach as a means to improve quality of care and to increase access to treatment. These guidelines were developed by consensus among regional coordinators, a 10-member STD expert committee, and medical staff working in "CESAMO" (health facilities with physicians). Following the dissemination of these guidelines, 306 health professionals from the MOH and 241 from the Honduran Social Security Institute were trained. AIDSCAP, the MOH STD specialists and clinical staff from the four regions also collaborated on developing a manual for STD syndromic management in CSWs, which is in the final stage of revisions.

The Lessons

Future Target Populations - Reaching those who do not seek treatment

- STIs are highly prevalent in the region and can increase the potential for HIV transmission by up to 40 percent.

  STI treatment seeking behavior is poor, with a high percentage of individuals receiving treatment through pharmacies, self-treatment or not treating suspected STIs. Contact tracing and partner referral rates are low. Many medical establishments have resisted implementing syndromic management protocols. Further interventions to improve levels of syndromic management and to reinforce STI counseling are needed, particularly among private sector practitioners.

- A large percentage of symptomatic men continue to seek STI treatment outside of the clinic setting.

  This population is an important target group for future service delivery efforts. Training of pharmacists in STI syndromic management is one approach, but strategies should also be developed to improve male attendance at STI clinics. AIDSCAP/Brazil also recommends the implementation of a pilot study, similar to the "MSTop" project in Cameroon, whereby STI kits for urethritis are distributed to men seeking treatment in pharmacies. These kits contain antibiotics to treat chlamydia and gonorrhea, condoms and partner referral cards. Given that self-treatment is so common, social marketing of STI drugs at pharmacies should be considered.

- Educational campaigns must address the general population's lack of understanding of the term "STI," poor knowledge of STI signs and symptoms, the link between STIs and HIV transmission, and low rates of treatment and partner referral.

  Education on STIs should use terminology familiar to the target populations rather than confusing medical terms.

  While HIV/AIDS communication campaigns have substantially raised the level of knowledge regarding HIV transmission and prevention, knowledge of STI symptoms, transmission, prevention and treatment need to be reinforced. In a 1996 general population survey in Jamaica, nearly half of all men reporting STI symptoms in the past 12 months did not seek appropriate treatment. In a separate study of 304 patients with genital ulcer disease, 125 (41.1 percent) self medicated prior to attending clinics.

  Opportunities abound for more aggressive contact tracing. Two-thirds of the respondents in a 1996 study of STI clinic attendees claimed it would be easy to inform their partner about the infection. Overall, 71 percent said it was either likely or very likely they could convince their partner to come for treatment.

- It is necessary to broaden the scope of HIV/AIDS education to include more consistent and aggressive attention to other STIs.

  In Haiti some of the most significant outcomes of the AIDSCAP project include improved STI care, increased utilization of STI clinical services, and increased partner referral for STIs. These improvements were the result of educational efforts that emphasized the promotion of specific STI clinics, the recognition of STI symptoms, the fact that many STIs are curable, and the detrimental effects of STIs on the health of women and infants. Once in the clinic, patients benefited from intense personalized counseling on reducing risk for STIs and HIV.

The impressive increase in STI service utilization in response to educational strategies stressing STIs is relevant in three respects. In terms of educational interventions, individuals with STIs constitute, by definition, a high risk group for HIV infection. STI clinic attendees represent a logical audience for HIV prevention efforts, both because of the opportunity to provide individual counseling and because STI infection provides a tangible dimension to an otherwise abstract discussion of sexual risk. For this reason, clinic-based counseling and education may have a greater potential to influence high risk behavior than popular or community-based education.

Secondly, there is compelling evidence that decreasing STI prevalence can reduce HIV incidence. Because STI infection facilitates HIV transmission, treating STIs can reduce the risk of transmitting HIV.

Finally, records of clinic utilization can be used to measure the impact of STI/HIV/AIDS prevention programming. Clinic utilization data are important evaluation indicators of the impact of HIV/AIDS prevention programs and, therefore, need to be considered along with reported sexual behavior change. For example, knowledge of HIV/AIDS in Haiti is very high, however that knowledge does not necessarily correlate with behavior change. The experience of AIDSCAP/Haiti suggests that focusing on non-HIV STIs may help bridge the gap between knowledge and behavior for some target audiences.

Sustainability

- The ultimate sustainability of STI prevention activities depends on their integration into reproductive and primary health programs.

  Given the high level of STI prevalence, the frequency of asymptomatic infections and the low level of treatment among symptomatic cases, there is a demonstrated need for improved STI screening in primary health care centers. Without this integration, STI campaigns face a natural limitation to their impact. In Brazil, STI prevention activities have been integrated with those provided by the Program de Assistencia Integral à Saúde da Mulher, Criança e Adolescente (Integrated Health Program for Women, Children and Adolescents). These services were linked because 70 percent of STI clients are women who attend gynecology and pre-natal clinics, and because the most serious health consequences occur among women and newborns.

The Process of Change - Overcoming Resistance

A major lesson learned is that algorithm validation studies and consensus building activities with STI providers at the country level are essential for sustainability of the public health focused, syndromic approach to STI control. These activities require resources and time. In many countries, the major constraints to project implementation are the scarcity of effective STI drugs and the lack of local data to use in convincing STI program managers and service providers of the validity of the recommended algorithms. The latter can be addressed by conducting studies, such as those done in Jamaica and Haiti. These have been effective in convincing local leaders and providers of the effectiveness and validity of the algorithms. The former issue too, is a more complicated one that merits intensive efforts by the donor community and ministries of health.

- Changing health care provider behavior to improve the counseling and case management of STI patients can be as difficult as changing target population's sexual behavior.

  Health care providers often have large case loads and limited resources, and rely on familiar and practiced clinical techniques. The institutionalization of new methods of STI case management requires continued education, supervision, and an understanding of public health prevention theory, in addition to specific training on case management. Physicians are more likely to attend trainings if a system of incentives is established. For example, STI case management training can be incorporated into recertification requirements.

- A comprehensive approach to the improvement of STI case management and surveillance must include the training of private sector STI health care providers.

  In Latin America and the Caribbean, private sector providers treat on average 50 percent of STI patients. These providers often do not report surveillance data according to regulations. In order to improve the surveillance of the HIV/AIDS epidemic and the appropriate treatment of STI patients, private sector providers must be included in STI capacity building efforts.

- The institutionalization of the syndromic management approach to STI treatment requires a long-term commitment, supervision, refresher training and continuous support.

  Institutional support is necessary to overcome health care provider resistance to obtaining additional training in countries where continuing education is not customary. The routine dissemination of current and local data on the trends of STIs is instrumental to maintaining clinician interest in STI programs. High turnover of clinic personnel is another reason why continuous training is necessary to maintain adequate services.

Simple etiologic diagnosis and treatment does not offer much in terms of prevention given the current structure of the public health system in countries such as Brazil. The syndromic approach to STI management is both viable and pragmatic. While the procurement and distribution of STI drugs are costly, the benefit of reducing STI prevalence is significant. In health clinics where the syndromic approach was utilized, it proved to be an effective alternative for STI/HIV prevention.

Nevertheless, in order to ensure the success of project activities, the following points should be considered:

- Medication and condoms should be available in all treatment centers.
- A logistics management system should be established and maintained that allows medications and condoms to be distributed as needed, avoiding the problem of stock depletion.
- Regular supervision of the health centers by trained teams is essential. Continuous direct contact is necessary for supervisors to identify and understand any problems that may occur during the admission, diagnosis, explanation of treatment, and counseling of clients. Early detection and correction of difficulties in the system could prevent repeated infections among clients and their partners. The recognition of system limitations allows supervisors to develop solutions and to follow the program guidelines and procedures.

■ Institutionalization of syndromic management will take time.

For example, the Brazilian medical establishment is still very resistant to the syndromic approach. The wide dissemination of AIDSCAP project results will eventually sensitize the universities to adopt the syndromic approach. To support this effort, USAID should allocate resources to promote the advantages of syndromic management to medical school faculty.

Policy Issues/Barriers

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

  Engaging the commitment and resources of public health officials and STI program managers and providers demands significant technical assistance and consensus building. AIDSCAP's experience in Haiti, where such efforts led to national consensus on STI guidelines and improvements in service delivery, shows that the time and resources necessary to orient and train policy-makers, managers and providers are well worth the investment. An initial assessment is necessary to determine the baseline level of care that is provided. This data can subsequently be used to evaluate improvements in care.

- Biological studies of STI prevalence and antibiotic susceptibility are essential to building consensus on national STI treatment guidelines.

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

- Countries' policies related to STI programs often pose substantial barriers to STI control and prevention.

  Policies, such as charging poor women fees for STI testing, informing brothel owners of the HIV status of CSWs, and denying services to adolescents, are counterproductive to STI/HIV prevention. It is only through concentrated work in the form of symposia, reports, and joint policy analyses with the appropriate local providers and policymakers that

other efforts in training, materials development and treatment algorithms will reap the intended outcome of improved STI prevention and control.

- Ensuring that STI drugs are available at the primary health center level demands political commitment from the top, a strong logistics management system and an educated staff at the clinic level.

- The social marketing of pre-packaged STI kits, similar to those piloted in Cameroon, should be considered for the LAC region.

Monitoring and Evaluation

While significant advances in surveillance, data collection, and STI diagnosis and treatment have been made during the life of this project, further improvements can be made in these areas and in the quality of STI care and the partner referral system. The lack of complete, accurate and reliable STI surveillance data is a major problem in the region. Although considerable resources will be necessary to establish a comprehensive information system to properly monitor STI in the region, this information is essential for future HIV/AIDS/STI prevention programs.

CONDOM PROGRAMMING

Context and Accomplishments

In 1992, lack of access to condoms was common in much of Latin America and the Caribbean. AIDSCAP and its subcontractors either initiated or strengthened condom social marketing (CSM) programs in Brazil, Haiti and the Dominican Republic in order to address this constraint. These interventions sometimes had dramatic results, not only in sales of the socially marketed product but also on other commercial condom sales and government policy. In Brazil and the Dominican Republic, AIDSCAP provided technical assistance to strengthen the logistics management systems, thereby improving condom availability in those countries. AIDSCAP also supported a short-term acceptability study of of the female condom in Brazil.

Brazil

The CSM program in Brazil was implemented by DKT do Brasil, an affiliate of Population Services International (PSI). Prior to its inception, Brazil had one of the lowest condom use rates in the world. In 1991, condom sales reached approximately 45 million pieces, yet the "market maturity" level was estimated to be 250-350 million. By the end of 1996, sales had more than tripled. During the four-year life span of the CSM program, more than 71 million Prudence condoms (the socially marketed brand) were sold. Of these, 45.8 million condoms were sold in AIDSCAP's geographic target areas of the states of São Paulo and Rio de Janeiro, with particular emphasis on the cities of Santos, São Paulo and Rio de Janeiro. Prudence is now the third largest brand in the Brazilian market, and research indicates that where Prudence is present, it outsells even the market leader.

A DKT position paper prepared in collaboration with AIDSCAP/Brazil is credited for the decision by Brazil's president in 1995 to decree a year-long "tax holiday" on the 60 percent duty charged on imported condoms. Although this holiday has since expired, the tax was reinstated at only 10 percent.

Through the AIDSCAP Women's Initiative, an exploratory study was conducted in Brazil to examine the perceptions, responses, and sustained use of the female condom when introduced into the partner relationship as a method of HIV/AIDS prevention and contraception. Results from the interviews, focus group discussions and peer-support group discussions indicate that overall, women were positive about the female condom. Approximately 75 percent liked the female condom very much, and nearly half preferred it to the male condom. Of the male partners who participated in the study, approximately 77 percent liked it. DKT do Brasil has since initiated plans to market the female condom in Brazil.

In the area of improving condom logistics management capabilities, AIDSCAP and John Snow Inc. (JSI) provided technical assistance in Brazil. This assistance focused on the public sectors in São Paulo and Rio de Janeiro and strengthened the logistics management system.

Haiti

Drawing from and building on PSI's experience in condom social marketing for AIDS prevention in Africa, the Haiti CSM project teamed with a Haitian pharmaceutical distributor (DOBACO) and NGO partners to institute an innovative and dynamic condom distribution mechanism that made affordable condoms easily available to rural and urban Haitians throughout the country. Numerous high-visibility promotional and educational campaigns using TV, radio, billboards, print media, and a variety of special events created virtual brand recognition of the Pantè condom. More importantly, however, these promotional efforts served the critical functions of providing basic information and education on STIs and HIV/AIDS to Haiti's general population, stimulating individuals to reflect on their personal risk of infection and "normalizing" public discussion of sexual risk and condom use. The CSM project, thus, assumed a key role in the Haiti program as a whole.

“Pa Pran Gòl” (Don’t Take a Hit)

Although a military coup in 1991 sent Haitian President Jean-Bertrand Aristide into exile and subsequent embargoes virtually shut down foreign aid for several years, AIDSCAP projects doggedly continued their fight against HIV/AIDS. The Pantè condom jingle, “Pa pran gòl” (Don’t take a hit) could be heard everywhere, and a news program sponsored by Pantè kept the public informed about political developments. Yet this high profile was not without its problems. Dr. Eddy Génécé, former AIDSCAP resident advisor, recalled an evening meeting with commercial sex workers, “ The police broke in and insisted the meeting was political and subversive and that we had to disperse.” In spite of harassment and fuel shortages, the project maintained a strong network among those working with the HIV/AIDS program. In fact these adversities enhanced their resolve and cooperation. Dr. Génécé recounted, “We shared information—when one group found fuel for sale or discovered a district or town was blockaded, we let each other know. We learned to make each gallon go a long way by shipping several months’ worth of condoms at one time.” Another group turned long gas lines into an opportunity. Ms. Gessy Aubry, director of the NGO Groupe de Lutte Anti-SIDA (GLAS) was only one example. “We took creative advantage of those hours spent in gasoline lines to talk to drivers about AIDS prevention. We developed a portable presentation that could be delivered as we walked up and down the line, and even began to sell condoms to other customers.”

Sources: AIDScaptions November 1996 & June 1997/MDadian and Washington Post article by Tod Robberson, November 6, 1994.

Over 14.6 million condoms were sold during the project period. In eight of Haiti's nine districts, PSI established partnerships with local NGOs to serve as condom "stockists," who, in turn, sold Pantè condoms to various "wholesalers" (including their community-based workers) and retailers in their districts. As a result, NGO condom sales outside of Port-au-Prince now account for one-third of all PSI/DOBACO sales. A total of 765 condom outlets were created. These outlets represent highly diverse points-of-sale, many of which are in non-traditional settings, such as boutiques, pubs, hotels, table-top vendors and others. Consumer research has indicated these non-conventional retail outlets are often preferred by condom consumers.

Dominican Republic

The AIDSCAP/Dominican Republic program took important steps to increase the availability of condoms for HIV/STI prevention in the country. A condom retail audit conducted by AIDSCAP and JSI in 1994 found the non-availability of low-cost condoms nationwide. Thus, the new condom brand "Pantera" was developed for the USAID-donated Panther condom. Market research was conducted to test consumer preference for condom packaging and to identify market opportunities. Subsequently, partnerships were negotiated involving NGOs working in HIV/AIDS prevention and a multinational pharmaceutical company, SmithKline Beecham. This partnership with the private sector was a unique and first time endeavor to ensure access to good quality, low-priced condoms on a national scale. AIDSCAP/JSI was instrumental in fostering these agreements and provided the technical support to initiate the venture. The support obtained from the private sector significantly contributed to AIDSCAP's strategy for private sector leveraging.

Through SmithKline Beecham, the Pantera condom was sold to colmados (convenience stores), supermarkets, and drug stores nationwide. Through the NGOs, the Pantera condom was sold in hotels, motels and bars in the geographical areas where their HIV/AIDS prevention programs were being implemented. Within a year, SmithKline moved Pantera into the number three spot in

the country in terms of sales, and into first place in terms of breadth of distribution. By July 1997, an additional 200 retail outlets were selling condoms compared to October 1994. Technical assistance and training in marketing and sales were also provided, and a promotional plan and advertising materials for the Pantera condom were produced and delivered through the NGOs. Furthermore, AIDSCAP/Dominican Republic also used its media leveraging power to air public service announcements (PSAs) in support of condom distribution through colmados.

Results of the relatively short social marketing effort were impressive. Two major advertising campaigns were financed by the income from sales, and the distributor invested significantly in the brand. A total of over 4.6 million condoms were sold.

The Lessons

Introducing Condom Social Marketing

- Overcoming religious and social barriers to condom distribution and sales in LAC has been a challenge. Use of aggressive marketing techniques, mass media and celebrity endorsements emphasizing the benefits of condom use, have been an effective solution. Additionally, these approaches have gone a long way towards destigmatizing the condom.

- Social marketing programs have, on the whole, been successful in the region. However, there are a number of issues that must be considered when initiating programs of this type:

    - The move from obtaining free condoms to purchasing condoms requires a paradigm shift for implementing agencies, government officials and, most importantly, the general population that may not be easily achieved.
    - Using existing distribution channels for social marketing of condoms is desirable. However, the willingness of private sector companies to be associated with a controversial product should be explored in depth prior to investing time in negotiating agreements.
    - Good logistics management and inventory controls are

necessary to preclude "leakage" of donated condoms meant for free distribution into the black market where they are then sold.

- In the absence of adequate public sector distribution of condoms, as was the case in Haiti, condom social marketing can fill this void and meet the needs of the population.

- Condom social marketing has proven to be an efficient, cost-effective, sustainable program that increases the availability of condoms to target groups as well as the general population. In Brazil, condom social marketing has proven to be one of the most important activities in HIV/AIDS prevention.

Redefining the target population

- Targeting these persistent non-users requires more than increasing knowledge or risk perception, but a focus on the structural and economic barriers faced by this group.

- Despite widespread condom use with non-regular partners, condom use in stable relationships is uncommon. Condom use is often perceived to indicate a lack of trust in one's partner. Moving beyond this perception towards the use of condoms as a way of protecting yourself and your partner is an essential message needed for future interventions.

- With the number of HIV/AIDS cases increasing among women in the general population, strategies that specifically target them need to be implemented. Future linkages with women's health and family planning institutions should be strengthened. The addition of the female condom as an option for women should be investigated.

Logistics

- Strengthening public sector logistics systems is extremely complex with few incentives for those involved to ensure success. A significant commitment in terms of resources must be made if progress is expected.

  Condom availability to meet demand remains an issue. For example, in Brazil, in the last five years the availability of condoms for free distribution by the public sector was unstable, insufficient and problematic. A functioning logistics system was not in place. In light of this situation, the 15 million condoms donated by USAID to the AIDSCAP projects were crucial for the success of the programs particularly when we consider the high risk, low income strata of AIDSCAP target groups. Despite all the difficulties related to condom donations to Brazil, USAID needs to consider buffer donations in the future especially in the northeast.

POLICY DEVELOPMENT

> "Experience has shown that active government involvement is crucial if AIDS is to be overcome."
>
> *Confronting AIDS: Public Priorities in a Global Epidemic*, World Bank, 1997.

Another result of AIDSCAP/LACRO programs has been an improved political and social environment in relation to HIV/AIDS. Government recognition of the costs of the HIV/AIDS epidemic and their commitment to providing resources to fund programs has increased in part due to the socio-economic impact studies sponsored by AIDSCAP/LACRO. As mentioned earlier, demonstration, or model, interventions with documented impact, have been scaled up and supported by government resources. Important policy changes have improved the efficiency of HIV prevention projects, and have improved the human rights environment of individuals at risk for, or already infected by, HIV.

The countries of Latin American and the Caribbean were in the unique position of being able to intervene before HIV became an epidemic as widespread as that in other regions. While seroprevalence had become epidemic in some urban areas, rates it remained relatively low throughout much of the region. As a result, HIV prevention was not receiving sufficient attention from either policymakers or the private sector in the early 1990s.

In order to provide policymakers with concrete information about the potential impact of an HIV epidemic in the region, AIDSCAP conducted policy assessments in Brazil and Jamaica and socio-economic impact studies in the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua and Peru. With funding from the Colombian Ministry of Health and SIDALAC/Mexico and technical support from AIDSCAP, Colombia and Costa Rica conducted similar studies. The Ministry of Health in each of the aforementioned countries assembled a team of epidemiologists and economists who used mathematical models to simulate the

trajectory of the epidemic from 1995 to 2005, using both high and low estimates, and to estimate the epidemic's economic impact. Each country projected the incidence of HIV/AIDS would rise sharply between 1995 and 2005.

These impact analyses raised awareness of HIV/AIDS as a multi-sectorial development issue, rather than as merely a health issue. As a result of the impact assessment in Honduras, USAID decided to make Honduras a priority country for prevention and control efforts under the AIDSCAP project and secured commitment from the Government of Honduras. In addition, a video based on the assessment was produced in Honduras and was used successfully to initiate workplace prevention programs in the private sector. The study in El Salvador led not only to attitude changes, increased risk awareness and less discrimination against people with HIV/AIDS, but also to increased funding for HIV prevention programs and to the creation of new STI clinics in the workplace. In both the Dominican Republic and Nicaragua, information from these studies contributed to the promulgation of new AIDS laws.

AIDSCAP also performed HIV/AIDS impact assessments in the Dominican Republic on the country's free trade zones (FTZ) and the tourism industry. As a result of the study of FTZs, there was increased acceptance of expanded workplace interventions. In the case of the tourism study, the industry agreed to put condoms in all hotels and motels throughout the country.

In addition to AIDS legislation in the Dominican Republic and Nicaragua, examples of the improved policy environment in the region include the lowering of duties on condom imports in Brazil from 60 percent to 10 percent; national STI guidelines adopted in Honduras and Haiti; and technical input into a national HIV/AIDS five-year plan (1995) in Haiti.

Many countries in the LAC region have also seen broad changes in social norms as well. For example, the Catholic Church in Haiti has reached out to HIV prevention organizations and taken an active role in providing care and support for people living with HIV/AIDS. Whereas five years ago Haitians who died of AIDS

were not allowed burial in Catholic cemeteries, today they are.

While these three broad results validate AIDSCAP/LACRO's approach, and attest to its persistent efforts, much remains to be accomplished. Many of these results represent only the initial steps towards completely sustainable organizations, fully protective behaviors, effective policies and supportive social, economic and political settings.

The Lessons

The Value of Data

The disclosure of HIV and AIDS statistics and future estimates has been instrumental in moving HIV/AIDS into public consciousness and debate. Media attention to the data played a role in the Dominican Republic in stimulating greater public and policy activism for prevention. The rising number of deaths from AIDS in Latin America and the Caribbean has moved the epidemic from an abstraction to a reality and forced policymakers to deal with the complex legal, social, cultural and economic implications for families, communities and the countries as a whole.

- Both quantitative and qualitative data are needed in developing and presenting socio-economic impact assessments to provide the required combination of specificity and humanity to appeal to most audiences. However, presentations can be dramatic and informative even when data are limited.

- It is important that projections not exaggerate the potential impact or costs of the epidemic as this can lead to a backlash against policy change and interventions. Since the data are projections, it is important that assessment findings include a range of possibilities and scenarios for the future.

- Incorporating both quantitative and qualitative data into presentations fosters a more comprehensive understanding of the impact of the epidemic and supports the definition of HIV/AIDS not solely as a health issue, but as a threat to devel-

opment.

> Framing the epidemic as a critical development issue is an important strategy for broadening the audience interested in the study, thereby promoting a more multi-sectoral approach to HIV/AIDS policy development and increasing potential collaborative opportunities within policy development and program design.

- A strategy to reach and inform policymakers should include timely, targeted and sustained dissemination of the socio-economic impact findings, including to the press.

> Strategic dissemination of the socio-economic impact findings is crucial to create pressure on and gain the attention of decision makers, policymakers and influential actors in policy advocacy. Considering multiple and creative routes to gain access to decision makers is critical because policymakers' interest in HIV/AIDS is often limited. HIV/AIDS policy development interventions are often based on the assumption that access to policymakers is direct and simple, and that decision makers are interested in becoming informed about the impacts of the epidemic. HIV/AIDS, however, presents policy issues that decision makers are often not motivated to take on. For one, the epidemic raises politically sensitive issues related to sexuality and gender relations. Secondly, the disease is not primarily affecting politically powerful communities. Finally, the impact of HIV/AIDS often lacks the immediacy needed to raise concerns among politicians or political appointees.

In the Dominican Republic, work in the area of policy was pri-

marily based on the data generated by the sentinel surveillance system with PROCETS. The lessons learned in this program related to both the process and dissemination of information.

1. Careful planning of resources and timing is needed to ensure effective collection of data and avoid shortages of materials, losing key personnel.
2. Findings generated by sentinel surveillance should be written up in language that not only technical program managers can understand but also so that national policymakers and the general population can understand.
3. Polished, brief, high quality presentations at upper levels of government are essential for getting support for programs, as these officials are pressed for time.

Changing Policy Takes Time

Ms. Freida Behets, research instructor at the University of North Carolina and AIDSCAP subcontractor, summarized the policy experience in Haiti, which is characteristic of the experience throughout the region:

> "The experience leading to the adoption of national STI guidelines in Haiti offers a number of policy lessons. First, it is not unusual for policy agreement and adoption to take many months or even years. In Haiti, the consensus-building process took three years. A strategy for achieving a desired policy goal is essential. In Haiti, the STI strategy included working with strong local partners, conducting local studies, presenting and disseminating study results to key audiences, training and consensus building. Haitian program specialists played a central role in moving the proposed policy agenda. The existence and persistence of a core group of committed individuals helped convince skeptics of the importance of the new approach to STI treatment. Most national health guidelines are developed by the Ministry of Health. Because of the political situation, development of Haiti's STI guidelines began with local institutions, who later collaborated with the Ministry of Health, a

novel bottom-to-top approach. The essential groundwork has been laid, and the government and NGOs can now work together to build a national STI control program." (Source: AIDSCaptions May 1996.)

- Collaboration broadens the constituency for policy change and adds to the skill mix for developing policies.

In Guatemala, Nicaragua and El Salvador, socio-economic impact studies were used to encourage the participation in HIV/AIDS policy development by a broad range of sectors and public and private institutions, including national legislatures, Ministries of Health, international donor organizations, parastatals, indigenous NGOs and multi-sectoral HIV/AIDS coordinating committees. These collaborative relationships accessed skills, experience and connections that enhanced policy development efforts.

Dynamic and sustained advocacy for policy development are a product of a strategy that can change when needed and remain creative and stimulating. Also, because the process of policy development is ongoing and long-term, policy interventions are strengthened by adopting a long-term approach that allows time for adaptation and follow-up.

- Policy is a specialized area which needs its own resources.

In a large country like Brazil, national policy actions can have a major impact on HIV/AIDS prevention not only locally but nationally. For example, AIDSCAP played a major role in the exemption of condoms from state taxes. Staff worked collecting signatures on a petition and mobilizing politicians, opinion leaders and NGOs. However it is important to realize that major actions similar to this require specialized staffing and adequate resources. In the future special resources should be committed to develop this component if planned under USAID strategy.

The policy development process benefits from flexibility,

- resourcefulness and ongoing support.

Ingredients for Success

The experience of AIDSCAP has been that AIDS policy reform is most likely when:

1. specific goals are defined
2. scientific analysis is available to ground policy decisions
3. issues are articulated in terms of concerns of target audiences
4. follow-up to presentations is made on an individual level and;
5. technical experts are allowed to participate in the formulation of policy decisions.

Putting together a process for policy development includes:

1. a clear agenda, not diluted by a proliferation of goals or sub-goals
2. committed workers/activists
. reliable and persuasive information, which can be adapted to different audiences
3. identified leadership, with authority to make decisions
4. organizational collaboration
5. ability and willingness to advocate for policy action
6. monitoring of policy development process and of eventual implementation.

Additionally, our experience with socioeconomic impact assessments has shown that:

1. A multisectoral approach is more relevant to addressing specific policy issues than the traditional direct/indirect costs approach.
2. It is important to examine how development is affecting the spread of the epidemic rather than just how the epidemic is affecting development. The development of international

highways, free trade zones etc. which result in easier travel and the movement of workers away from their homes, are factors likely to contribute to the spread of HIV/AIDS.

BEHAVIORAL RESEARCH

Context and Accomplishments

Behavior change interventions are key components of HIV/AIDS prevention programs - seeking for example increased condom use or a reduction in numbers of partners or appropriate STI treatment seeking behavior. The development of these interventions starts with an understanding of the determinants of behavior in particular populations and design strategies based on theories of behavior and behavior change.

If prevention efforts cannot rely on simply providing information on HIV/AIDS to effect behavior change, then interventions must be developed to influence the other factors which can. In order to design such interventions we need to understand the factors which strongly influence a person's decision to perform, or not perform, a given behavior.

Sexual transmission of HIV accounts for 80 percent of the estimated 1.6 million HIV infections in the Latin America and Caribbean (LAC) region.[6] Modifying sexual risk-taking behaviors is, therefore, an essential component of HIV/AIDS prevention efforts. But how does behavior change occur? What are the patterns and determinants of risky sexual behavior? How can programs most effectively encourage and sustain behavior change in a given population? To answer these questions, AIDSCAP implemented a behavioral research strategy.

As part of its strategy and commitment to building research capacity, AIDSCAP trained over 50 researchers in the LAC region to conduct behavioral research for designing and evaluating behavioral interventions related to HIV/AIDS. Scientists were trained in quantitative and qualitative research design, data management, analysis and interpretation, as well as the behavioral and psychosocial aspects of the HIV/AIDS epidemic.

AIDSCAP also sponsored the participation of a number of local scientists in the Center for AIDS Prevention Sciences (CAPS) scholars program at the University of California in San Francisco. The program's main emphasis was helping scientists design HIV/AIDS prevention research projects to be conducted in their own countries.

In addition to building the capacity of local researchers in behavioral research, AIDSCAP strengthened the networks between research organizations and implementing agencies in numerous countries. In organizations without the staff or resources to have a research component, AIDSCAP developed the capacity of program managers in the interpretation of research results and the application of results to program design. These approaches gave local researchers a stake in ensuring that their findings were used to improve prevention programs.

AIDSCAP particularly emphasized the following in its research efforts:

- expanding the basic knowledge of sexual risk behaviors (formative research)
- identifying the determinants of sexual risk behaviors (formative research)
- examining the acceptability, effectiveness, and sustainability of interventions (evaluative research)

These objectives provide a minimum of information needed to start programs with defined target populations and to evaluate their effectiveness. These objectives can be measured through relatively rapid research techniques, including knowledge, attitude, behavior and practice (KABP) surveys, focus group discussions (FGD), and key informant interviews (KII).

Specific examples of research conducted in the LAC region include the following:

1) Research to increase basic knowledge of risk behaviors, such as: "Protecting Paradise, Tourism and AIDS in the Dominican

Republic," and "Knowledge, Attitude, Behavior and Practices among Jamaican STI Clinic Attendees."

2) Research to identify determinants of risk behaviors, i.e., "AIDS Risk-Taking Behavior during Carnival in São Paulo, Brazil," and "Measuring Sexual Risk Behaviors of Jamaican Homosexual and Bisexual Men."

3) Research to identify means of modifying risk behaviors, such as: "An AIDS Risk Reduction Program for Young Adults in Nights Schools in São Paulo, Brazil," and

4) Research to examine acceptability, effectiveness and sustainability of interventions, i.e., "100 Percent Condom Use: A Structural/Environmental Intervention," and "The Female Condom as a Woman-Controlled Protective Measure."

The Lessons

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

  Answering many of the most important research questions requires perspectives from such disparate fields as STI management and prevention, social marketing, medicine, counseling, psychology, epidemiology, communications and family planning. In Jamaica, research from all these areas was used to design and improve program activities.

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

  Partnerships offer NGOs a sustainable source of technical assistance and help strengthen local research capacity. For example, in Jamaica, the research firm HOPE Enterprises worked with local NGOs to conduct KAPB surveys of commercial sex workers, adolescents and people in the work site, focus group discussions with adults with multiple part-

ners and people who were positive and key informant interviews with positive individuals.

- 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 group; or 4)adapted from successful interventions from other regions or target populations.

  For example, results from a nine-month 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.

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

  Such research is particularly useful for designing programs and policies to remove or overcome structural and environmental barriers to behavior change. For example, 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. Research into community participation would be instructive. Specifically, we would like to know: What is the role of the community in behavior change, we know that individuals can and do change their behavior when education, counseling, etc. are provided. However, when a person is encouraged to change by their immediate community, the results are much more impressive. How do we get communities to become involved in promoting behavior change, and what are the pros and cons of doing this? Also, there is growing interest in understanding the process by which a community affects the individual behavior, who talks to whom? Are certain people more effective at influencing others? How can you get a community group to begin

addressing HIV/AIDS prevention? How do you keep them interested in the issue once the outsiders leave?

- Directly linking research to program interventions is a critical component of effective interventions.

A disjunction often exists between behavioral research on prevention and prevention programs themselves. Researchers may assume that findings from research leading to understanding risk behavior will automatically be used to design and test new interventions. For example, in Brazil, findings from behavioral research examining the sexual risk-taking of a group of port workers were used to design and test an intervention. This intervention resulted in significant behavior change.

EVALUATION

Context and Accomplishments

Evaluating HIV/AIDS prevention programs is a challenging task which aims to monitor overall trends in the HIV epidemic while identifying effective interventions which interrupt its relentless pace. FHI/AIDSCAP has played a leading role in evaluation of HIV prevention programs. From the beginning, evaluation issues were strategically incorporated at the design and ongoing phases of the AIDSCAP project. FHI/AIDSCAP mandated a mixed methodological approach to data collection, including the use of qualitative and quantitative data, in all of its country programs. In the Latin America/Caribbean Region, nearly 100 quantitative and qualitative studies were conducted with a wide range of target populations including: men who have sex with men, commercial sex workers, youth, factory workers, STI patients, prisoners, antenatal clinic attenders, farm workers, etc. to examine the basic characteristics of risk behaviors among target populations, and to evaluate changes in knowledge, behavior and practice as a result of interventions.

FHI developed a framework for comprehensive program evaluation (outlined in Table 1) which included research throughout the program life cycle, from project design to monitoring, outcome and impact assessment, and the analysis of cost-effectiveness and sustainability.

Comprehensive Evaluation Framework

Intervention-Linked Formative Evaluation Research (Concept & Design)	Project Monitoring (Input & Output)	Outcome & Impact Assessment (Including Modeling)	Policy & Cost-Effectiveness Analysis (Including Sustainability Issues)
Basic Questions:			
Is the intervention needed?	To what extent are planned activities actually realized?	What outcomes are observed?	Do program priorities have to be changed or expanded?
Is there a better way to do it?		What do the outcomes mean?	To what extent would resources have to be re-allocated?
How should the intervention be implemented?		Does the program make a difference?	

AIDSCAP used multiple complementary evaluation approaches and multiple methodologies (qualitative and quantitative) to address different evaluation needs:

a) Formative evaluation was conducted during the planning stage of the program to identify and resolve intervention and evaluation issues. This type of evaluation provides the information necessary to define realistic goals and objectives for project interventions, and to guide tentative decisions about effective and feasible intervention strategies and how to implement them.

Formative evaluation can also be used as an exploratory tool during project implementation to provide feedback to project managers that helps them adjust program objectives to the changing epidemic.

b) Process evaluation occured throughout the life of the project to track program implementation. It addresses basic questions such as "To what extent are planned interventions activities actually realized?" and "What services are provided, to whom, when, how often, for how long and in what context?" Process evaluation can also help document program achievements for donors. For example, AIDSCAP's process indicator form (PIF) system, for process indicator monitoring and reporting, uses the output level indicators and activities, as summarized in each subagreement Log Frame, as a reporting form to track the targeted outputs of each subproject.

c) Assessment of outcome and impact: Outcome and impact evaluations were used to answer the questions "What outcomes are observed?", "What do the outcomes mean?" and "Does the program make a difference?"

Taking into account the various implementation stages of AIDS prevention programs, it is advisable to stratify effectiveness evaluation by short-term and/or intermediate program effects (program outcome) and long-term program effects (program impact). Examples of program outcome and impact indicators for these different stages are illustrated in Table 2. Accurate knowledge about HIV risks, the reduction of risk behaviors, and adoption of protective behaviors are considered to be the most appropriate proximate (short-term or intermediate) outcome indicators for interventions designed to reduce sexual transmission of HIV. Long term effects include impact on HIV/AIDS trends, sustainablility issues and improved societal response.

Potential Program Outcome/Impact Indicators

Program Outcome (Short Term and Intermediate Effects)	Program Impact (Long Term Effects)
Changes in HIV/STI-Related Knowledge	Sustained Changes in HIV/STI-related Risk Behaviors
Changes in HIV/STI-Related Attitudes	Changes in HIV/AIDS Trends
Changes in HIV/STI-Related Risk Behaviors	Improved Capacity of Community
Changes in STI Trends (e.g. gonorrhea)	Reduced Individual and Societal Vulnerability to HIV/AIDS
Increase in Social Support/ Community Response	Sustained Changes in Societal Norms
Changes in Societal Norms	

d) Evaluating organizational and institutional development: The measurement of capacity building efforts can be divided into the analysis of the increased capacity of organizations (and their staff) and of institutions. Measuring the increase in local capacity to sustain HIV/AIDS prevention efforts is an important complement to the evaluation of behavioral outcomes.

e) Cost-effectiveness analysis: After more experience is gained with formative, process and outcome evaluation and a body of findings has been accumulated from such evaluations, it may be useful to launch another stage of evaluation research. Cost-effectiveness analysis also measures program effectiveness, but it expands the analysis by adding a measure of program cost. Cost analyses and cost-effectiveness estimates can provide critical data for public health decision making and program design.

f) Policy assessment and socio-economic impact analysis: Policy assessments provide information on priority issues of various groups, on decision-making processes and structures, and on groups able to be advocates for policy development. Socio-economic impact analysis examines the current and projected impact of HIV/AIDS on sectors, national economy, or individual businesses.

The Lessons

- An important tension exists between the rapid collection of relevant evaluation data by an outside, technically trained research group, and the slower development of behavioral and evaluation research capacity within implementing agencies.

  AIDSCAP has taken different approaches according to the local circumstance - hiring a research firm in Haiti and Jamaica vs. hiring evaluation officers responsible for building capacity among implementing agencies in Honduras, Brazil and the Dominican Republic. Regardless of the choice it is important that the data be useful - both relevant and good quality - and that the demands of the research not overwhelm the resources of the implementing agencies. Rigorous research designs should not be undertaken for every project. Project delivering a standard set of services do not need more than formative and process evaluation, while pilot or demonstration projects may require more detailed designs.

- Cross-sectional studies are still vital in sentinel and population-based surveys but more emphasis should be placed on younger age groups and finer age stratification to identify risk reduction strategies adopted.

  Coordinated, repeated, behavioral surveys of multiple target populations - such as those conducted in Jamaica - provide an essential overview of trends in the epidemic and can establish the long-term effectiveness of intervention efforts, and identify emerging risk groups or behaviors.

- The process of triangulating evaluation results (such as biologic data with quantitative and qualitative outcome and process data) in annual "evaluation reviews" with program managers and evaluation researchers can lead not only to improved, and more insightful findings, but also to an improved understanding and appreciation for the process of evaluation and the means of applying evaluation results.

- A comprehensive evaluation framework should include the measurement of project "coverage" rates, such as the percentage of target audience recognizing BCC campaign slogans or materials; the percentage of target audiences contacted by a peer educator or accessing outreach facilities; etc.

  These types of surveys can be conducted with a minimum of questions, minimal training of interviewers, and limited analysis, to insure low cost and rapid completion. Target population's access to condoms can also be measured to assess condom promotion/social marketing projects. Results from coverage surveys improve the triangulation of evaluation results and allow for the attributibility of program efforts, but do not replicate the trends uncovered by the behavioral studies.

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

CAPACITY BUILDING AND SUSTAINABILITY

Context and Accomplishments

AIDSCAP has been strongly committed to capacity building as a critical component to the success and sustainability of HIV/AIDS prevention projects. While the overall goal of the project has been to reduce the rate of sexually transmitted HIV infection, an underlying purpose was defined "to expand the capacity of host country institutions to design, manage, evaluate, and sustain HIV/AIDS prevention programs."

AIDSCAP developed seven strategies of capacity building (table 1) which emphasized three levels of interventions: at the level of individuals, emphasis was on human resource development through technical and management skill building. For organizations, the focus was on organizational development, including systems and structure strengthening, leadership and governance, resource diversification and network building. For institutions, organizational cross-fertilization and multi-sectoral collaboration were targeted (table 2).

Capacity Building Strategies

Capacity Building Strategy	Definition
Technical skill building	The improvement in the skills necessary to carry out specific technical aspects of programs or initiatives.
Management skill building	The improvement in the skills necessary to effectively manage programs and efficiently utilize organizational resources.
Management systems development	The improvement of internal systems, operational procedures, or tools that facilitate more effective management.
Resource diversification	The diversification of sources of financial and physical resources.
Network building	The improvement of organizational ties to constituents, peers, and policymakers to increase support for project activities.
Organization cross-fertilization	The improvement in the exchange of information and experience between program managers involved in HIV/AIDS programs.
Multi-sectoral collaboration	The expansion of program activities and ties to other public and private sectors not actively engaged in addressing the HIV/AIDS epidemic.

Relationship of capacity building strategy to outputs, outcomes, and impacts

Focus	Individual	Organization	Institution
Strategy	Technical Skill Building Management Skill Building	Organizational/ Systems Development Resource Diversification Network Building	Organizational cross-fertilization Multi-sectoral Collaboration
Outputs	Individuals trained	Management systems established	Multi-sectoral meetings/ conferences held
Outcome	Improved technical and management skills	Improved effectiveness of financial, human resource, monitoring and evaluation systems; multiple funding sources; improved stakeholder involvement; policy engagement.	Improved formal and informal coalitions; exchange of lessons learned and dissemination of information.
Impact	Improved technical and management effectiveness	Technical, management, financial, and political sustainability	Sustainability of benefits (impact sustainability)

Although differentiated into three levels, there is an important synergy among and between each level in the achievement of the objectives. The development of national guidelines for syndromic management in Haiti provides an example that demonstrates this synergy and the resultant sustainability at the institutional level. AIDSCAP conducted two formative research studies in Haiti related to health seeking behaviors and STI seroprevalence which found an extremely high level of STIs and low level of knowledge of treatment options. Using this information to catalyze response, AIDSCAP brought together representatives from a range of organizations to discuss the possible appropriateness of a syndromic managemnt approach to STI treatment based upon the development of a simple, locally derived, algorith of treatment alternatives. Collaboration on a case management approach led to the development of a training manual which was used in training STI care providers. As familiarity with the system of case managemnt increased, consensus was built around the effectiveness of this approach, which was subsequently endorsed for adoption by the Ministry of Health. This process of building capacity in the provision of STI services demonstrates how increasing individual capacity, organizational capacity, and ultimatley institutional capacity creates an entrenched sustianability of program benefits which is not dependent upon individual or organizational sustainability, but is built on the strengthened interrelated levels.

Overall, AIDSCAP/LACRO provided support and training to local organizations, including NGOs, universities, and Ministries of Health, through more than 180 subprojects resulting in strengthened technical and management skills, management systems, physical resources and interorganizational networks. Consequently, HIV prevention program managers and staff reported a greater understanding and sophistication in the use of both technical skills (in peer education, BCC materials development, evaluation methodologies, condom logistics and social marketing, STI clinic upgrading) and management tools (strategic planning, financial management, monitoring, reporting). By encouraging the establishment of organizational cross-fertilization and multisectoral collaboration, AIDSCAP was able to improve information

dissemination and exchange of experiences. The program created informal and formal coalitions which were able to exercise political leverage and generate increased resources.

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

AIDSCAP/LAC country offices have led the effort to ensure the organizational sustainability of implementing agencies, and have also insured their own sustainability by becoming independent NGOs with diversified funding sources:

- The Fundación Fomento en Salud in Honduras competed for and won a local USAID/Honduras contract to continue interventions started under AIDSCAP.
- The Associação Saúde da Familia(ASF)/Brazil is involved in ongoing HIV interventions funded by a range of international donors and foundations, and is coordinating a high profile HIV/AIDS fundraising campaign targeting the Brazilian general population.
- In the Dominican Republic, Fundación Genesis has secured local private sector support for a mass media education campaign.

- In Haiti, Prometeurs Objectif Zerosida (POZ), is working to organize an active coalition of local NGOs.

The Lessons

- Capacity building of local individuals, organizations, and institutions in design, management and evaluation is essential to the long term sustainability and success of HIV prevention efforts.
- Capacity building requires a long term commitment and significant resources from donors, and requires the consensus of all collaborators to the overall objectives and the process of measuring those objectives.
- When coalitions of organizations are engaged in strategic planning and capacity building together, the strengthened ties and networks which result ensure that regardless of the sustainability of specific organizations, the sustainability of the network will continue.

OTHER STRATEGIES

Gender-Sensitive Initiatives

Context

In many developing countries, women's vulnerability to HIV/AIDS will continue without fundamental changes in their social, economic and legal status. Empowerment of women through legal reform, education and greater access to employment and credit requires political commitment, human and financial resources, and true collaboration among health and development agencies and organizations. Conversely, while men in these countries traditionally occupy "power" roles, they should not be treated as "add-ons" or "buy-ins" in the efforts to institutionalize changes in sexual behaviors. Men are often willing partners and advocates, yet few studies pertaining to STI/HIV/AIDS prevention have explored the dynamics of sexual communication and control between couples. Men should be addressed not only as sexual beings but in their roles as fathers, husbands, workers and community members.

HIV/AIDS interventions hold the most promise by focusing on improving understanding and communication between the sexes. Integrating gender-sensitive initiatives (GSIs) into every other strategy is crucial in the translation of information into action. Throughout Latin America and the Caribbean the heterosexual transmission of HIV/AIDS is growing, placing both sexually active women, their partners and their children at risk.

LA/C gender training was conducted only recently, and the full impact of the training on programs is not yet known. AIDSCAP established its Women's Initiative (AWI) in 1994. Using AWI guidelines, project staff reviewed all their activities in the region to determine ways to reach a broad range of women while addressing the needs of both women and men. To strengthen the capacity of HIV/AIDS programs in LAC to address the gender issues that make both women and men vulnerable to infection, AIDSCAP LA/C resident advisors and their colleagues met in 1995, 1996 and

1997 and developed strategies to encompass training in gender analysis, research and pilot intervention projects.

Ongoing conferences exploring the impact of GSIs into prevention strategies. This has resulted in networking among top-level managers, and the formation of alliances. Partnerships between HIV/AIDS organizations in Brazil and Bolivia, between Honduras and Nicaragua, and between the Dominican Republic with Brazil, Honduras and Peru ensure that AIDSCAP's GSI incorporation in prevention strategies will continue to influence efforts throughout the LAC region.

Gender-sensitive dialogue was used to get families and youth talking about STIs/HIV/AIDS in a constructive manner in the Centre de Promotin des Femme Ouvrieres (CPFO) program in Port-au-Prince, Haiti.. Between 1994 and 1996, CPFO organized five educational sessions that included women factory workers, their partners and their teenage children. The sessions instructed them about high-risk activities using dialogue to discuss STI prevention. Through the use of dialogue, an open atmosphere was created without any of the adversarial tension typical in such encounters.

One of the most significant of the AWI projects was the intervention research concerned with the adoption of the female condom in two countries, Brazil and Kenya. This exploratory study examined the perceptions, responses, and sustained use of the condom in sexual relationships as a method of contraception and STI/HIV/AIDs prevention. The intervention component of the study consisted of sessions called "peer support-group discussions" where women shared experiences related to the use and impact of the condom on the partner relationship. The peer-support sessions appeared to have had an important influence on women's acceptance of the device and its continued use, and many women reported feeling, for the first time in sexual relationships, "empowered."

The Lessons

Every person who receives information to combat the spread of HIV/AIDS and STIs is either a man or a woman. Coupling GSIs with other strategies is a logical way of making each intervention relevant to each recipient. The most crucial perspective GSIs can incorporate in HIV/AIDS interventions is that beyond targeting men or women, GSIs are most successful when they focus on improving understanding and communication between couples.

Based on experiences in Latin America and the Caribbean as well as in developing countries throughout the world, AIDSCAP has learned the following lessons it would like to share with organizations that intend to institutionalize GSIs as a fundamental tactic in HIV/AIDS prevention programs. Five specific strategies, easily integrated with other initiatives, have been identified:

- Top Level Management — Empowerment of women should be a goal explicitly pursued through the distribution of senior positions available in organizations implementing HIV/AIDS programs.

  Top-level managers are key players who influence staffing, budgets and structuring of programs. They can ensure the monitoring of all activities for their gender sensitivity in design and implementation. They are in the best position to continually examine efforts and to expand programs to include new populations touched by the epidemic.

- Dialogue — HIV/AIDS interventions should not target women as one group and men as another; rather they should focus on improving understanding and communication between them.

  In fact, focusing on separate genders or ignoring the bridges needing to be built between them weakens overall policies, programs and strategies for HIV/AIDS prevention.

- Research — Increased resources for research and development of women-initiated methods, especially microbicides, need to be made available.

  Additional operations research should be conducted to explore the use of dialogue as a gender sensitive strategy for improving sexual communication and promoting HIV risk reduction.

- Gender Advocacy — HIV/AIDS organizations should collaborate with womenÕs groups, particularly those that address other health and development issues, to empower women and promote a more integrated approach to prevention.

  HIV/AIDS organizations should also continue to promote a better understanding among these groups of the threat that HIV poses to health and development efforts and of the need to work together for womenÕs empowerment and gender equity.

- Evaluation — HIV/AIDS efforts should be continually examined and expanded to include new populations at risk.

  GSIs should be integrated into all central headquarters and field actions, not as an option at the discretion of field staff, but a measure of staff performance.

- The incorporation of GSIs into strategies for taking action against STI/HIV/AIDS promises an intriguing and effective perspective.

  Unless a program can communicate on a level which supports behavioral changes, it has little chance of success. GSIs provide an in-road to motivating behavior change by analyzing and accepting the realities of sexual roles. Working from this point of view, individuals can be encouraged to find effective ways to introduce safe practices into their sexual relationships.

Civil-Military Collaboration

Context

Civil-Military Collaboration (CMC) is an important strategy central to the fight against HIV/AIDS for two main reasons: the military is one of the groups most affected by the pandemic in virtually all parts of the world; and military personnel typically become infected by civilians, and similarly the military infect civilians. As its HIV/AIDS problem is not purely military, the military cannot solve it internally nor single-handedly. It is not solely a public health problem, but also a political, economic and security threat requiring a coordinated, multi-sectoral response. Therefore, civil-military collaboration becomes an essential technical strategy in HIV/AIDS prevention. Furthermore, CMC can be advantageous in testing, counseling, care, research, training of personnel, condom social marketing, outreach to families and community relations as well as in providing educational materials and programs for prevention.

The military is defined at its core as the uniformed personnel of the army, navy and air force but is often expanded to include the coast guard, the military's civilian personnel, military families and child soldiers. Two large peripheral groups, the national police and seafarers, have military characteristics and are sometimes included in discussions of the military. In Peru, for example, the national police are included in an integrated HIV/AIDS/STI planning system for its armed services. Seafarers are also a closely related occupation with parallel lifestyles, including high pay, extensive travel, long periods away from home, shipping functions on behalf of the military, and sometimes naval reserve officer status.

Current CMC efforts to combat HIV/AIDS are taking place in a variety of ways. In Peru, COPRECOS (Commission for the Prevention and Control of HIV/AIDS in the Armed Forces) operates within the overarching cross-sectoral framework of PROCETSS (Program for the Control of STIs and AIDS), the national planning and administrative system for the campaign against HIV/AIDS. Brazil is in the early stages of implementing a variety

of activities. A "Protocol of Intentions" frames cooperation between each of the three military services and the Ministry of Health, and a Permanent Interministerial Council has been established to address health problems. Bolivia's Sentinel of Health system is based on the principle that "one can apply to the defense of life the concepts used in defense of the country…the health of the families can be improved if all soldiers, upon returning to their community, teach all that they have learned." AIDSCAP support for civil military collaboration to date has been small. With AIDSCAP funding, the Civil-Military Alliance conducted two workshops during the 1995 international gatherings on STIs and HIV/AIDS, as well as preparation of a regional policy and strategy paper for the alliance's meeting in Honduras in 1997.

The Lessons

- Civil-military collaboration has been slow to develop due to the military's initial internal focusing on its own HIV/AIDS problem as well as the military's exclusion from national planning efforts.

  As the pandemic affects all of society, a coordinated and multi-sectoral response is required, one which includes the military sector. The function of the military is to protect, and it is this social service of protection that must also include the health of the individual and the collective health of the country's population. The civilian and military populations possess human, physical and economic resources which are synergistic and complementary.

- In terms of civilian and military partnerships, it is increasingly being recognized that common agendas and mutual benefits exist amongst and within different governmental and non-governmental institutions, including regional and international organizations.

  CMC builds on both the functional complementarities and commonalities among the sectors and makes more effective use of resources. The military typically has a presence in all geographic areas of a country, thereby having the potential to reach millions of individuals. The military also possesses convening power, the ability to focus the attention of the government on a particular subject and elevate it to the national policy level. Regional approaches are effective as they enable cross-national sharing of programs, initiatives, and policies, which can lead to mutual assistance across countries and regional utilization of expertise. Cultural affinity and common languages facilitate regional approaches.

- International support, as well as a brokering and/or coordinating body, is essential to bring together the international organizations, donors, experts and the civilian and military sectors.

  To be successful, program development: (a) must be sensitive to the various cultural contexts, affinities and differences at every level inside and outside national boundaries; (b) needs more attention and time to provide innovative HIV/AIDS prevention and control models; and (c) should be based on, but not limited to, current needs in policy knowledge, training of trainers assistance, and international exchange of preventive and cost-effective efforts.

- Expansion of CMC is an essential strategy for the prevention of HIV/AIDS.

  Future programs should include: (a) information dissemination regarding current efforts and lessons learned; (b) advancement of the brokering role to bring interested par-

ties together; (c) expansion of the focus on the military to include peacekeeping troops, police, prison guards, and maritime personnel; (d) utilization of key personnel of more mature programs to assist those programs under development; (e) policy dialogue to establish an environment conducive to civilian and military cooperation; (f) planning and implementation of joint endeavors with potential for expansion and replication; and (g) monitoring and evaluation of interventions in order to strengthen, diversify and expand CMC programming.

Religious-Based Initiatives (RBIs)

Context

The social context of HIV/AIDS in Latin America and the Caribbean is complicated by gender, policy, political and economic issues. Cultural, biological, religious and economic factors strongly impact the vulnerability of women to HIV/AIDS within the region. Open discussion towards just and rational policy-making around HIV/AIDS has been difficult. Scarce resources for prevention and care have been the rule rather than the exception. As more members of the Church are living with HIV/AIDS, the Church is increasingly being challenged and motivated to develop prevention and care strategies and to include these individuals in the life of their congregations. Rather than condemning others, the Church is studying how HIV/AIDS can be a "chance to express the grace of God."

RBIs are pivotal to the success of prevention and care efforts in Latin America as well as globally. Churches are found in nearly all communities in the region and wield a significant level of cultural, political, social, educational and economic influence. The Church can be viewed as the largest, most stable and most extensively dispersed non-governmental organization in any country. Churches are respected within communities and most have existing resources, structures and systems upon which to build. They possess the human, physical, technical and financial resources needed

to support and implement small and large-scale initiatives. They can undertake these actions in a very cost-effective manner, due to their ability to leverage volunteer and other resources with minimal effort. Unfortunately, the resources, capabilities and potential of the Church are considerably neglected or untapped, and it has not been considered part of the solution and/or a driving force in the fight against HIV/AIDS. Religious leaders and institutions have a powerful voice in society, encourage greater focus on belief and value change efforts, promote policymaking that includes the whole "family unit," and foster and provide access to care for those affected by HIV/AIDS. On the other hand, the Church is challenged by HIV/AIDS. In order to maximize the Church's potential contribution, both the Church and those organizations partnering with it must overcome two main challenges — the need for institutional and structural change within the Church and the need for "limited domain collaboration" concerning prevention and control strategies adopted by RBIs.

Current church-based interventions taking place in Latin America are generally not well known. However, they are having a profound impact on HIV/AIDS programming within the region and serve as the basis for RBIs strategy strengthening, diversification and expansion. A sample of the different types of models and efforts presently underway in Latin America can be categorized as follows: a) *local capacity building* through NGO programs in Chile, Venezuela and Ecuador; b) *participatory approaches* through church congregation or parish programs in Argentina, Colombia, Ecuador and Honduras; c) *collaborative actions* through network-based programs in Ecuador, Panama, Guatemala and the Dominican Republic; d) *care and management* through hospital-based programs in Ecuador, Honduras and Brazil; and e) *coalition building* through international programs, such as the work of MAP International in Latin America and Africa, and WHO/PAHO in Central America.

Foremost among the achievements of RBIs has been the Church's ability to encourage voluntarism and to leverage resources in the fight against HIV/AIDS. Many Christian NGOs, churches and parishes as well as Christian networks and/or Christian hospitals

have stepped forward to combat the pandemic and to give hope to those who are affected by it. Church pastors, priests and congregations are increasingly changing their attitudes towards people living with HIV/AIDS. Local congregations have participated in marches, all-night vigils, health campaigns and World AIDS Day celebrations. The Church is filling a gap that exists for people living with HIV/AIDS —that of responding to their spiritual needs and questions about suffering and death. In the absence of the most advanced treatments in the developing world, AIDS remains a death sentence and, thus, the greater need for emotional and spiritual support. Local churches may be the only place where people receive understanding, compassion and answers to their complex questions and situations. HIV/AIDS has led Catholic, Evangelical and Episcopal churches to work together and commit to concrete interdenominational actions. Collaboration between health professionals and people from the religious sector advocates for a holistic approach to address the variety of needs of people living with HIV/AIDS, primarily the integration of spiritual and emotional health needs with the bio-medical ones. Regional efforts coordinated by international agencies or development organizations allow for the exchange of experiences and lessons learned.

The Lessons

- A certain degree of mutual distrust remains between the Church and many multi-lateral, governmental and non-governmental organizations in Latin America, despite their many shared goals in the struggle against HIV/AIDS.

  RBIs can have a powerful impact on public policy and need to be mobilized as an important part of any HIV/AIDS effort. RBIs in the region have shown the effectiveness of using different communication strategies to reach different population segments. Training materials that respect denominational and church context differences and that focus on topics of sexuality, counseling and pastoral support are proving effective in fighting HIV/AIDS. Positive changes in attitudes and perspectives have occurred in churches and

other affiliated groups working on health issues in the region, but conceptual barriers to collaboration in HIV/AIDS work still exist. RBIs already working in HIV/AIDS can play a key educational role in facilitating further growth and openness within these Churches and institutions.

- Difficult ethical issues raised by certain strategies, such as the promotion of condom use, can be resolved sufficiently to allow collaboration and compromise, if addressed openly and with mutual respect.

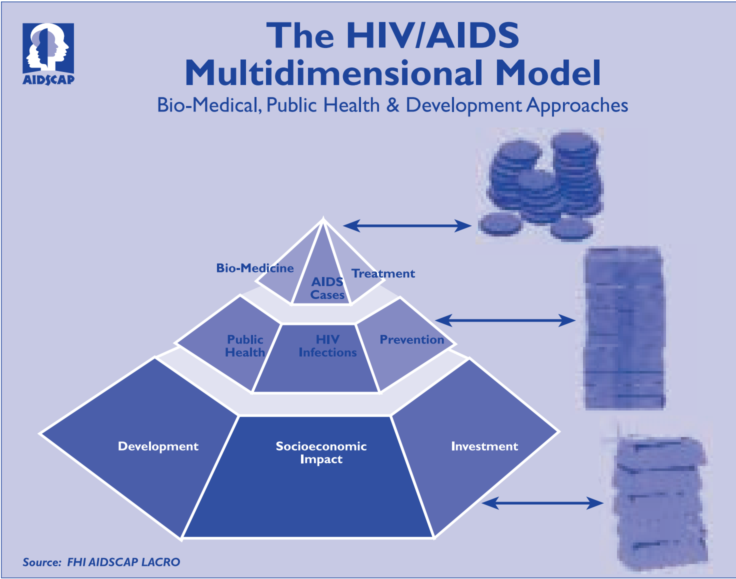
  Agreeing to limit the range of cooperation to the issue at hand and to set aside other areas of disagreement can perhaps defuse some of the tensions inherent in collaboration among diverse groups and foster cooperation. Genuine debate and action concerning how the Church in Latin America can best show solidarity with those living with HIV/AIDS and their families is sorely needed. The strengths and achievements of RBIs to date — interdenominational action, high rate of voluntarism, changes in church and health personnel towards a more holistic attitude and so forth — can be the building blocks for future coordination between the Church and multi-lateral, governmental and other non-governmental efforts in Latin America. In brief, the fundamental point regarding HIV/AIDS is that the response of Christian communities to the pandemic should above all be based on compassion and a commitment to serve others.

- The Church and multi-lateral, governmental and non-governmental organizations have a great deal to offer each other by partnering in the struggle against HIV/AIDS through religious-based initiatives.

  The Church can gain new tools, perspectives and partners with which to pursue its responsibility towards the community, and multi-lateral and other non-religious efforts can gain an effective ally in the Church — an institution with vast reach, resources and potential for impacting prevention

and care in the region. Recommendations for future HIV/AIDS prevention and care programming and partnering include: a) an open dialogue and compromise to replace any lingering mistrust and separation between religious-based and non-religious international, national and local efforts; b) the participation of RBIs in the development of HIV/AIDS related legislation and policies, particularly as they focus on justice and dignity; c) greater resources allocated for the production and distribution of educational and training materials specifically designed for use by Churches; d) development of partnerships between religious and secular institutions based on mutual respect, flexibility, and the commitment to cooperate towards limited, mutually-agreeable goals; e) pursuit of enhanced coordination and networking within the Church and across lines of denomination; and f) increased allocation of resources and support to those RBIs committed to the compassionate care of individuals living with HIV/AIDS and their families.

ADVOCATING A HOLISITIC APPROACH: A MULTI-DIMENSIONAL MODEL FOR HIV/AIDS PREVENTION



The HIV/AIDS pandemic has become a permanent challenge to health, development and humanity. With 30.6 million adults and children currently living with HIV/AIDS, it is estimated that one in every hundred sexually active adults worldwide is infected with HIV. If current rates of transmission continue, more than 40 million people will be living with HIV by the year 2000. In spite of advances in the areas of prevention and treatment, the virus continues to spread at a rate estimated at 16,000 new infections a day. No country is beyond the reach of HIV/AIDS. The pandemic has moved beyond predominantly affecting "high-risk groups" associated with HIV/AIDS at the outset, to the general population, particularly women and those living in poverty and otherwise marginalized. The spread of the virus is fueled by poverty, precarious health conditions, illiteracy, the inferior status of women, as well as other

sociocultural, structural and environmental factors. Today, more than 90 per cent of all HIV infections are found in the developing world. Consequently, a successful HIV/AIDS prevention effort must be multidisciplinary and multisectoral in order to confront the pandemic for what it is, a complex socioeconomic development problem. Such a strategy is depicted in the Multidimensional Model for the prevention and control of HIV/AIDS.

The Multidimensional Model

The MM is conceptualized as a strategy that when viewed horizontally, it consists in three HIV/AIDS prevention and control approaches: *Medical Approach, Public Health Approach* and *Development Approach.* Each of these approaches has three dimensions. When viewed vertically, the MM consists of a set of foundational disciplines or sciences that support and guide interventions, a set of the impacts at the individual and collective levels caused by the pandemic, and a set of key interventions crucial to resolve the problem.

The top portion of the MM illustrates the **Medical Approach** and includes the foundational discipline, which is Bio-Medical Science, the impact, in this case the number of AIDS cases, and the key intervention which is the Treatment of AIDS cases. The middle portion of the MM represents the **Public Health Approach,** with its foundational discipline being Public Health, its impact shown as the number of HIV infections, and its key intervention of Prevention. The base of the MM reflects the **Development Approach,** which illustrates its underlying approach as Development, the effect exerted by HIV/AIDS as Socioeconomic Impact, and its key intervention as Investment.

What makes the MM multidimensional is not only the three horizontal approaches and nine vertical dimensions of the model, but also the fact that each approach and each individual dimension is intertwined with the others. Separately, each approach is and can only be partially effective. It is as a whole, that these approaches are truly effective and hold the only chance for humankind to control the HIV/AIDS pandemic.

Levels of Causation of Disease

HIV/AIDS is a complex problem, with many *levels of causation*, from individual high risk behaviors to social and economic high risk situations. The four levels of causation in HIV incidence are individual, environmental, structural and superstructural. *Superstructural factors* include macrosocial and macropolitical arrangements, physical and resource characteristics, and other elements such as economic underdevelopment, sexism, racism which often evolve over the long term. Mechanisms for change at this level include social movements, revolution, land distribution and war. *Structural factors* include laws, policies and standard operating procedures. Mechanisms for change at the structural level include constitutional and legal reform, civil and human rights activism, legislative lobbying and voting. *Environmental factors* include living conditions, resources, social pressures and opportunities, examples of which include forced relocation/migration in pursuit of employment, and urbanization. Processes for change at the environmental level range from community organization and legal action to the provision of services. The *individual level factors* relate to how the environment is experienced and acted upon by individuals and may include, amongst others, isolation, boredom, and low perception of risk. Change at the individual level is most often achieved through education, counseling, reward and punishment, and the provision of information.

The Lessons

Successful Multidimensional Approaches

Successful and sustained public health interventions of the past have relied on changes at the individual as well as the structural and environmental levels. Examples of public health interventions which have moved beyond the individual to the structural and environmental levels include, but are not limited to the following: lowering cigarette consumption, seat-belt usage, fluoridating water, enriching foods with micronutrients, increasing educational opportunities for women which results in lower fertility rates, syphilis screening on all hospital admissions, and motorcycle helmet laws.

Given the epidemiology and demographic patterns of HIV, it is difficult to measure the success on HIV prevention programs in the short-term. However, several initiatives illustrate that it is possible to reduce incidence of HIV when interventions reduce individual high risk and environmental and structural high risk situations. In Uganda, initial indications are that HIV prevalence is declining as a result of concerted efforts by the government, NACP, NGOs, religious organizations, communities and individuals to stop the spread of the HIV virus. In Mwanza, Tanzania, there has been a 42 per cent reduction in new HIV infections as a result of a comprehensive STI case management program based on the syndromic approach. In Belle Glade, Florida, a sexuality education program in schools succeeded in reducing the number of sexual relations and partners reported by adolescents, and in increasing condom use. The 100 percent condom program pioneered in Thailand appears to have reduced the level of unprotected sex and the incidence of STIs and HIV. Unfortunately, HIV/AIDS prevention programs which have operated on these various and complementary levels are rare. However, results to date indicate that these reinforcing strategies achieve results beyond those attainable through purely individualistic approaches to risk reduction. Clearly, future HIV/AIDS prevention efforts need to be multidimensional and address individual risk factors as well as structural, environmental and superstructural high risk situations which facilitate HIV transmission.

Recommendations:

Lessons learned from the past decade of HIV/AIDS prevention efforts must guide future interventions in order to obtain optimal results, particularly in an era of declining donor support and constrained government budgets. HIV/AIDS must be integrated into broad-based development efforts which will not only reduce HIV but ameliorate the precarious conditions which put the majority of the world's inhabitants at risk to this and innumerable developmental ills. To maximize development efforts, funding must be targeted at long term investments in education, infrastructure, health and production. Governments and international agencies need to move away from a focus on short-term results in HIV/AIDS prevention and control which are impossible to attain

when confronting superstructural conditions such as global imbalances of wealth, power and resources. Clearly the most comprehensive way to address the pandemic is through a recognition of the four levels of causation, from superstructural to individual. Although many sets of interventions could be generalized, the design of interventions according to the four causation levels must be country-specific and culturally appropriate. The Multidimensional Model is proposed by AIDSCAP/LACRO as a strategy to guide such thinking and programming, and to carry the current state-of-the-art approaches forward in the fight against HIV infection.

REFERENCES

The references utilized for this SYNOPSIS include:

- Behavioral Research SYNOPSIS
- Capacity Building SYNOPSIS
- Civil-Military Collaboration SYNOPSIS
- Gender-Sensitive Initiatives SYNOPSIS
- Religious-Based Initiatives SYNOPSIS
- STD Syndromic Management SYNOPSIS
- The Multidimensional Model SYNOPSIS
- Country program final reports
- Subproject final reports
- Regional Office final report
- Regional Office quarterly, semi-annual and annual reports
- Files, notes and contributions from current staff

Functional Organizational Chart
Latin America & Caribbean Regional Office, FHI/AIDSCAP

Priority Country Programs
Honduras
Haiti
Jamaica
Brazil
Dominican Republic

Associate Country Projects
Mexico
Guatemala
Nicaragua
El Salvador
Costa Rica
Colombia
Ecuador
Peru
Bolivia

Public and Private Implementing Agencies

Target Populations