

IMPACT

a decade of global leadership and innovation



FINAL REPORT ON
**Implementing AIDS Prevention
and Care Project, 1997–2007**

In July 2011, FHI became FHI 360.



FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

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Cover photo: Adherence support worker and client in Ethiopia (Jim Daniels)

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In developing-country settings all over the globe, IMPACT has extended lives, prevented disease, allowed infants to enter the world free of illness, cared for orphans, helped adolescents make life-saving choices, and enabled others to die with dignity. By strengthening the capacity of local governments and institutions, IMPACT has ensured that developing countries will benefit from USAID's work for years to come.



Where IMPACT Worked

Albania
 Angola
 Bahrain
 Bangladesh
 Benin
 Bolivia
 Botswana
 Brazil
 Burundi
 Cambodia
 Caribbean Regional
 Program (St Kitts
 & Nevis, St Lucia,
 St Vincent and
 the Grenadines,
 Guyana, the Ba-
 hamas, Suriname,
 and Trinidad and
 Tobago)
 China
 Côte d'Ivoire
 Democratic Republic
 of Congo
 Djibouti
 Dominican Republic
 East Timor
 Egypt
 El Salvador
 Eritrea
 Estonia

Ethiopia
 Georgia
 Guatemala
 Guinea
 Haiti
 Honduras
 India
 Jamaica
 Jordan
 Kazakhstan
 Kenya
 Kosovo
 Kuwait
 Kyrgyzstan
 Laos
 Latvia
 Lebanon
 Lesotho
 Libya
 Lithuania
 Madagascar
 Malawi
 Mexico
 Morocco
 Mozambique
 Namibia
 Nepal
 Nicaragua
 Nigeria
 Oman

Pakistan
 Palestine
 Panama
 Papua New
 Guinea
 Philippines
 Russia
 Rwanda
 Saudi Arabia
 Senegal
 South Africa
 Sudan
 Swaziland
 Tajikistan
 Tanzania
 Thailand
 Tunisia
 Uganda
 Ukraine
 Uzbekistan
 Vietnam
 Yemen
 Zambia
 Zimbabwe





CHAPTER 1

The IMPACT Project

A Comprehensive Response
to an Evolving Epidemic



Twenty-five years after the first case of AIDS was reported, an estimated 40 million people, including millions of children, are living with HIV and AIDS. Among adults, HIV/AIDS is a leading cause of mortality in an increasing number of countries.

The IMPACT (Implementing AIDS Prevention and Care) project responded to this crisis. IMPACT, a global USAID program, was implemented by Family Health International (FHI) and five partners. One of the world's largest and most ambitious HIV/AIDS programs, IMPACT provided comprehensive prevention, care, and treatment services while expanding the numbers of people and geographical areas covered by HIV interventions. From 1997 to 2007, IMPACT reached more than 75 countries with programs that focused on four priorities:

- reducing HIV transmission in large segments of the population
- reducing morbidity and mortality due to HIV/AIDS
- improving the quality of life of the majority of people living with HIV/AIDS
- mitigating the impact of the epidemic, especially on orphans and other vulnerable children

FHI, with its world-recognized technical and managerial leadership in HIV/AIDS programming, was an ideal organization to achieve these goals. Since 1971, FHI has worked with national governments and communities to meet the public health needs of the world's most vulnerable people. FHI has 15 years of leadership in HIV/AIDS prevention and care worldwide, working with multiple partners and service models to reach the greatest number of people and make the greatest possible impact. FHI is a global leader in the commitment to comprehensive care, driving expansion and improvement of a range of services, including counseling and testing, clinical diagnosis and treatment, and delivery of antiretroviral therapy.

FHI's five key partners contributed their own expertise to IMPACT: The Program for Appropriate Technology in Health (PATH), in Seattle, Wash., brought skills in behavior change communications; Population Services International, in Washington, DC, specialized in social marketing and mass media communications; Management Sciences for Health, in Boston, Mass., contributed expertise in management training as well as drug management, policy, and logistics; and the University of North Carolina-Chapel Hill and the Institute for Tropical Medicine, in Antwerp, Belgium, offered expertise in clinical management of sexually transmitted infections. Along with its partners, FHI collaborated with over 1,500 organizations at the global, regional, country, and community levels. With their help, IMPACT's accomplishments were numerous and far-reaching.

Mother and child at health clinic in Indonesia (Jim Daniels).

IMPACT at a glance

Project life: 1997–2007

Funding: \$441 million

Countries served: 75

Number of partner organizations: 1,500

The Evolution of IMPACT

The IMPACT project built on the achievements of two landmark projects in the previous decade. In 1987, USAID and FHI established the AIDS Technical Support (AIDSTECH) Project to help developing countries design, implement, evaluate, and sustain programs to prevent HIV transmission. AIDSTECH's two-pronged strategy focused squarely on prevention. The first priority was to prevent and slow the sexual transmission of HIV. The project identified high-risk populations and developed educational programs to target them; promoted access to and use of condoms; and implemented strategies to control sexually transmitted infections. The project's second priority was to prevent nonsexual transmission of the virus via transfused blood by improving screening programs and transfusion practices and encouraging blood donation by people at low risk of HIV.

AIDSTECH provided the basis for important interventions that followed, reaching people at highest risk of HIV infection, upgrading sexually transmitted infection diagnosis and treatment, training healthcare workers, supporting research, educating policymakers, and validating key HIV prevention methods such as the peer education model, the workplace and social center model, and the clinic-based model.

Following AIDSTECH was the 1992–97 AIDS Control and Prevention (AIDSCAP) project, also managed by FHI, which collaborated with organizations at all levels of society to mobilize communities and resources. At this point HIV/AIDS had spread extensively to the general population in several countries. Applying the lessons learned from earlier, small-scale prevention projects, AIDSCAP began developing comprehensive, large-scale programs that focused on three central strategies: minimizing risk behavior through behavior change communication, improving the diagnosis and treatment of sexually transmitted infections, and increasing access to and use of condoms. AIDSCAP established more than 540 HIV/AIDS prevention projects in 42 countries during its five-year span. The project also emphasized the importance of providing technical and financial support to private voluntary organizations and nongovernmental organizations to help them implement and sustain prevention programs. The project trained over 150,000 people in this effort and reached more than 14 million people with comprehensive HIV prevention education.

With the conclusion of AIDSCAP in 1997, IMPACT was designed to continue serving people living with HIV/AIDS using a comprehensive approach. The project's partners had learned important

One of the critical success factors of the IMPACT project was capacity building to support local ownership and sustainability.

lessons about the need to address HIV/AIDS on numerous fronts and to respond quickly as the pandemic evolved. IMPACT began the transition from primarily preventive interventions to a more comprehensive prevention and care response.

Key Factors in IMPACT's Success

One of the critical success factors of the IMPACT project was capacity building to support local ownership and sustainability. IMPACT developed locally owned and integrated programs by working with local partners and communities, making sure to include people living with HIV and AIDS in its capacity-building efforts. The project worked to create integrated programs as much as possible to ensure that services would continue beyond the life of the project. IMPACT also built upon and improved existing infrastructure and human and institutional resources, which increased the likelihood of sustainability.

IMPACT's programming approach also emphasized the importance of partnering with a range of existing organizations serving different sectors and interests. Such organizations have established constituencies whose needs they understand and with whom they have credibility. Introducing HIV/AIDS programming into these institutions was therefore more effective than creating new institutions, and allowed IMPACT to expand its reach more rapidly and efficiently. IMPACT forged partnerships with organizations in the private sector, faith-based organizations, nongovernmental and community-based organizations, and educational institutions to achieve its ambitious goals.

Another distinguishing feature of IMPACT was its implementation of innovative, evidence-based technical approaches across the continuum of care. IMPACT served as a forum for knowledge production, dissemination, and sharing through websites and publications, tools, country programs, training programs, and participation in task forces. The project also pushed the envelope on making care, support, and treatment a reality, in some cases going directly to health ministries and national AIDS control programs to push governments to take action.

Finally, IMPACT's management strategy provided flexibility in technical approaches and implementation options to develop programs that were accountable and that could be adapted to the needs of local epidemics as well as national action plans.

IMPACT laid the foundation for programs that will continue well beyond the close of the project.

Preparing for the Future

IMPACT's interventions were targeted at changing behavior and policies and reducing stigma and discrimination. Linkages with partners ensured that contextual interventions addressed gender inequities and social, economic, and political factors that increase risk and vulnerability, especially of women and youth. As local capacity was increased through IMPACT programs, FHI and its partners' roles deliberately devolved to oversight, guidance, and quality assurance. This strategy was founded on an understanding that partner agencies remain responsible and accountable for activities in their communities. By taking a comprehensive approach to the problem of HIV/AIDS and strengthening the continuum of care, IMPACT laid the foundation for programs that will continue well beyond the close of the project and will support lasting improvements in the lives of individuals and families.

CHAPTER 2

Behavioral Surveillance Surveys

Turning Data into Action



Behavioral surveillance surveys (BSS) make important contributions to informing responses to HIV. The surveys use reliable methods to track HIV risk behaviors over time as part of an integrated surveillance system that monitors various aspects of the epidemic.

Developed and widely tested in many settings, BSS are especially useful in providing information on behaviors among subpopulations who may be difficult to reach through traditional household surveys, but who may be at especially high risk for contracting or transmitting HIV. These groups include sex workers and their clients, men who have sex with men, and injecting drug users. Behavioral surveys may be combined with biological surveys in a surveillance method known as Bio-BSS, which includes testing survey recipients to determine their HIV status. In this way, changes in HIV prevalence can be tracked along with HIV-related risk behaviors.

An essential part of successful BSS is the involvement of stakeholders at each stage, from planning and implementation to data analysis and interpretation. Once BSS were conducted, FHI found it was critical to gather people to discuss the findings rather than simply distributing reports. Findings were shared with different audiences, including partners in HIV prevention, decisionmakers, members of the survey respondent groups themselves, and providers of HIV prevention services.

BSS results are used to examine policy decisions as well as determine whether individual programs and messages are working. Survey data is also used for planning programs at both the local and national levels. At the national level, for example, BSS conducted in Myanmar were used in planning the country's National AIDS Program. In Zambia, the participatory nature of disseminating BSS results spurred stakeholders to set up and seek funding for additional programs for orphans. At the local level, the State AIDS Control Societies in India used BSS results to prepare an annual action plan. And in Bangladesh, BSS results helped improve interventions to reduce needle sharing and spurred greater investment in HIV prevention programs.

Under the IMPACT project, BSS involved collaboration with public health officials, government agencies, nongovernmental organizations, and individual communities. IMPACT conducted BSS in more than 20 countries and led BSS trainings in countries such as Thailand, Egypt, Ethiopia, Guatemala, and Senegal. These capacity-building efforts contributed to increasing the number of people qualified to carry out BSS worldwide.

Former injecting drug user in Bangladesh (FHI-Bangladesh).

BSS revealed a disconnect between knowledge and behavior.

Getting a Clearer Picture in Kenya

Kenya has a high rate of adult HIV infection—estimated at 15 percent in 2001—with 2.5 million people believed to be living with HIV/AIDS. IMPACT supported BSS in Kenya to determine levels of knowledge, attitudes, and practices related to sexually transmitted infections (STIs) and HIV/AIDS. BSS was conducted among 1,000 sugar and paper processing company workers in Kenya’s Western Province. Participants voluntarily responded to a questionnaire and were screened for three STIs. The fieldwork was conducted by a survey team of healthcare professionals from the University of Nairobi.

Survey participants were predominantly male, married, highly skilled permanent employees. Nearly 25 percent reported having had intercourse with at least two sexual partners in the 12 months before the survey. Condom use was generally low—only about 48 percent had ever used a condom—and ranged from about 7 percent of contacts with spouses to 44 percent of contacts with sex workers. Participants reported that trust of their partners was the main reason for not using condoms.

Laboratory tests revealed a 3.4 percent combined infection rate for the three STIs, but the self-reported annual incidence of STIs was 32.4 percent. The high level of self-reported STIs and risk behavior confirmed the high risk of HIV infection in the participating workplaces. Based on the BSS findings, several types of interventions were determined to be the most promising:

- increased distribution of STI/HIV/AIDS-related information
- encouragement of condom use and acceptance
- promotion of counseling and testing services
- development of a tailored behavior change program
- more active involvement of company management to avert workplace stigmatization

Also in 2000 in Kenya’s Western Province, BSS provided insight into the HIV-related challenges female sex workers face. IMPACT supported a BSS project targeting 368 sex workers in four community sites. Data was collected by means of a standard questionnaire along with testing for STIs. The data revealed that the women surveyed began sex work at a median age of 20, usually because of economic need. More than 80 percent were part-time sex workers and had other income, which indicated they might be receptive to opportunities to gain income from sources other than sex work. All had unpaid sexual contact with casual and regular partners, and consistent condom use was low—about 50 percent (and only about 14 percent with regular partners). The main reasons for not using condoms were given as partner refusal and trusting

BSS results revealed multiple facets of knowledge, attitudes, and beliefs among high-risk groups, and even beyond.

the partner. This finding made clear the importance of emphasizing consistent condom use with all sexual partners, especially because the more intimate partners were likely to have other sexual partners as well.

Almost all the sex workers had been exposed to information on STIs and HIV/AIDS, and more than 80 percent were aware that HIV infection could be present in an otherwise healthy person. But BSS revealed a disconnect between knowledge and behavior: only about 20 percent of sex workers surveyed believed their clients could be infected, and 28 percent considered themselves at no or low risk of contracting HIV. Adolescent sex workers had less knowledge of HIV prevention methods, used condoms less consistently, and perceived themselves as less at risk of contracting HIV. The low knowledge levels and risk behavior among adolescent female sex workers made this group of young women a priority target group for intervention.

A Window of Opportunity in Bangladesh

BSS provided an early warning in Bangladesh, where the HIV epidemic is currently limited mainly to injecting drug users. As part of the IMPACT project, FHI provided technical and managerial support to the government for five rounds of BSS among high-risk and hard-to-reach populations. FHI's expertise was invaluable in such key activities as questionnaire design, sampling, data analysis, and report writing.

Research has shown that Bangladesh is on the cusp of a concentrated epidemic, and that risk behavior among injecting drug users—specifically, the sharing of needles—could soon lead to the rapid spread of HIV beyond this group. Observations of epidemics in other countries have shown that it is vital to stem the spread of HIV infection among injecting drug users before it leads to a heterosexual epidemic; the pattern of HIV seen among injecting drug users in other countries is usually a “low and slow” spread, followed by a sudden, rapid burst of infection.

Injecting drug users are the first population in Bangladesh to be affected by the epidemic, but they are not an isolated population. BSS results from the fourth round of surveys conducted in 2002 showed that 60 percent of male injecting drug users had purchased sex from sex workers in the past year, while condom use among sex workers in Bangladesh was the lowest in Asia—under 5 percent. In this way infection can spread from the injecting drug users to sex workers, to the sex workers' other clients, and then the clients' other partners. This “network of risk” can lead to a large-scale epidemic.

BSS results revealed multiple facets of knowledge, attitudes, and beliefs among high-risk groups, and even beyond. For example, in Bangladesh, a conservative society, a common belief is that young people are not sexually active and therefore not at risk. However, BSS conducted in 2002 showed that among a group of single young men, one-quarter had bought sex from sex workers in the past year. In other results, BSS showing the extremely low incidence of condom use among male clients of sex workers indicate that many of these men did not see HIV as enough

Pioneering behavior surveillance surveys in Vietnam

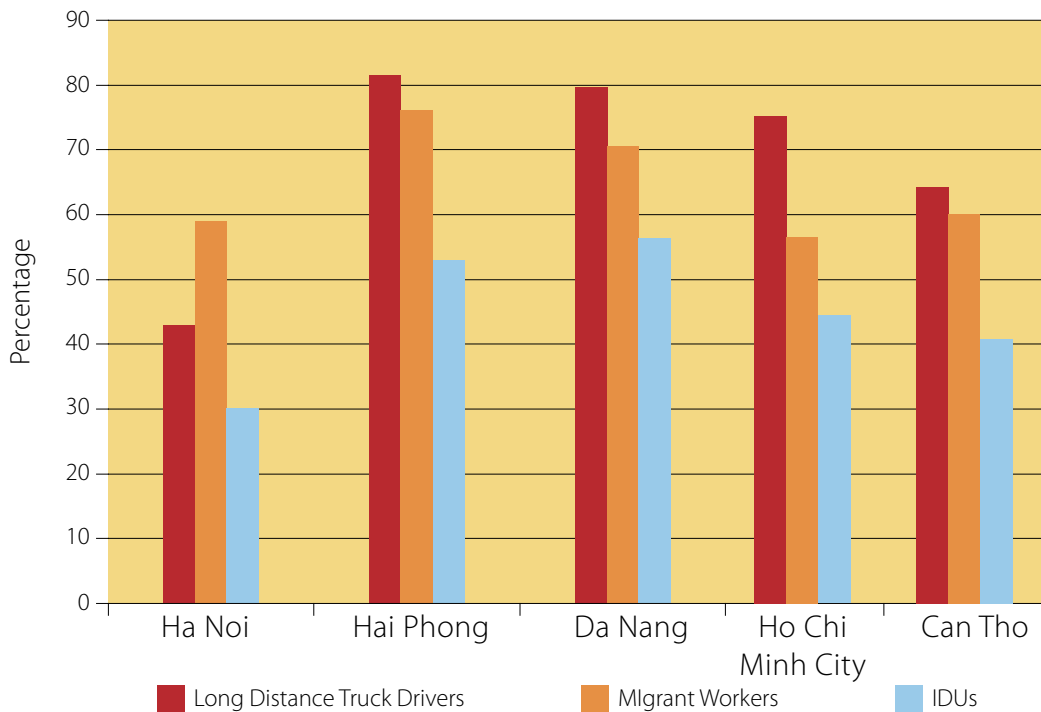
Pioneering BSS in four cities of Vietnam in 2000 revealed that street-based sex workers were more likely to use drugs and have more sex partners than karaoke-based sex workers. Their knowledge of condom use was high, but the prevalence and consistency of condom use varied. Only about one-third of sex workers in Ha Noi and Ho Chi Minh City reported consistent condom use in the past 12 months with one-time clients, and only one-sixth in Ho Chi Minh City reported consistent use with regular clients. Intervention activities relating to safe injection were called for, along with behavior change interventions targeting inconsistent condom use, particularly in areas frequented by mobile populations and tourists.

Long-distance truck drivers reported the most visits to sex workers in the past 12 months, especially in Can Tho. Though more than 90 percent reported consistent condom use during last sex with commercial partners, they reported a much lower rate with casual and regular partners. These data suggested interventions relating to condom use would be a priority for this group, along with those making condoms more accessible.

Migrant workers also registered a low rate of consistent condom use: with casual sex partners, it ranged from 13 to 32 percent and was below 5 percent with regular partners, except in Hanoi (13 percent). Those reporting at least one commercial sex partner ranged from a high of 20 percent in Hai Phong to a low of 7 percent in Can Tho. Like long-distance truck drivers, migrant workers are vulnerable to bringing the virus home to wives and regular sex partners as the reported HIV prevalence of sex workers rises.

A large proportion of injecting drug users reported injecting two to three times a day. Needle-sharing was practiced by 44 percent in Ho Chi Minh City and by almost one-third in Ha Noi and Da Nang. A quarter of those surveyed in Ha Noi had visited a commercial sex worker in the past year, 15 percent said they had visited four or more, and only 28 percent reported consistent condom use. To diminish the alarming prospect of HIV transmission from this group to sex workers and to the rest of the population, the survey suggested that expanded harm reduction interventions were urgently needed, such as peer education, needle exchange, and condom promotion.

Percentage Using Condoms Consistently with Sex Worker Partners in Past 12 Months in Four Vietnamese Cities, 2000



of an immediate threat to alter their behavior. In other words, the behavior change communication programs and other interventions were not successfully reaching them. The BSS results made clear the urgent need for new approaches to this problem.

By responding quickly to the evidence generated by BSS, Bangladesh may be able to replicate the success of Laos. In the 1990s, the Laotian government backed an aggressive condom marketing campaign, targeted at sex workers and their clients, which effectively averted a heterosexual HIV epidemic. Although surrounded by countries with high or rapidly rising HIV prevalence, Laos was able to stop the spread of the infection within its borders.

Constant Vigilance: Two Outcomes in Nepal

BSS conducted under IMPACT was instrumental not just in guiding the design of future interventions but also in evaluating current interventions. In Nepal, approximately 58,000 people are infected with HIV and, as of 2001, 2,400 people had died in the epidemic. BSS data was collected annually for five years (1998–2002) at intervention sites of the Terai “Safe Highways” program. Safe Highways set up drop-in centers in several districts along the Terai Highway. Interventions were targeted toward sex workers and their clients and focused on strategic communication activities promoting STI services. Drop-in centers, counseling and testing, and STI services were scaled up over time.

The BSS indicated measurable improvements in many areas as a result of Safe Highways. For example, among sex workers, exposure to brochures, educational materials, and interpersonal communication were shown to be effective in increasing condom use. Compared with 1998, more than twice as many sex workers now carry condoms (from 26 percent to 58 percent), and condom use with regular clients increased from 60 percent to nearly 86 percent.

Another example from Nepal shows the danger of letting down one’s guard. In the early 1990s, a series of programs run by the Lifesaving and Life-giving Society had documented success in risk reduction among injecting drug users. With HIV infection rates of less than 2 percent among this population, public healthcare workers believed the situation to be under control and ended surveillance of this subpopulation. In 1997, however, 114 injecting drug users were arrested in a police crackdown and tested: 107 were HIV-positive. Sustained BSS would likely have revealed that the risk behavior was continuing and the interventions had not prevented an epidemic.

Using BSS to Reach a High-Risk Group in Egypt

The HIV epidemic in Egypt is considered low grade, with infection levels of less than 5 percent in high-risk groups and below 1 percent in the rest of the population. In 2006, biological and behavioral surveillance surveys (Bio-BSS) were conducted in Cairo and Alexandria. The surveys were implemented in collaboration with the Egyptian Ministry of Health and Population and USAID. IMPACT provided technical assistance.

Surveillance focused on four high-risk subpopulations: street children, sex workers, injecting drug users, and men who have sex with men. Of these four groups, men who have sex with men are the most difficult to identify and assess. Due to religious beliefs and social pressures that hinder their ability to publicly acknowledge their sexual behavior, they are often at increased risk of contracting

NGOs and members of the high-risk groups themselves were involved in choosing the terminology.

and transmitting HIV. Moreover, because their sexual activities are often hidden and cause them feelings of shame, it is difficult for these men to seek the healthcare they need.

One of the challenges to this round of surveys was the lack of a standard method to collect baseline data for use as a future monitoring tool. To fill this need, FHI translated its IMPACT-produced manual, *Behavioral Surveillance Surveys: Guidelines for Repeated Behavioral Surveys in Populations at Risk of HIV*, into Arabic and adapted it to the Egyptian setting. NGOs and members of the high-risk groups themselves were involved in choosing the terminology, which was instrumental in gaining the confidence of study participants and helping them feel comfortable with the questions.

The BSS questionnaires gathered data on several aspects of the lives of men who have sex with men: their sexual histories, knowledge of HIV/AIDS and its prevention, stigma, and other factors. Participants also underwent voluntary, confidential HIV testing. Once involved in the study, the men were asked to refer others to participate. Thus a small inroad was gained to this population with the help of appropriately designed BSS tools and systems.

The HIV testing revealed that approximately 6 percent of the men who have sex with men were HIV-positive. Notably, even the HIV-positive participants showed stigmatizing and discriminating attitudes toward HIV-infected people. The BSS also showed a clear and dangerous gap between knowledge and behavior: although 77 percent had heard of condoms and nearly 88 percent who had heard of them knew where to obtain them, only 9 percent reported having used a condom during their last commercial sex activity. Reasons ranged from not liking condoms to not thinking they were necessary or even important. The 2006 Bio-BSS in Egypt demonstrated the need for interventions that address the tendency of men who have sex with men to have multiple sex partners; programs that help remove obstacles to healthcare presented by stigma and discrimination; and greater numbers of NGOs to participate with the health ministry in expanding programs.

BSS: A Powerful Tool for Change

Under IMPACT, FHI and its partners developed BSS tools that address the complexity of risk behavior. FHI provided technical and managerial support in designing and administering surveys and collaborated with other organizations—and members of high-risk groups themselves—to tailor surveys, obtain accurate results, and ensure the results were used to benefit communities.

By demonstrating that behavior can change as a result of prevention activities, data from BSS

conducted under the IMPACT project encouraged policymakers to promote HIV prevention. Findings were presented to the public through the media and other channels and increased awareness of the risk of unprotected sex. In addition, IMPACT-generated BSS data were used to gauge the success of some programs and identify the need for improvement or new approaches in others. IMPACT showed that BSS results, presented persuasively to the right audience, can turn data into action.

CHAPTER 3

Behavior Change Communication

Addressing the Behaviors That Increase Risk



Reducing the spread of HIV and improving care and treatment for people living with HIV/AIDS require programs that address the specific behaviors that put people at risk. Communication interventions aimed at meeting this need were a cornerstone of FHI's work under the IMPACT project.

Strategies that integrated behavior change communication (BCC) into the full continuum of prevention, care, and treatment interventions effectively promoted change, maintained positive behaviors, supported open discussion, and created environments conducive to successful action.

In its BCC work under IMPACT, FHI and its partners emphasized local shareholder participation in developing interventions compatible with community customs and traditions. To reach target groups effectively, BCC programs took into account both barriers and motivations to change. Interventions were carefully designed with an appropriate combination of activities, communication channels, and links to services. Most importantly, interventions were coordinated with other health, policy, social, and economic programs for the greatest impact on behavior and, ultimately, on health.

BCC messages are communicated through a combination of mutually reinforcing channels. The most direct channels are interpersonal, including counseling, support groups, hotlines, and peer education. Also important are small media, including charts, brochures, job aids, comics, and videos; and mass media, such as television and radio, print, outdoor signage, and the internet. Innovative BCC can be carried out using traditional media, such as local rituals and celebrations, festivals, music, and drama. Traditional media are especially effective in influencing attitudes and social norms, because they are linked to the customs of a culture. Large special events, including sports, contests, and World AIDS Day events, can reach large numbers of people. BCC makes use of all these channels of communication to reach a wide range of populations.

Challenging Stigma and Discrimination in Ethiopia

The IMPACT project recognized that stigma and discrimination against people living with HIV/AIDS present major barriers because they stifle information seeking, discussion, and disclosure of HIV status. Stigma and discrimination create an "us versus them" mindset and inhibit access to quality care and treatment. For people living with HIV/AIDS, stigma and discrimination can be worse than the disease. They are often treated with suspicion and hostility, denied access to needed services, and subjected to harassment, physical violence, or condemnation. Even family members and friends may refuse to support those infected with HIV. The IMPACT project developed anti-stigma campaigns that took on the

In a survey of 1,700 members of the campaign's target populations, 90 percent correctly recalled the entire content of each of the campaign's three radio spots.

challenge of changing these attitudes and improving the treatment of people living with HIV/AIDS.

In Ethiopia, the adult HIV prevalence rate as of 2001 was 6.4 percent, with more than 2 million people living with HIV/AIDS. In response to this epidemic, the "CATS" campaign targeted out-of-school youth, female sex workers, and taxi drivers in Addis Ababa with the theme of "Compassion, Tolerance, and Sensitivity." The campaign promoted dialogue on how to reduce stigma and enable behavior change. With interventions such as radio programming and a music video, CATS reached more than 5 million Ethiopians. The campaign's theme song, *Compassion is Modernity*, was broadcast widely and became a number-one hit for several months on Ethiopian radio and television. People reported that listening to the song encouraged them to change their stigmatizing attitudes and actions toward people living with HIV/AIDS. The campaign received critical acclaim from the public, media, religious and government leaders, and community-based organizations. In a survey of 1,700 members of the campaign's target populations, 90 percent correctly recalled the entire content of each of the campaign's three radio spots.

To complement the anti-stigma interventions, FHI, the Addis Ababa Health Bureau, and the HIV/AIDS Prevention and Control Office created a mass media campaign promoting the use of counseling and testing services. The campaign's powerful theme captured people's attention and conveyed the seriousness of the HIV/AIDS epidemic: "We have never lost a war; why start now?" Results were impressive. Before the campaign's launch, 2,000 Ethiopians had accessed counseling and testing services in all 20 government health centers in Addis Ababa. Just six months later, the number had increased to 6,000.

Reaching Out to Youth in Guyana

Under the IMPACT project, a successful anti-stigma initiative was a key component of Guyana's HIV/AIDS/STI Youth Project. Prevalence of HIV in Guyana is estimated at 3.5–5.5 percent among the general population, the second highest prevalence in the Caribbean. The majority of those infected are unaware of their HIV status, and among many groups of young people, stigma and discrimination directed at people living with HIV/AIDS are extreme. The project's anti-stigma activities centered on the overall theme "Words Have Power," particularly apt for Guyana's verbally oriented youth culture.

In-depth study of the culture itself revealed a unique way to spread messages of acceptance and respect for people living with HIV/AIDS: through the young men who work as drivers and conductors of the minibuses that are the primary form of transportation around the country. Considered

The Ready Body program engaged youth in exploring its theme by asking, “The ready body—is it really ready?,” challenging them to consider the possibility that looks could be deceiving.

a dangerous influence by parents, teachers, and police, these young men—fast-talking and flashy, with lots of spare cash—are in many ways the “rock stars” of Guyanese youth culture. Although they were a difficult group to engage, once they were given an opportunity to express their hopes and aspirations, it became clear they could be effective “change agents” and exert a positive influence on young people. Minibus drivers and conductors craved respect and had a genuine desire for more stable lives. The message created specifically for them, then, was “Give Respect! Get Respect!”

Within the minibus culture, misconceptions about HIV/AIDS and people living with HIV/AIDS were rampant, with drivers and conductors openly discriminating against them and insulting them with crude slang. Many were afraid of contact with them. A crucial element of Words Have Power was the participation of people living with HIV/AIDS at every step of campaign development and implementation. Owing to this and other factors, drivers and conductors quickly adapted to—and even came to enjoy—their roles as change agents. They adopted new attitudes, conveyed positive messages, handed out informational materials, and provided referrals to prevention, care, and treatment services for their young passengers. The drivers felt respected, the program was immensely popular, and young people paid attention: 75 percent of young people exposed to the Words Have Power campaign could recall key campaign messages after only three months—even in a region not targeted by the campaign.

Another important initiative of the Youth Project was the interactive television talk show *YTV–Youth, Talent, and Voices*, which has become one of the most popular television shows in Guyana (and continues today), giving young people a forum and voice to discuss issues related to HIV/AIDS, sexually transmitted infections, sexuality, stigma, and discrimination.

In addition to its anti-stigma efforts, the Youth Project used music, drama, and popular culture to reach young people with HIV prevention messages. A key initiative, the “Ready Body” campaign, made use of a common slang expression—someone with a “ready body” is good-looking, sexy, cool. The campaign began with short teaser advertisements on television, featuring attractive young people. Next, posters appeared around Georgetown, Guyana’s capital, repeating the Ready Body theme. Finally, when young people’s curiosity about the slogan had been sufficiently piqued, a street fair on Georgetown’s Main Street, pumping out dance music, drew them in. As hundreds of young people enjoyed the music and performances, they also picked up free condoms and information on how to stay healthy and protect themselves from sexually transmitted infections, including HIV. The Ready Body program engaged youth in exploring its theme by asking, “The ready body—is it really

Knowledge of these culture-specific practices and values was vital to the creation of culturally acceptable, engaging programs for this community.

ready?," challenging them to consider the possibility that looks could be deceiving, and that casual, unprotected sexual activity could be more dangerous than they realized.

Another remarkable achievement of the Guyana Youth Project was the creation of a steering committee of the nongovernmental organizations involved in the initiative. Previously, the NGOs, each with its own special skills and resources, had worked in isolation. The steering committee changed that by meeting monthly, which led to the NGOs coordinating efforts and sharing resources and perspectives. This collaboration made the Youth Project a true success story, and the NGOs continued to meet after the conclusion of the project under the National NGO Coordinating Committee.

A Comprehensive BCC Response in Nigeria

In 2001, about 3 million Nigerians were HIV-positive and an estimated 170,000 had died of AIDS. With prevalence rates rising rapidly, IMPACT implemented an expanded and comprehensive response. In consultation with the National Action Committee on HIV/AIDS, FHI focused on four of Nigeria's 36 states. In-depth assessments identified both risk factors and opportunities for prevention and care activities. BCC activities employed IMPACT's strategy of collaboration among implementing partners, government officials, project beneficiaries, and other stakeholders. Also key was the integration of channels and programs. For example, peer education and print materials reinforced the messages communicated through radio and TV spots, while peer educators referred their contacts for counseling and testing.

Programs were designed based on information collected during the planning stages. In Taraba State, people were found to place a high value on health, yet risky behavior was taking place and overall HIV prevalence was 5.5 percent. Sex work was discovered to be increasing, accompanied by low levels of condom use and lack of knowledge about sexually transmitted infections. Many low-income women were found to be supplementing their incomes through sex transactions. Alcohol consumption and cultural practices such as forced marriages and local festivals were also identified as risk factors. Knowledge of these culture-specific practices and values was vital to the creation of culturally acceptable, engaging programs for this community.

After careful study of Taraba State, IMPACT chose to target youth, transport workers, sex workers, healthcare providers, people living with HIV/AIDS, and church members. To tie in with the community's view of the importance of health, a simple theme, "Care to Live Healthy," was created. Objectives included promoting the ABC messages of abstinence, being faithful, and consistent and correct

condom use among the targeted populations. Additional interventions encouraged increased use of counseling, testing, and treatment services and provided care and support for people living with HIV/AIDS. As is typical of IMPACT programs, FHI's implementing partners, including faith-based organizations, played critical roles. Other partners included a teachers' union, a youth development association, a road transport workers' union, and the Nigerian Medical Association. This collaboration allowed programs to draw on a range of perspectives and resources.

In each of the three other states, themes were devised to resonate with people in that particular culture. In Anambra State, where people tend to be commerce-focused and competitive, the theme was "Join the Race for a Healthy Future." For Lagos, the emphasis was slightly different: "Care

Influencing taxi drivers to be behavior change advocates in Ethiopia

In Addis Ababa, Ethiopia, IMPACT brought messages of HIV prevention and behavior change to 28,000 taxi drivers, assistants, and inspectors. Most of these men were young and unmarried, had little education and information about HIV, and were vulnerable to infection because they travel across the city at all hours and encounter many people. Although turning taxi drivers into educators was not easy, they were especially well suited for the role because of their mobility and ubiquity, and because of the numerous opportunities they had to talk to strangers across Addis Ababa.

The program helped drivers become comfortable discussing HIV with their passengers and with each other, since drivers are more likely to consider information from others in their industry than from health educators. IMPACT also prepared taxi inspectors to become core trainers and trained a small number of drivers to be peer leaders. In turn, these men trained dozens of others, ultimately educating the city's fleet of drivers about using the ABC strategy to reduce infections. None were paid for this work.

The peer education is augmented by street theater presentations at the taxi stations where drivers gather. The dramas, performed by volunteers, are participatory: the taxi drivers help determine how stories end. At the taxi stations, targeted pamphlets improve the drivers' HIV knowledge, and condoms are distributed. Other messages appear on vehicular advertisements and bumper stickers and are broadcast on car radios.

The program helps counter widespread HIV denial and stigma, along with the drivers' reluctance to seek HIV testing and counseling or to be seen buying condoms. Another obstacle is that an hour spent at a counseling and testing service is an hour without income for a taxi driver, so some of the 25 public-sector testing and counseling sites supported by FHI are open late and on Saturdays.

The potential of peer education as an HIV prevention strategy has been confirmed by a range of IMPACT-funded BCC programs.

for a Healthy Future.” And in Kano, a religious, predominantly Muslim state, where people are very concerned about their families and health, the theme became “Care for Your Health and Family.” This close tailoring of themes to communities was an effective strategy of IMPACT BCC initiatives. As BCC initiatives were implemented in Nigeria, a steering committee in each state monitored messages to ensure their quality and cultural appropriateness. The committee also looked for ways to link together the activities of individual implementing agencies.

BCC efforts in Nigeria sparked community dialogue about HIV and AIDS in each of the four states, and stigma and discrimination are now being addressed. Capacity building for local partners has improved, and diverse organizations are now working together toward common goals. The steering committee in Nigeria, as in Guyana, served as a source of technical assistance and helped create strong networking relationships. Also significant is the fact that people living with HIV/AIDS are represented on the steering committees. They have taken on leadership roles in prevention initiatives in Anambra and mass media campaigns in Lagos.

Peer Education in Rwanda, Kenya, and Indonesia

Knowledge and information about HIV/AIDS, while critical, does not always lead to behavior change. The missing piece of the puzzle may be the face-to-face interaction that peer education provides. The potential of peer education as an HIV prevention strategy has been confirmed by a range of IMPACT-funded BCC programs.

For example, in Rwanda, a major initiative launched in 2001 targeted youth with HIV prevention and stigma-reduction messages and activities. Community members and leaders were involved in selecting youth peer educators, and church members also played a role in developing programs. Four years after the project began, in 2005, a survey showed measurable results among the young people who had been exposed to peer education. They had much greater familiarity with common symptoms of sexually transmitted infections than those who had not been exposed, their reported condom use was higher, and they reported much less sexual activity during the previous 12 months. Youth who were exposed to peer education were also twice as likely to use counseling and testing services in their communities.

In selecting and training peer educators, the quality of training and follow-up support is critical, as is contextualizing themes and methods, developing camaraderie among peer educators, and taking full advantage of local resources—such as the Catholic church, which is strongly influential

As a result of IMPACT programming the Ghana Armed Forces reported a reduction in HIV prevalence among the ranks from 4.2 percent in 1989 to an estimated 2.0 percent at the end of 2003.

in Rwandan communities. An important tool in an integrated approach to BCC, peer education provides opportunities for intimate discussion of issues, allowing participants to explore related topics in depth. Peer education complements and reinforces other strategies, such as mass media, which is effective at stimulating concern, motivating curiosity, and creating a sense among audiences that they are part of something important that reaches beyond their day-to-day lives and interactions.

In communities worldwide, IMPACT peer education initiatives saw success. Radio peer education discussion, for example, combined the use of radio (to reach large numbers) with peer education (to give opportunities for select groups to discuss topics in depth). In Kenya, men from large workplace settings who participated in a radio discussion group were more likely to visit a counseling and testing site than those not participating. Female sex workers involved in radio discussion groups were more likely to use a condom at last sex with a client than those not reached by the groups.

In Indonesia, where half of all injecting drug users are HIV-positive, peer outreach networks helped reduce risk and encourage safer behavior. After three years of participation in a program, injecting drug users in contact with outreach workers were more than twice as likely to use condoms with casual partners than those who had no such contacts. They were also found to be three times more likely to clean their needles with bleach and about half as likely to use another person's needles. These relatively simple changes, encouraged by peer educators, had significant positive results.

Changing Risk Behavior among Uniformed Services

Armed forces, police, and other members of uniformed services around the world face a serious risk of HIV infection. Separation from family and community is partly responsible for this increased risk, as is a pervasive "culture of invincibility" created by the sense of danger that many people in uniform face daily. Fortunately, because of their command and control structures, uniformed services are also uniquely placed to integrate HIV prevention, care, and treatment services into their systems. Under IMPACT, FHI worked with uniformed services in 20 countries, with behavior change initiatives targeted at police, immigration, customs, fire service, deminers, and prisons. IMPACT's work with the uniformed services in Ghana is considered a model on the African continent and globally.

In 1998, IMPACT initiated activities to strengthen HIV/AIDS programming for the Ghana Police Service. One of the main objectives was to implement a behavior change program among police personnel. Activities included conducting peer one-on-one and group HIV/AIDS education; sensitizing the top hierarchy of the police; providing in-service training for middle rank and senior police officers;

and developing, producing, and distributing targeted communication materials. In 2001, IMPACT expanded activities to cover Ghana National Fire Services, Immigration Services, and Customs, Excise, and Prison Services to strengthen the capacity of the different services to design and implement behavior change programs to prevent HIV and other sexually transmitted infections and build supportive attitudes about people living with HIV and AIDS.

The IMPACT project developed training-of-trainers' manuals and instructor's guides for each category of uniformed service personnel and expanded activities to reach the wives of uniformed service personnel and other civilians. IMPACT also assisted in structuring the training provided at uniformed services training schools and integrating HIV/AIDS education into regular in-service training. Peer education training, the key activity of the behavior change intervention, included film screenings, role-plays, and group discussions.

Service-specific activities spanned a wide range of programs, including HIV/AIDS education for civilian employees living in barracks; counseling skills training for religious leaders within the seven battalions of the armed forces; training of "mess hall" workers to promote and sell condoms; and training choir music and band program participants in the Immigration Service and National Fire Service to compose songs about AIDS prevention.

As a result of IMPACT programming the Ghana Armed Forces reported a reduction in HIV prevalence among the ranks from 4.2 percent in 1989 to an estimated 2.0 percent at the end of 2003. The Ghana Police Force reported significant changes in knowledge and behavior since launching its program: approximately 36 percent of police identified police stations as a source of condoms in 2002, compared with 0.6 percent in 2000. During the same period, reported consistent condom use with non-regular, non-commercial partners in the past 12 months increased from 20.8 percent to 50.8 percent.

A major factor in the successful implementation of these programs was the sensitizing of top-ranking officials. Top leadership of the uniformed services participated actively in advocacy and program launch activities, program discussions at management meetings, and condom promotion; an official program launch was conducted by the highest-ranking official of each service.

In Cambodia, active involvement of commanders and superior officers was also critical to program success. To maximize coverage of military personnel, a cascade peer education approach was used,

Once committee members were comfortable with the content, they could promote it confidently among their memberships.

with a structure comprising four levels that mirrored the hierarchical structure of the uniformed services. The structure called for training core trainers from the ministerial, regional, provincial, division, and brigade levels, who in turn guided and supported peer educator trainers at the provincial, brigade, and battalion levels. Peer educator trainers then trained and supported peer educators at the district, company, and platoon levels and provided information, education, and links to services in military barracks. In 2005, the program expanded to target uniformed services personnel in all 24 provinces.

Data show a steady decrease in HIV prevalence among Cambodia's uniformed services—from 4.6 percent in 1997 to 2.7 percent in 2003. In addition, the number of military who reported having sex with sex workers in the past year significantly declined, from 70 percent in 1997 to 37 percent in 2003. Military personnel who had more peer education sessions had higher levels of consistent condom use with both sex workers and casual partners, and were more likely to have sought HIV testing.

Despite extensive risk behavior among their personnel, uniformed services proved to be a population with a built-in structure able to sustain effective behavior change communication programs. IMPACT's emphasis on local partnerships contributed significantly to the buy-in of the top members of the service hierarchies and ensured that these programs saw results.

That's Entertainment: Engaging Audiences with Positive Messages

In Kano, a city in one of Nigeria's 12 northern states that adhere to Islamic law, sex between unmarried people can lead to public punishment, and adultery may be punished by death. Despite such laws, high-risk behavior exists, and the inability to confront and discuss it has been a major obstacle in prevention efforts. Effective HIV/AIDS programming must navigate a complicated religious and cultural landscape. Entertainment provided a unique opportunity in Kano: many Nigerians enjoy movies with soap-opera-like storylines, and many of these movies are produced in "Kannywood," Kano's successful film industry. In this environment, a film combining entertainment with important messages about HIV/AIDS had good potential to succeed.

With backing from IMPACT and the Program for Appropriate Technology in Health, the feature film *Awakening* went into production. To get buy-in from local stakeholders, a behavior change committee was created with membership that included representatives from government, NGOs, community-based organizations, and religious groups. The committee reviewed the script to make sure the messages were positive and culturally acceptable. Once committee members were

With its safe-sex messages woven into the plot, the feature film *Awakening* sparked discussion about topics previously considered unmentionable.

comfortable with the content, they could promote it confidently among their memberships. To further ensure the film's effectiveness, trained peer educators answered questions and guided discussions after screenings.

With its dramatic storyline, *Awakening* appealed to a young audience, and it simultaneously conveyed important messages about risky sexual behaviors and HIV/AIDS. With its safe-sex messages woven into the plot, the film sparked discussion about topics previously considered unmentionable. Millions of Nigerians saw the film—in theaters, at committee meetings, or on television. Perhaps the best indication of the movie's success is that sequels are underway.

The Future of Behavior Change Communication

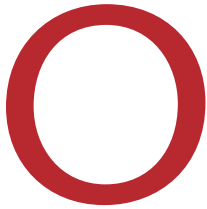
Thanks to the experience and lessons learned through the IMPACT project, BCC activities are now essential elements of HIV/AIDS programming: increasing knowledge, stimulating conversation, encouraging advocacy, reducing stigma, and promoting the use of prevention, care, and support services. Effective communication interventions motivate behavior change on an individual level and help set public and policy agendas. As the pandemic evolves, BCC strategies will evolve as well to adapt to new communication needs and take advantage of innovations to reach people at risk.

CHAPTER 4

Counseling and Testing

A Critical Entry Point to
Prevention, Care, and Support





Only 10 percent of the people estimated to be HIV-positive worldwide know their status. HIV counseling and testing, one of the most rapidly expanding HIV program services worldwide, serves as an entry point to needed prevention, care, and support services.

Effective counseling and testing allows people to learn their HIV status in an informed and supportive way: with counseling both before the test to educate them about HIV infection, and afterward to help them deal with the results. Counseling and testing catalyzes behavior change—for those who test both HIV-negative and HIV-positive. HIV-negative clients are counseled about HIV prevention and have the opportunity to develop HIV risk reduction plans; they may also receive referrals to post-test support groups to reinforce behavior change. Counseling and testing can also realize larger benefits for a community, such as promoting HIV awareness and knowledge, encouraging openness, reducing stigma, and stimulating community response to HIV care and support for people living with HIV and AIDS.

Under the IMPACT project's counseling and testing initiatives, FHI continued its strategy of collaboration with local partners. IMPACT implemented targeted interventions to address the needs of couples and high-risk groups, including sex workers and their clients, injecting drug users, men who have sex with men, and mobile populations. IMPACT initiatives included training staff, developing communication strategies, strengthening community support systems, creating linkages with other services, developing care strategies for counselors, and improving commodity and supplies management. Beginning with five sites in five countries in 1997 and growing dramatically to more than 1,200 sites in 25 countries in Africa, Latin America and the Caribbean, and the Asia-Pacific regions, IMPACT initiatives produced results by expanding existing services and rolling out new counseling and testing models.

The primary approach to counseling and testing during the IMPACT project was called *voluntary counseling and testing*, whereby an individual or couple voluntarily undergoes counseling in order to make an informed decision about being tested for HIV. As the pandemic evolves, however, new approaches are being introduced, including *provider-initiated counseling and testing* and *outreach and mobile counseling and testing*. Provider-initiated counseling and testing brings services to groups with higher prevalence rates or others whose care will benefit from testing, such as clients at sexually transmitted infection and tuberculosis clinics. For example, a provider might initiate a test when a person shows signs

Applying lessons from pioneer counseling and testing programs in Nigeria

IMPACT began supporting two counseling and testing sites in Nigeria in 1993, the first standalone facilities in the country. The center in Lagos was operated by the Salvation Army, and the other, in Kano, was run by the Society for Women and AIDS in Africa/Nigeria. Plans to expand to 22 sites triggered concerted efforts to gather lessons learned and ask clients how services could be improved. These efforts paid off, and the following recommendations informed the establishment of new centers.

- Publicize the service and its value for maintaining health, and make community members feel comfortable about using it. Ask community and religious leaders to take an active role in the publicity, and involve volunteer outreach workers and peer educators in spreading the word. To encourage participation, waive or lower fees for young people, and offer refreshments, free condoms, or special youth days.
- To overcome fear and stigma and ensure privacy and confidentiality, make anonymous testing available. Emphasize counseling rather than the HIV test, and offer and promote broad services, such as testing for more common sexually transmitted infections.
- Address misconceptions about counseling and testing, HIV, and AIDS in promotional messages, and target messages to highly vulnerable groups, such as young people, sex workers, and poor women.
- Strengthen referral networks and basic operations, such as logistics and commodities supply systems. Sensitize healthcare workers to the need for prevention counseling for healthy clients.
- To ensure highest service quality, implement broad monitoring and evaluation procedures. This may require uniform computerization and staff training.
- Before expanding service delivery, institute management policies that create efficient operations, including hiring fulltime procurement officers to help manage the movement of commodities and supplies.
- Create post-test support clubs that reinforce the counseling messages clients receive.
- Ensure that counseling staffs are diverse and that services are culturally appropriate. Provide ongoing counselor training and hold regular staff meetings to discuss difficult issues.
- Provide staff with high-quality visual aids that are locally appropriate. Materials should prepare clients for the counseling and testing process and should include educational videos about HIV that can be shown in waiting rooms, simply worded and illustrated flip charts, and handouts.

IMPACT targeted specific facilities to reach people most in need of services, working to rapidly expand testing.

or symptoms consistent with HIV-related disease or AIDS. Outreach and mobile counseling and testing brings services to those who do not have access or who do not traditionally seek services in health facilities.

From 1997 to 2002, IMPACT projects focused on the design, implementation, monitoring, and evaluation of voluntary counseling and testing services, through technical assistance to national governments and support of a range of NGOs well placed to deliver services. From 2002 to 2004, FHI began to expand its service delivery sites and models due to increasing demand. By September 2002, FHI had developed programs in more than 150 sites in 22 countries, and by 2006, FHI was supporting 515 sites in 22 countries.

In some countries, demand for counseling and testing is high, but access is insufficient; in others, services are available but rarely accessed due to the stigma surrounding HIV and the fact that the onus is on the client to seek the service. IMPACT targeted specific facilities to reach people most in need of services, working to rapidly expand testing in such settings as sexually transmitted infection, tuberculosis, and family planning clinics; inpatient and outpatient departments; home-care programs; and pediatric clinics. The project also expanded links between testing and services for pregnant women, strengthened freestanding and integrated sites to meet the needs of youth, and reached out to those most at risk through peers, lay counselors, and mobile teams.

In 2004, FHI completed the *VCT Toolkit*, a compendium of documents providing guidelines that can be adapted to a range of countries and contexts. Other FHI initiatives included applying a human rights approach to voluntary counseling and testing and ensuring informed consent, confidentiality, and appropriate counseling. Although the voluntary aspect of counseling and testing has recently been deemphasized, FHI continues to advocate that the process must be voluntary—patients must understand that they always have the right to decline the service. FHI also continues to focus on meeting the need for quality assurance, adequate referral mechanisms to ensure those who test positive will receive appropriate treatment, and effective monitoring and evaluation.

Ethiopia: A Regional Approach

Under IMPACT, counseling and testing services were scaled up in all regions of Ethiopia. The country has the sixth highest number of HIV infections in the world; FHI estimates that a quarter

The taxi community in Ethiopia was empowered to conduct its own HIV prevention and AIDS care and support efforts. Monitoring feedback revealed that counseling and testing use had increased.

of urban Ethiopian households may contain a person living with HIV or AIDS. Yet in 2001, there were just over 150 testing sites for a population of more than 77 million.

FHI provided technical assistance in scaling up HIV/AIDS programming in collaboration with the Ministry of Health and regional health bureaus in four of the country's main states: Addis Ababa, Amhara, Oromia, and SNNPR (South Nations and Nationalities Regional state). Before beginning to integrate counseling and testing services into public health centers, FHI facilitated a series of consensus-building meetings, which included representatives from the regional, zonal, and health-center levels, to identify resource and quality gaps and brainstorm ways to accomplish rapid scale-up. The government's decision to institutionalize counseling and testing into the national health system was a key factor in the project's success. Strong communication and education initiatives also contributed to reducing the stigma surrounding counseling and testing and encouraging people to access services.

Throughout the program, FHI worked to strengthen existing structures while respecting the mandates of government bodies at each level of the health system. IMPACT procured furniture and equipment to initiate counseling and testing services at health centers, and helped fill in gaps by purchasing such supplies as test kits and reagents. This ensured that services could start immediately following training. Over the lifetime of the program, however, responsibility for provision of supplies was passed on to the regional health bureaus. FHI also worked with each of the four regions to develop local training materials based on national protocols. Large numbers of health workers were then trained as trainers. Peer supervisors, one per counseling and testing center, were also key to the program's success. The supervisors observed and monitored quality and stepped in when volume was high or counselors needed a break. All four regions now run their own training courses with minimal assistance from FHI. IMPACT also supported the gradual transfer of counseling and testing management and supervision skills to the regional, zonal, and woreda (district) health staff, providing the basis for long-term sustainability.

A particularly effective program was implemented in the Addis Ababa taxi community, which was at high risk for HIV infection and had never before been targeted by any HIV prevention program. FHI worked with local partners to train taxi inspectors as core trainers; the core

trainers then trained peer leadership trainers, who in turn trained a large number of peer leaders among taxi drivers, assistants, and inspectors. The taxi community was thus empowered to conduct its own HIV prevention and AIDS care and support efforts. Monitoring feedback revealed that counseling and testing use had increased, and taxi community members reported reducing their number sexual of partners after HIV testing. They also reported being able to discuss HIV risk behavior more openly, which helped them address the factors that put them at risk. The peer leadership program gained high acceptance, with many taxi drivers, assistants, and inspectors volunteering to become peer leaders and expressing a desire to become catalysts for change.

With FHI's help, the number of testing facilities has increased dramatically in the past five years: counseling and testing is now available in 483 government health centers in the four target regions, with an accompanying rise in the number of people being tested. In the Amhara region alone, 136,000 people were tested in 2005, a 400 percent increase from the year before.

Kenya: Rapid Scale-up

Kenya is among the countries hardest hit by the HIV/AIDS epidemic, with a prevalence rate of almost 15 percent of the population. Fortunately, the government is strongly committed to expand counseling and testing services—and overcome the enormous challenges. Fifty-five sites were established in less than two years in the three regions of the country where HIV prevalence and risk of new infection are highest. IMPACT supported the government and Kenyan partner institutions in developing service models, standardizing services, creating quality assurance systems, developing a training curriculum for counselors, and promoting site services.

IMPACT used two models of service provision: standalone sites and sites integrated into public health facilities, including large hospitals, smaller health centers, and rural dispensaries. *National Guidelines for Voluntary Counseling and Testing*, which IMPACT published in 2001, provided a road map for ensuring standardized, high-quality services among all the sites.

District health management teams of health professionals, community leaders, and people living with or affected by HIV/AIDS were central to planning and implementing the counseling and testing sites, thus promoting ownership and sustainability of the program. Religious groups were also important allies. In the Coast Province, the strategy involved collaboration

IMPACT's approach in Rwanda was to rapidly integrate counseling and testing into health centers and district hospitals where related services were already available.

with the National Council of Churches of Kenya for Anglican and Methodist clergy, as well as collaboration with local Muslim leaders. In addition, a mass media component used a combination of approaches to reduce stigma, create awareness, and encourage counseling and testing among both adults and youth.

The early success of the program was reflected in the numbers of Kenyans who sought services. Between January 2001 and September 2002, more than 36,000 Kenyans visited program sites and received services. In 2006, FHI counseled and tested more than 177,000 clients, and many of them referred friends and relatives to get tested.

Rwanda: Responding to High Demand

Convincing clients to get tested is not a problem in Rwanda. Even before FHI became involved in 2000, clients were known to camp out, sometimes for two or three nights, waiting for appointments at the single counseling and testing center in Kigali. Blood was sent to a single central laboratory where results could take up to three months (and almost one-third of clients never received results). Today, clients receive individual, anonymous, same-day testing at 22 integrated sites in Kigali and in seven of the country's 12 provinces. All clients receive individual pre- and post-test counseling, plus information, education, and communication sessions. Ninety-eight percent receive their results, typically on the same day. Those who test positive are referred for services such as prevention of mother-to-child transmission (PMTCT), prevention of tuberculosis and opportunistic infections, and, at four sites, antiretroviral therapy.

IMPACT's approach in Rwanda was to rapidly integrate counseling and testing into health centers and district hospitals where related services—prevention of mother-to-child transmission, tuberculosis prophylaxis, and support for people living with HIV/AIDS—were already available. The existing center in Kigali became the launch pad for the scale-up. The challenge was to scale up rapidly enough to meet the extremely high demand.

Rwanda's population and its leaders embraced counseling and testing as a promising tool for preventing the spread of HIV. The involvement of political, religious, and community groups greatly contributed to the initiative's success, demonstrated by such results as unusually high number of couples attending counseling and testing together, and frequent requests for premarital counseling and testing. The Ministry of Health's involvement allowed FHI to standardize

The effect of offering services at the community level has met a need particularly among women who would not otherwise have been tested.

testing and care nationally. With backing from the ministry's AIDS Control Program, IMPACT developed national guidelines, a training curriculum for counselors, and technical standards for laboratories. All sites in Rwanda adopted a computerized client recordkeeping system, which provides data to the FHI/Rwanda office on a monthly basis. IMPACT also worked to increase referrals for and linkages to support and care services.

Counselor burnout is a side effect of such high demand, and IMPACT helped institute a variety of practices to counter it. For example, counselors held daily meetings to share the challenges of the workday and discuss difficult emotional issues. Each counselor also identified a peer as a personal counselor that he or she could talk to about stress and depression as necessary.

FHI pioneered Rwanda's decentralized policy for counseling and testing services by supporting the launch and operation of 49 sites in 10 provinces. Since 2000, at FHI-supported sites alone, over 400,000 clients have learned their HIV status.

India: Community-based Counseling and Testing

With approximately 5.7 million people living with HIV/AIDS and an estimated overall prevalence of 0.9 percent, HIV/AIDS is a major public health problem in India. The epidemic is concentrated in six states that account for 90 percent of all infections. Under IMPACT, FHI provided technical assistance and grant support to projects working with at-risk groups including female sex workers, injecting drug users, and men who have sex with men. Counselors at counseling and testing centers provided ongoing counseling and referred clients who tested HIV-positive to local care and support services. The capacity-building of counselors included periodic trainings and technical updates. Supportive supervision was provided to the counselors, and care was taken to prevent burnout.

In the Tirunelveli district, one of the high-prevalence districts in the state of Tamil Nadu, FHI established innovative community-based counseling and testing in response to the growing needs of migrants and their families. With about 40 percent of the district's population living below the poverty line, and a lack of livelihood opportunities, migration continues to be a key factor in the transmission of HIV in Tirunelveli. Until 2002, there was only one government counseling and testing center for 2.7 million people, and it was managed by counselors who were inadequately trained and supervised. Distance, location, timing, stigma, and lack of sensitivity of healthcare providers were other barriers. FHI and its partners increased accessibility

significantly by making counseling and testing available at doorsteps and at other convenient locations that clients suggested.

The effect of offering services at the community level has met a need particularly among women who would not otherwise have been tested. These women were often unable to negotiate changes in the risk behavior of their spouses, some of whom traveled on business, engaged in multipartner sex, or were abusive. Providing counseling and testing to these women was one of the most significant achievements of FHI's work in India.

Dominican Republic: Collaboration with Government and with NGOs

In the Dominican Republic, where the HIV epidemic is generalized, overall prevalence among adults is 1 percent. But rates as high as 5 percent can be found in the eastern, northern, and border regions, which have ports, free trade zones, tourism, and migratory populations, including communities of Dominican and Haitian sugarcane workers. Despite numerous discussions with the Ministry of Health about the importance of counseling and testing, little progress was made until the 2002 National Demographic and Health Survey was implemented, which required adherence to bioethical standards ensuring HIV counseling and testing for survey participants. This provided an opportunity to quickly ramp up the number of counseling and testing sites.

IMPACT's primary objective in the Dominican Republic was to provide technical assistance and support to the health ministry's program. Accomplishments included developing the national strategy, training counselors in HIV pre- and post-test counseling, and producing radio spots, signs, and posters to promote counseling and testing services.

In collaborative efforts with Fundación Genesis, a local NGO, IMPACT targeted health service providers in supporting data collection and monitoring to achieve rapid startup of counseling and testing sites. Programs renovated space for services, trained healthcare providers, and conducted monitoring and evaluation services. In the past, the ministry had perceived NGOs as competitors and resisted collaboration. But partnering with an NGO to set up counseling and testing services showed the potential for collaboration and the value of using NGOs to strengthen ministry programs.

IMPACT's experiences in the Dominican Republic also revealed the benefits of helping to build

The benefits of knowing one's status are many: those who learn they are HIV-negative may be motivated to learn more about prevention; those who test positive can gain access to care and treatment options.

the skills of local organizations and community leaders. During a pilot community mobilization project that aimed to increase demand for counseling and testing services, newly formed community committees helped promote services and follow-up. They conducted educational activities using creative yet low-cost promotional methods. Eventually the committees struck out on their own, continuing their work long after FHI's support ended. Under IMPACT, the network of counseling and testing service sites expanded to 110, providing a gateway to comprehensive HIV/AIDS services for the population and serving more than 100,000 clients nationwide.

Counseling and Testing: The Gateway to Health

Counseling and testing is a powerful tool against the spread of HIV/AIDS and a key entry point for medical, psychological, social, and legal interventions. The benefits of knowing one's status are many: those who learn they are HIV-negative may be motivated to learn more about prevention; those who test positive can gain access to care and treatment options. Rapid expansion of counseling and testing is now a priority in all countries affected by HIV/AIDS.

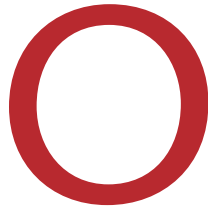
Under the IMPACT project, FHI's strategy of working with multiple partners and different service models was highly effective in expanding access to counseling and testing services. New developments, including the increased availability of antiretroviral therapy, have made client-initiated testing inappropriate in many cases, and in 2004 the global consensus was that the range of testing entry points must be increased through innovative new models in which counseling and testing is a more routine practice, with service providers initiating offers for testing throughout health facilities.

CHAPTER 5

Care and Treatment

Expanding the Range and Quality
of Comprehensive Services





Only a small number of people living with HIV worldwide have access to the full range of care and treatment services, including antiretroviral therapy. In recent years, however, falling antiretroviral drug prices and global funding initiatives to expand HIV care have made delivery of antiretroviral therapy in resource-constrained settings a real possibility.

FHI, under the IMPACT project, committed to integrating antiretroviral therapy into a continuum of care. Challenges were numerous, including problems related to drug supply, health infrastructure, provider availability and capacity, equitable service provision, and drug adherence.

FHI took many of the first steps in solving these problems, working closely with a wide range of partners, including national, provincial, and local leaders, health providers, community-based organizations, universities, and people living with HIV/AIDS. One of the first steps was to identify settings that offered the greatest potential for success. IMPACT and its key partners selected sites in Ghana, Kenya, and Rwanda, countries that offered strong government commitment to providing HIV treatment, well-established national AIDS programs, and existing IMPACT prevention and care interventions. In 2001, FHI provided funds to develop antiretroviral therapy “learning sites” in Ghana. In 2002, USAID announced it would support these learning sites as well as programs to integrate delivery of antiretroviral drugs into existing IMPACT programs in Kenya and Rwanda. FHI used its own resources to obtain initial drug supplies for Kenya and Rwanda, which helped leverage funds from USAID, the British Department for International Development (DfID), and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. In 2003, antiretroviral therapy learning sites were launched at hospitals in Ghana, Kenya, and Rwanda, and in late February, 2003, treatment began at Rwanda’s Biryogo Medical and Social Center. Four HIV-positive women, so ill that they had been unable to work, received the drugs for the first time and responded well.

Preparing for Antiretroviral Therapy

By 2001–02, leading officials in Ghana, Kenya, and Rwanda were committed to introducing antiretroviral therapy, but had yet to develop concrete plans. FHI brought together a range of organizations in each country to refine guidelines on antiretroviral therapy delivery. As in many other IMPACT initiatives, community involvement was a critical component of success. Research showed that many people were not being tested for HIV or seeking services because of the high level of stigma and

discrimination, even among health workers, against people in their community living with HIV and AIDS. IMPACT-sponsored advocacy, sensitization activities, and communication initiatives worked to reduce the stigma and remove this barrier to accessing services. At several sites, including Coast Provincial General Hospital in Kenya and the Biryogo Medical and Social Health Center in Rwanda, groups of people living with HIV and AIDS, as well as traditional local leaders, were engaged in the planning and implementation.

Providing ART to a growing number of countries

In 2006, the countries where IMPACT was managing antiretroviral therapy for the greatest number of people were Zambia (over 19,000), Kenya (nearly 13,000) and Nigeria (over 5,000). Since 2003, the number of sites providing ART grew from 1 to 40 in Kenya and from 1 to 18 sites in Rwanda. Not only is the number of sites increasing, but ART services are being provided at district and subdistrict hospitals and health centers. These successes are due in part to FHI's commitment to working within parameters established by host governments, its understanding of the issues involved in providing ART, and its extensive experience managing programs and funds in many countries.

Another important contributing factor is FHI's close collaboration with strong national partners, whether these are national governments, organizations of people living with HIV and AIDS (PLHA), universities, or faith- and community-based organizations. PLHA organizations build program sustainability. Their involvement from the beginning helps to increase the usage of ART by other PLHA by providing support counseling, adherence counseling, and couples counseling. Healthcare workers are also helping to scale up ART by providing quick HIV test results.

ART learning sites in Ghana, Kenya, and Rwanda established in 2003 provided critical lessons for providers introducing ART elsewhere:

- Work with local stakeholders and community members, including PLHA groups, to design, support, and evaluate clinic and community services.
- Act early to ensure a secure, uninterrupted supply of antiretroviral drugs.
- Inform communities about eligibility criteria for ART so they can promote adherence.
- Involve stakeholders to reduce stigma and discrimination.
- Strengthen links among health facilities and community-based programs, including home-based care and PLHA support groups.
- Formalize referral systems to meet patient and household needs.

Many new procedures and protocols had to be learned and workloads increased. IMPACT worked to lessen these difficulties while supporting high-quality service delivery.

At sites in all three countries, people needed accurate information about antiretroviral therapy. A frequent misperception was that antiretroviral drugs were a cure for HIV/AIDS; another was that the drugs would be available to anyone who wanted them. FHI contributed to the design of new education interventions, including materials produced in local languages, to counter such misinformation. It was also important that programs clearly explain eligibility criteria. Clinical criteria, drawn from national guidelines and World Health Organization recommendations, were similar across countries, while social criteria varied. In Ghana and Rwanda, for example, social criteria included the requirement that a patient disclose his or her HIV-positive status to at least one family member or friend. In Kenya and Rwanda, preference was given to health facility staff and their families. At all sites, criteria were thoroughly explained and widely disseminated, making clear the rationale for offering therapy to some and not others. This transparency was critical to maintaining community support.

Although the learning sites were already offering a complement of HIV prevention and care services, extensive preparations were required to optimize their ability to safely and effectively deliver antiretroviral services. IMPACT worked closely with its partners to renovate the delivery service areas at all sites to create more comfortable and functional environments for patients and health workers, build up laboratory capacity, and train laboratory staff. In some cases, basic requirements like uninterrupted electricity and clean water had to be procured. Lockable cupboards for drug storage were installed and refrigerators for the pharmacy were obtained. Drug procurement and distribution was a major concern, as each country had its own system for managing these activities.

IMPACT facilitated training for health workers at all three sites. Adding antiretroviral delivery to the facilities' roster of services placed enormous burdens on them, not just financially but also in terms of human resources. Many new procedures and protocols had to be learned and workloads increased. Burnout and staff attrition became obstacles to scaling up services. IMPACT worked to lessen these difficulties while supporting high-quality service delivery by developing and orienting staff on standard operating procedures and providing mentoring and on-the-job training opportunities to help keep staff informed and motivated.

In preparing sites for comprehensive HIV services including antiretroviral therapy, IMPACT also worked with its partners to establish delivery systems to address the needs of children and their families. Facility staff were trained in diagnosing and managing HIV in children, and antiretroviral pediatric formulations were procured. The education of caregivers was an area of primary focus to optimize the accurate administration of drug doses and tailor adherence strategies to each child's circumstances.

Counseling informed patients about the importance of adherence, as well as how to deal with medication side effects. Counselors stressed that drug therapy is not a substitute for prevention measures.

Bringing Antiretroviral Therapy to Patients

For antiretroviral therapy to succeed, patients needed to be motivated to adhere to a complex medication regimen. In Ghana, Kenya, and Rwanda, IMPACT helped develop protocols to prepare patients for this. Counseling informed patients about the importance of adherence, as well as how to deal with medication side effects. Another critical message imparted during counseling was that even when on antiretroviral therapy, patients are able to pass on HIV to others. Counselors stressed that drug therapy is not a substitute for prevention measures.

Overall immunologic and clinical responses to antiretroviral therapy at the three sites were very positive, with few patients discontinuing treatment. One of the most important factors contributing to these outcomes was the partnership developed between patients and service providers. With the proper preparation and training, providers were shown to be both technically capable and emotionally sensitive. In Ghana, for example, when nurses were concerned about patients they visited them—even during their off hours.

In all three countries, nurses were trained as adherence counselors, monitoring and supporting patients, especially in the early months of treatment. Patients themselves were encouraged to become active partners in their own care. In Kenya, FHI developed low-literacy materials for both patients and providers. The materials, along with counseling and family support, helped patients stay on track with their medications. Strong links between health facilities and community-based programs also contributed to patients' ability to achieve and sustain high rates of adherence. After six months of antiretroviral therapy delivery at the learning sites, patients were seeing significant improvements in CD4 cell counts and weight.

Children received antiretroviral therapy at all three learning sites, which required special attention to their needs. In Kenya, about 7 percent of people with HIV/AIDS receiving antiretroviral drugs in FHI-supported sites are children under age 15. FHI worked closely with the national AIDS program and stakeholders to develop low-literacy materials targeting caregivers of children known to be HIV-infected, and healthcare workers providing treatment and care services for children and their families. Of clients currently on antiretroviral therapy at the sites in Rwanda, about 12 percent are pediatric clients. FHI-supported sites are providing preventive therapy to 95 percent of infants involved in programs to prevent mother-to-child transmission of HIV.

Another component of effective HIV care and support programs was timely and reliable information management. IMPACT developed recording and reporting protocols and basic database systems at the learning sites.

To maintain a continuum of care and support for both children and adults, FHI helped formalize referral systems to ensure communication among a wide range of service providers and programs. In Ghana, IMPACT expanded its existing relationship with the Queenmothers Association, a traditional group providing services for vulnerable adults and children in the community. In Rwanda, existing referral links between Biryogo Medical and Social Center and Kigali Central Hospital facilitated rapid patient hospitalization and access to acute medical care. In Kenya, the Comprehensive Care Center at Coast Provincial General Hospital brought several HIV-related services together at one location, but even with services in such close proximity, referrals were not always systematic. Efforts to formalize referral networks are ongoing.

Another component of effective HIV care and support programs was timely and reliable information management. IMPACT developed recording and reporting protocols and basic database systems at the learning sites. In Ghana, program staff made the transition from hard-copy clinical forms to a software program that could handle large numbers of patients. In Kenya, FHI helped design a computer-based system. In Rwanda, staff filled out forms, and the information was entered into a database. Because data collection can easily be perceived as a bureaucratic burden, IMPACT reinforced the benefits of such practices: healthcare workers were educated about the importance of health management information systems as a way to ensure safety, optimize clinical effectiveness, and bring to light important lessons that can help improve services.

The learning sites served as models that were replicated in many countries, including Namibia, Nigeria, Tanzania, Zambia, Vietnam, and Cambodia. Working with a range of partners in Cambodia, for example, IMPACT developed a continuum-of-care program in Battambang Province. Activities included technical assistance and training, with involvement of community members and people living with HIV/AIDS throughout the process. In 2003, the Moug Roussey Referral Hospital became the first facility in Cambodia to offer comprehensive services including counseling and testing, all linked through an extensive referral system. When antiretroviral drugs became available in 2004, this strong continuum of care was in place to accommodate new client needs.

The long-term success of antiretroviral therapy programs for adults and children requires continuing expansion of programs to new sites and additional countries, while ensuring that existing programs are sustained. The demand for treatment is high, and challenges are many, but the learning sites have proven a critical point: even in the poorest settings, antiretroviral therapy can be delivered safely and effectively.

Targeting tuberculosis in areas with high HIV infection rates is critical because tuberculosis is one of the few infectious diseases fueled by the HIV epidemic that does not remain confined to people infected with HIV.

Tuberculosis: Tackling HIV's Co-Epidemic

HIV and tuberculosis are very different diseases, but both are prevalent in many of the same regions, and each accelerates progression of the other. HIV contributes to the reactivation of latent tuberculosis infection and makes individuals with recent tuberculosis infections more susceptible to rapid progression to active disease. Targeting tuberculosis in areas with high HIV infection rates is critical because tuberculosis is one of the few infectious diseases fueled by the HIV epidemic that does not remain confined to people infected with HIV. It is also one of the first opportunistic infections to appear in those who are infected with HIV, providing a warning sign that offers opportunities for early intervention. IMPACT programs worked to strengthen the capacity of tuberculosis programs, expand tuberculosis services to HIV-infected populations, and integrate HIV prevention and care interventions into tuberculosis control activities.

In Rwanda, IMPACT interventions helped the country's national tuberculosis program put in place strategies to ensure that clients with tuberculosis were screened for HIV, and those with HIV were screened for tuberculosis. IMPACT addressed the interaction between tuberculosis and HIV through pilot projects at two well-functioning, high-volume counseling and testing centers based at district hospitals in Kabyagi and Rwamagana. The purpose was to integrate preventive treatment for tuberculosis and other opportunistic infections into HIV counseling and testing services. The program promoted awareness of tuberculosis through outreach to clients' sexual partners and to communities, and provided HIV counseling and testing to tuberculosis patients.

The demand for tuberculosis preventive treatment in Rwanda was high, and by the end of May 2003, more than 6,500 people living with HIV and AIDS had sought these services for tuberculosis or other opportunistic infections. IMPACT activities expanded to include all counseling and testing sites in the country. The programs at Kabyagi and Rwamagana continue, and both have become antiretroviral treatment sites for clients who need HIV treatment.

IMPACT also helped scale up tuberculosis/HIV activities in Kenya—almost all tuberculosis patients are now screened for HIV. IMPACT assisted the national tuberculosis program in upgrading the National Tuberculosis Reference Laboratory, which is now equipped to perform tuberculosis cultures. Other activities included helping the national tuberculosis program implement a strategy to control tuberculosis in urban areas; supporting the national program in implementing a tuberculosis communication strategy that targeted symptom recognition, health-seeking behavior, and adherence; and assisting the national program in expanding community-based tuberculosis care in Western Province.

In Cambodia, IMPACT collaborated with the Gorgas Memorial Institute at the University of Alabama to develop a tuberculosis pilot project to address hard-to-reach populations in Phnom Penh, including squatters, prisoners, and people and families living with HIV/AIDS. The goal was to improve tuberculosis treatment-seeking behavior and treatment compliance among these vulnerable groups. The range of activities included surveys to determine prevalence, behavior change communication, community mobilization and education, and improvement of referral systems. IMPACT helped develop linkages to community and home-based care programs, strengthened government institutional care and services including tuberculosis screening and preventive therapy, and promoted counseling and testing as an entry point to prevention, care, treatment, and support.

Because HIV and tuberculosis are parallel infections, it is critical to respond to them not as separate challenges but as components of the same public health problem. IMPACT's tuberculosis interventions made measurable progress in integrating HIV and tuberculosis counseling, testing, care, and treatment worldwide.

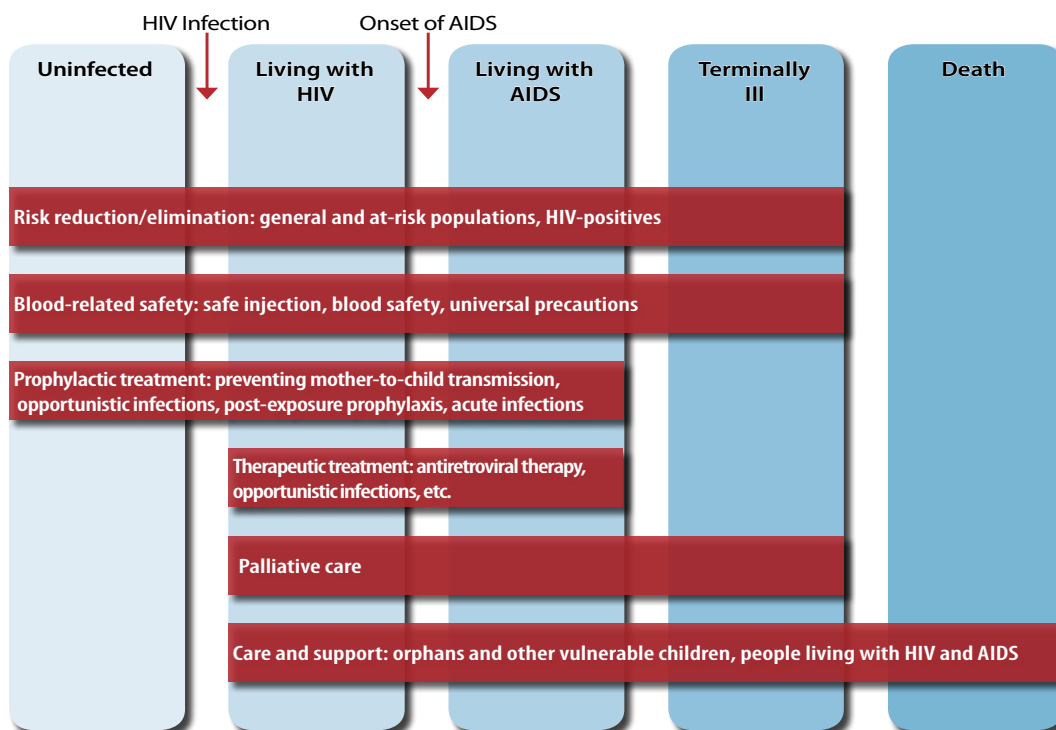
Preventing Mother-to-Child Transmission

IMPACT also focused on a rapidly evolving specialty in the continuum of caring for people affected by HIV/AIDS: preventing mother-to-child transmission of HIV, or PMTCT. FHI worked to integrate these programs into existing maternal and child health clinics, providing program implementation, technical assistance, training for health personnel, and development of tools, strategies, and technical documents. Programming included interventions to prevent women of childbearing age from becoming infected with HIV, as well as to prevent unintended pregnancies. For pregnant, HIV-positive women, interventions focused on preventing transmission of the virus during pregnancy, delivery, and breastfeeding. IMPACT also promoted male involvement to help prevent HIV transmission from mother to child, using a variety of innovations, such as fast-tracking men through clinics or offering separate counseling and testing services near antenatal clinics.

The PMTCT package delivered by IMPACT included HIV education, counseling, and testing; short-course antiretroviral therapy for mothers and infants; full-course antiretroviral therapy for mothers requiring treatment; counseling and support for optimal infant feeding; management of sexually transmitted infections; condom promotion; and follow-up care and support for women and children.

IMPACT supported PMTCT programs in more than 20 countries. In Ghana, for example, it was

HIV Prevention-to-Care Continuum



Under the IMPACT project, FHI developed the prevention-to-care and support-to-treatment continuum-of-services model shown here. Services are interconnected and seamlessly delivered to those who are uninfected, those living with HIV, and those living with AIDS—from onset through terminal illness if treatment is unsuccessful and, after death, to their families and children who may need support. The continuum shows that services can target the general population or specific populations such as orphans and other vulnerable children, youth, or women.

integrated into the maternal and child health clinics of Atua Government Hospital and St Martins Catholic Hospital. This involved training local nongovernmental organizations to sensitize community members, upgrading the maternity departments of the two hospitals, training staff, providing antiretrovirals, formalizing referral systems, and monitoring and evaluating the program. In 2004 the program was expanded to Korle Bu Teaching Hospital. The National AIDS Control Program and other partners are now applying the lessons learned from these three hospitals as they expand PMTCT services to other health facilities in the region.

As with all IMPACT interventions, local partners were shown to be effective in ensuring the success of programs. By establishing outreach clinics in brothel areas, for example, the project gained the support of brothel owners and managers.

In Rwanda, IMPACT supported PMTCT programs at 21 sites. From June 2001 to April 2005, 84 percent of the more than 30,000 women who attended antenatal clinics were offered counseling and testing during prenatal visits, and 97 percent of them were tested for HIV. Among 908 HIV-positive women who gave birth, 90 percent received antiretroviral preventive treatment during labor. IMPACT scaled up PMTCT offerings in Rwanda by supporting several new sites, some of which will provide antiretroviral treatment.

Through these and other PMTCT programs in countries including Kenya, Mozambique, Namibia, Nigeria, India, Nepal, Guyana, and Haiti, IMPACT significantly contributed to the global development of programs to prevent the transmission of HIV from mother to child. In keeping with IMPACT's overall strategy, interventions addressed PMTCT in the context of comprehensive HIV programming, with PMTCT as part of a continuum of HIV/AIDS prevention, care, treatment, and support.

Preventing an Epidemic: STI Control in the Philippines

In countries where HIV/AIDS has not yet taken hold, care and treatment for sexually transmitted infections, or STIs, can play a key role in preventing an epidemic from developing. In the Philippines, although HIV prevalence is low, rates have been increasing. As of December 2005, 2,410 AIDS cases had been reported. Primary at-risk populations include sex workers, men who have sex with men, injecting drug users, and male clients of STI clinics. Although there is awareness among these groups of HIV and how to prevent it, high rates of STIs indicate high levels of risky behavior—and the potential for a devastating HIV epidemic. Effective STI treatment can help shorten the period during which STIs can be transmitted, contributing to a reduction in STI prevalence and in HIV transmission.

Challenges to STI control include poor accessibility, acceptability, and availability of services, as well as the use of ineffective drugs. FHI research revealed low HIV prevalence but high rates of syphilis in some areas, including Angeles City, the former site of a US military base. Angeles City hosts a large number of sex-oriented establishments that attract tourists and local patrons. Thousands of registered and freelance sex workers operate from both licensed establishments and informal settings, including brothels and on the street. Registered sex workers have good access to STI services through the system of social hygiene clinics, but the quality and efficacy of the services are minimal. Freelance sex workers and others who are not part of the clinic system generally have even poorer access to care. Stigmatization and lack of privacy also deter at-risk individuals from seeking treatment.

IMPACT helped expand and enhance treatment to attain a rapid decrease of STIs in Angeles City. Improvements included reinforcement of routine screening of registered sex workers, improved access,

and promotion of 100 percent condom use in commercial sex. Services included a round of treatment (a single dose of the antibiotic azithromycin) for both registered and freelance sex workers and their clients. This treatment was effective in rapidly reducing high rates of gonorrhea, syphilis, and chlamydial infection. Approximately 1,500 registered and 1,000 freelance sex workers in Angeles City were eligible for the treatment, along with clients who had had sex with a female sex worker in the previous month. STI rates among these clients dramatically dropped after the single round of treatment.

As with all IMPACT interventions, local partners were shown to be effective in ensuring the success of programs. By establishing outreach clinics in brothel areas, for example, the project gained the support of brothel owners and managers. IMPACT also helped to develop a manual of operations to establish and maintain standards of care and treatment, and assisted in training a group of social hygiene clinic staff in the use of the manual.

Enhanced STI control efforts combined with a single round of presumptive treatment were effective at significantly reducing STI prevalence, but presumptive treatment is a short-term intervention to reduce high prevalence rates in key populations, not a sufficient control measure by itself. Maintaining low levels of STI prevalence requires a broad range of preventive and curative services. Through interventions worldwide, IMPACT addressed this challenge by working to improve the quality, availability, and demand for STI services.

Care and Treatment: Part of a Comprehensive Response to HIV/AIDS

The effective, equitable, and ethical delivery of HIV/AIDS care and treatment is an ongoing challenge. Care and treatment interventions must be linked with counseling and testing to identify and support people in need of services and deliver those services successfully. And once programs are in place, resources must continue to be allocated to ensure sustainability. IMPACT's strategy of developing a strong continuum of care not only provided adults and children worldwide with access to quality HIV/AIDS counseling, testing, care, and treatment; it also laid the groundwork for the continuum to be strengthened at each critical point as the pandemic evolves.

CHAPTER 6

Orphans and Other Vulnerable Children

Increasing Communities' Ability
to Care for Those Most at Risk



While most people living with HIV/AIDS are adults, the pandemic affects millions of children and puts many more at risk. An estimated 15 million children have lost one or both parents to the disease, a figure expected to rise to 18 million in sub-

Saharan Africa alone by 2010. Millions more children are adversely affected before they become orphans. When parents and other family members become ill, children have to take on greater responsibility for food production, income generation, and care of the sick and of younger siblings. While adults are more likely to contract HIV, the number of infections among children has steadily risen despite advances in treatment to prevent mother-to-child transmission. Every minute of every day, a child under age 15 dies of AIDS-related illness, and every year approximately 640,000 children under 15 are newly infected.

IMPACT programs recognized the need to target not just orphans but all children made vulnerable by HIV and AIDS, and to consider the numerous and complex challenges in their lives. Orphans and other vulnerable children face overwhelming obstacles: poverty, neglect, abuse, poor health and nutrition, and lack of education. Children without the care and protection of parents are particularly vulnerable to sexual exploitation. And many families that lose a male head of household to AIDS become victims of property grabbing—relatives may take household items and even the home of the deceased man away from his widow and children.

For children to be able to cope with such circumstances, they need the support of family and community. While orphanages may seem like a good solution to some, they should in fact be understood as a last resort. Institutions can provide food, clothing, and education, but usually can't meet children's emotional and psychological needs. There are too few caregivers to provide the attention and affection children need to grow and develop successfully. Children in institutions, lacking family connections, often fail to develop a strong identity and sense of belonging. Institutional care is also more expensive than care by a family; it's simply more cost effective to support families so that children can stay in their own communities.

Strengthening family units and creating healthy, supportive environments for children were major goals of FHI under the IMPACT project. FHI designed programs to strengthen families' ability to care for children by prolonging the lives of parents, providing economic aid, psychosocial support, and other assistance, and making involvement of community- and faith-based organizations a priority.

Some of the women had lost everything to property grabbing when their husbands died, but assistance from SCOPE enabled them to provide food and school fees for their own children.

Building Community Capacity in Zambia

In response to the growing numbers of children orphaned and made vulnerable by HIV and AIDS in Zambia, IMPACT launched the SCOPE-OVC project (Strengthening Community Partnerships for the Empowerment of Orphans and other Vulnerable Children) in 2000. SCOPE-OVC became one of the most comprehensive efforts among FHI programs to support children and their families by mobilizing communities and strengthening their capacity.

Based in 12 districts throughout Zambia, SCOPE provided grants to community-based organizations and supported more than 70 projects proposed by faith-based and nongovernmental organizations, charities, healthcare providers, government agencies, and the private sector. These projects benefited more than 200,000 Zambian children and their families. Programs focused on key areas such as psychosocial support. One successful strategy involved training home-based-care volunteers working with AIDS-affected families, who already understood the needs of children and recognized the behaviors indicating emotional stress (including withdrawal, delinquency, truancy from school, and difficulty interacting with others). The training helped these volunteers integrate psychosocial approaches into the assistance they provided families and improved their ability to identify children in need of counseling and other support. SCOPE also contributed to the creation of committees made up of leaders and stakeholders active in the community to define strategies and deliver interventions. Because of their deep roots in their communities, these committee members were especially good at identifying the needs of children affected by HIV and AIDS.

Other SCOPE interventions worked to achieve economic stability for children and their families. For example, projects provided assistance to the Makeni Women's Cooperative Society, a group made up largely of widows determined to increase their household incomes and also help orphans in the community. With a SCOPE grant, the group increased production and built a market for its chosen product, oyster mushrooms, a high-value crop. The Makeni Catholic Church and other organizations helped the group open a daycare center. Some of the women had lost everything to property grabbing when their husbands died, but assistance from SCOPE enabled them to provide food and school fees for their own children, recruit new group members, and offer support to new widows and their children.

Another SCOPE innovation was the creation of no-fee community schools. Owned and managed by the community, and largely volunteer-run, the schools provided basic primary education to vulnerable children, especially orphans and girls. SCOPE supported these schools with training, grants, psychosocial support, books, and furniture, as well as networking benefits. The Mulenga

To counter resistance from parents community schools set up school-parent committees that promote attendance and encourage parents to see children's education as a necessary investment in the future.

Community School near Kitwe, for example, served a poor community with high unemployment and high AIDS morbidity and mortality rates. SCOPE provided a range of materials, supplies, and training. Psychosocial support training for teachers and staff helped them to feel more comfortable and informed when dealing with vulnerable children and to become better advocates for these children. Enrollment increased from 150 to more than 1,000 in just four years, the school continues to improve its curriculum, and the Ministry of Education is now supporting the school. To counter resistance from parents, who may want to keep children—especially girls—at home, community schools set up school-parent committees that promote attendance and encourage parents to see children's education as a necessary investment in the future.

Solving the problems of children affected by HIV/AIDS requires an in-depth understanding of all aspects of their lives and environments, and demands more support than just the materials necessary for physical survival. A wide range of services and strategies must be employed to ensure that children have stable families and communities to help them grow and thrive. By strengthening communities, IMPACT created more positive, healthy environments for Zambian children vulnerable to HIV/AIDS.

Partnering with Government in Tanzania

In Tanzania, an estimated 1.4 million people are living with HIV/AIDS. Approximately 6.5 percent of people ages 15 to 49 are infected, and of the country's 14 million children, 110,000 are living with HIV/AIDS. Orphans are less likely than other children to attend school, and they are at greater risk of living in extreme poverty and contracting not only HIV but also other diseases, including malaria.

On behalf of the Tanzania AIDS Commission, a team of specialists led by IMPACT assessed the Tanzanian national response to the challenges facing orphans and vulnerable children, the first such effort to focus specifically on the needs of these children. Field visits were undertaken to regions with high HIV prevalence rates and a high number of orphans. After the assessment, IMPACT partnered with the government to develop a strategy to improve the quality of life for orphans and vulnerable children, their families, and all people with HIV/AIDS, through increased access to quality care, treatment, and support services. FHI helped Tanzanian national agencies to lead and coordinate programs by providing technical support to both the Ministry of Labor and Social Welfare and the Tanzania Commissioner for HIV/AIDS in their efforts to develop a national strategy, which resulted in a national plan of action to ensure quality programs for orphans and other vulnerable children. FHI also designed a national data management system for tracking children and service providers. Responding to the government's request, IMPACT took on a leadership role in the development of national quality standards of service

Mobilizing communities to support orphans and other vulnerable children

IMPACT launched the Strengthening Community Partnerships for the Empowerment of Orphans and Other Vulnerable Children (SCOPE-OVC) project in Zambia in 2000. At that time, more than three-quarters of Zambia's estimated 1 million orphans had lost at least one parent to AIDS, and it was estimated that the number could double by 2010.

SCOPE takes a multisectoral approach to support orphans and other vulnerable children and their extended families by mobilizing and strengthening community capacity to respond. Working through district- and community-level committees, SCOPE provides grants to support projects and community-based organizations. It also contributes training, technical assistance, and small loans for community initiatives and training in organizational and financial management for community-level committees.

SCOPE also works with district-level committees to identify gaps and bottlenecks in service delivery, create referral systems and links to resources and services, scale up existing interventions, and advocate for OVC. SCOPE also works with community-level committees, whose members define strategies and deliver interventions that address the needs of OVC in their immediate localities.

SCOPE-supported programs pioneered culturally appropriate, community-based psychosocial support for OVC. The project also trained program managers on how to initiate interventions for grieving children and how to detect signs of physical, emotional, and sexual child abuse. Links forged with a broad spectrum of community organizations and official agencies help programs deal with cases of property grabbing, child abuse, and neglect.

SCOPE also initiated training for home-based care volunteers who already work with AIDS-affected families so that they can integrate psychosocial approaches into their assistance and identify children who will need ongoing counseling and other support. The creation of memory books and memory boxes now form part of this assistance. Volunteers help children (and sometimes dying parents) to assemble photos, letters, and other mementos that create a consoling physical legacy and offer opportunities to talk about the future.

To improve the financial security of AIDS-affected households and OVC, SCOPE provides agricultural training and access to improved farming technologies. The project has helped widows support each other and survive land-grabbing and other predatory behaviors, and its small grants have helped build a market and open an orphans' day care center. Income-generating activities in nonagricultural areas have included a business training program and a loan fund.

Because many OVC are forced to forgo formal education—they lack school fees or must work to replace lost income or take over household duties—helping them stay in school is a critical issue for Zambia's future. The creation of no-fee, largely volunteer-run, community schools is one solution that SCOPE supports by providing books, furniture, and other supplies; teacher training in psychosocial support and advocacy; grants; and networking opportunities.

provision that demonstrated to program implementers the kinds of services that should be provided in programs targeting orphans and other vulnerable children; they also provided guidelines on how programs should be evaluated. Rollout of the national plan of action and the data management system is currently underway, while discussions continue on the national quality standards of service provision.

Under the IMPACT project, FHI supported national facilitator teams, which were created by the government to monitor and enhance the capacity of care providers at the district and community levels. IMPACT trained teams in integrated home-based care and care for orphans and other vulnerable children, specifically focusing on caregiving, identifying children in need of services, and community justice. Facilitator teams were trained to uphold community justice by implementing proper frameworks at community levels to ensure that orphans and other vulnerable children were provided legal protection to secure their rights.

Working in alliance with international humanitarian organization CARE, FHI partnered with nongovernmental organizations to provide care and support to adults and children affected by HIV/AIDS in several regions of the country. Each organization supplied a different component, including nutritional support, economic strengthening, monitoring and evaluation, and stigma reduction. CARE provided management support and FHI offered training in child care and support. Together, CARE and FHI formed the Tumaini Alliance (*tumaini* means *we hope* in Swahili).

IMPACT initiatives in Tanzania showed the importance of integrated interventions targeting vulnerable children with home-based care. They also demonstrated the benefits of collaboration with government to reach the greatest possible number of children with high-quality, sustainable programs.

Building Capacity in Namibia: Supporting Government and NGOs

Namibia has a distressingly high HIV prevalence rate and is home to an estimated 180,000 orphans and other vulnerable children. The country's recent independence and history of apartheid left it with few civil society organizations. Food insecurity, bureaucratic obstacles to basic social services, and the high prevalence of violence against women and children are serious barriers to care and support for orphans and other vulnerable children. IMPACT programs worked on both the national and community levels to improve these children's lives.

Working at the national level was essential to develop policies and guidelines that would ensure programs could be successfully implemented. FHI undertook a range of activities, including support for the Ministry of Gender Equality and Child Welfare National Program for Action for Children and the

At the regional and community levels, IMPACT focused on expanding educational opportunities for children affected by HIV and AIDS and developing community and faith-based support system.

Permanent Task Force for OVC, which guides programming for orphans and other vulnerable children in Namibia. IMPACT also supported the ministry in developing the National OVC Policy, which was launched by the president in 2005. At the request of the ministry, IMPACT began the process of developing a national database to register all orphans and vulnerable children; the database will facilitate and coordinate care, support, and protection services.

IMPACT also partnered with multiple local nongovernmental and faith-based organizations to offer care and support through church and community systems. At the regional and community levels, IMPACT focused on expanding educational opportunities for children affected by HIV and AIDS and developing community and faith-based support systems—with special emphasis on psychosocial support through experiential learning camps, after-school programs, and home visitation by specially trained home-based-care volunteers. Psychosocial training, including training in grief and bereavement counseling and the creation of support groups, increased families' and communities' ability to support orphans and other vulnerable children.

IMPACT partners each offered particular resources and strengths. In partnering with the group LifeLine/Childline, for example, IMPACT contributed to their program that focused on teaching children about sexual abuse and how to prevent it, giving them the skills to respond to unwanted sexual approaches, and educating them about HIV/AIDS. With IMPACT's support, the program expanded to include a national call-in radio program for and by children; a participatory drama program involving more than 65,000 third and fourth graders; and a referral program for children in need of long-term counseling and support.

IMPACT and its partners also concentrated on expanding educational opportunities. In 2001, IMPACT partnered with Catholic AIDS Action (CAA), a local NGO, to promote full school participation for orphans and other vulnerable children, with an emphasis on increasing educational opportunities for girls. CAA's campaign reached out to educate community leaders, volunteers, and caregivers about the rights of all children to attend school, and worked to waive school fees. Over the course of the program, over 27,000 orphans and other vulnerable children received school uniforms and supplies, enabling them to attend school with pride and dignity. IMPACT staff also administered two privately funded scholarship programs with CAA, providing complete school expenses for 350 of Namibia's "best and brightest" secondary school students annually. In addition to providing educational support, CAA offered services including psychosocial support, access to health services, and supplemental nutrition.

In collaboration with three partners, IMPACT developed a monitoring and evaluation toolkit to assist providers in collecting quantitative and qualitative information to help improve services. Staff from the Ministry of Gender Equality and Child Welfare and local organizations have used or adapted parts of the toolkit. In keeping with its strategy of building local capacity, IMPACT also sponsored both governmental and nongovernmental stakeholders to attend a variety of trainings and conferences. By enabling stakeholders to participate in local, regional, and international technical meetings, FHI contributed to the sustainability of programming well beyond the end of the IMPACT project.

Compassion and Spiritual Influence in Cambodia

Cambodia is home to more than 400,000 vulnerable children, and an estimated 77,000 who have lost one or both parents to HIV/AIDS. Many of these children are at risk of being caught up in a vicious cycle of poverty, sex work, and HIV infection. In 1999, IMPACT began supporting the government's effort to help children affected by HIV and AIDS by conducting workshops, consensus meetings, and trainings, disseminating information, and providing technical support. In addition to collaborating with national institutions, FHI helped strengthen local NGOs to provide care and support to children and families affected by HIV and AIDS.

One initiative centered on the Kien Kes Health and Education Network (KKHEN), which operates out of a Buddhist temple in Battambang, not far from the Thai border. Starting with a small budget and no paid employees, KKHEN began offering care and support to people living with HIV and AIDS. As respected leaders, the temple's monks provided not just spiritual support but also an example of treating people living with HIV and AIDS with understanding and compassion. FHI held numerous trainings to familiarize the monks with HIV/AIDS and to teach them how to conduct home-based care, provide psychosocial support, and mobilize a community response. The monks then trained volunteers carefully chosen from the community.

The IMPACT project supported KKHEN's many interventions, such as helping orphans and other vulnerable children stay in school by negotiating exemptions from school fees and providing basic food support to people living with HIV and AIDS. KKHEN taught vocational skills including gardening and sewing to families affected by HIV and AIDS, and provided music lessons so that some of the children could learn to play traditional musical instruments, for pay, at community gatherings. KKHEN provided care and support to nearly 10,000 families. To reach even more families, the network facilitated a workshop and other meetings with monks from 30 pagodas, to guide them in bringing similar programs to their communities.

KKHEN programs provided children and their families with four major types of services: access to essential health services, socioeconomic assistance, human rights and legal support, and psychosocial support. The network's staff and community assistants regularly offered community education sessions covering such topics as nutrition, hygiene, HIV transmission and prevention, and palliative care for people living with HIV and AIDS. IMPACT worked to help local hospitals serve as strong referral outlets for services including HIV counseling and testing, antiretroviral therapy, and prevention of mother-to-child transmission of HIV.

FHI and its partners in Cambodia developed a communication strategy that included a series of books created especially for children. The colorfully illustrated *You Are Special* books, for example, helped children learn to deal with stress and other issues related to HIV/AIDS. The books incorporated both Western biomedical practices and traditional cultural wisdom. Along with illustrations of children and adults, both sick and well, at home and in other familiar environments, the book describes how HIV/AIDS affects families and how children can cope. The text gives advice on how to stay healthy, suggests ways of talking with friends about HIV status, and explains how to use traditional breathing practice and meditation.

IMPACT initiatives in Cambodia took a multisectoral, collaborative approach to providing for the needs of children affected by HIV and AIDS. Partnership with faith-based organizations greatly contributed to the programs' success, and the Buddhist value of compassion underpinned many effective interventions. With the encouragement of local religious leaders, communities that had once shunned these children learned to embrace and support them.

Including All Children in the Continuum

Orphans and other vulnerable children around the world face overwhelming hardships and uncertain futures. A holistic approach is required to reach them with the care, support, and treatment they need. By partnering with both governments and nongovernmental organizations, IMPACT ensured that programs were supported locally and tailored to individual communities and country contexts. From programs that supported basic services such as school assistance, to community-led activities like home-based care and pastoral counseling, to regional and national policy efforts to establish guidelines and standards, IMPACT provided critical support worldwide to children and families struggling to meet the challenges of HIV and AIDS.

CHAPTER 7

Looking Ahead

Strengthening Infrastructure, Integration,
Quality, and Human Capacity



USAID's IMPACT Project accomplished what it set out to do and more, reducing HIV transmission in large segments of the population; reducing morbidity and mortality due to HIV/AIDS; improving the quality of life for those living with HIV/AIDS; and helping mitigate the impact of the epidemic. IMPACT also introduced behavioral surveillance surveys to understand how and why the epidemic was spreading, integrated home-based and palliative care, greatly expanded counseling and testing programs, introduced antiretroviral therapy for the first time, and provided prevention and treatment services for tuberculosis and sexually transmitted infections. In short, IMPACT began the transition from primarily prevention responses to a more comprehensive prevention and care approach, carefully adapted to the varied local contexts in which the epidemic occurs.

Looking ahead, it is clear much more needs to be done. Working together with governments, the private sector, civil society, and local communities, the international community needs to sustain the progress made so far and continue to increase and improve the coverage and scale of the response. As of this writing, over 1 million people are on antiretroviral therapy, but many millions more—including infants and children—remain untreated due to high prices of medications and laboratory equipment, problems with the supply chain, and inadequate human and health services infrastructure.

In addition to increasing the numbers of people on antiretroviral therapy, there is a need to increase the scope and improve the quality of services included in the continuum of care model pioneered by IMPACT. For example, as healthcare systems strengthen, more reproductive health and family planning services can be offered, in addition to interventions to improve nutrition and food security; combat malaria, tuberculosis, and sexually transmitted infections; and use strategic behavior change activities to reduce high-risk behaviors. Other services to be expanded include psychosocial and palliative care, and pain management. To enable this expansion, investments in infrastructure will be required to develop, strengthen, and scale up such services and coverage. Human resources will also have to be trained and sustained.

With improved and better-staffed healthcare systems, the range of services must be better integrated to seamlessly meet the needs of individuals and families seeking HIV/AIDS care. The services should be made available throughout the life-cycle of the epidemic, from before HIV conversion, to AIDS,

and ultimately to end of life and bereavement. Moreover, services should be provided in whatever settings they are needed, whether healthcare facilities, homes, schools, or workplaces.

Finally, the pace of research must be accelerated to provide insights into how best to respond to an ever evolving epidemic. As our knowledge increases so will our ability to respond in appropriate and creative ways. Possible research questions include

- What are the best contraceptive methods (in addition to condoms) for preventing unintended pregnancies in HIV-positive women who do not wish to become pregnant?
- Can prophylactic use of antiretroviral drugs decrease the risk of HIV acquisition?
- Can traditional practitioners safely perform male circumcision to reduce the chances of HIV transmission?
- Can improved laboratory testing technologies help better estimate rates of acute infection (the early, primary phase of infection when the virus seeds itself throughout the body) and thus determine the optimal time to intervene in a particular epidemic?

Finally, future efforts should explicitly recognize that, while the model of working through implementing agencies (as IMPACT did) is most likely to lead to sustainable change, this approach requires building the capacity of the implementing partners not only to carry out the work, but to manage and sustain themselves for the long term. Building such capacity takes time, and implementers such as FHI and its partners need to seek creative ways to bridge the donor needs for timely results with the longer-term goals of strengthening organizations' capacity to sustain their efforts after the donors have left.

In future interventions, some of the key lessons learned from IMPACT should be applied in their design and implementation. For example, improved methods of monitoring should be sought to measure and evaluate activities on an ongoing basis. Quality improvement practices should be incorporated into the design and implementation of projects to ensure desired outcomes are achieved. Promising new interventions, lessons learned, and best practices need to be more fully documented, and the insights gained should more directly inform programming.

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