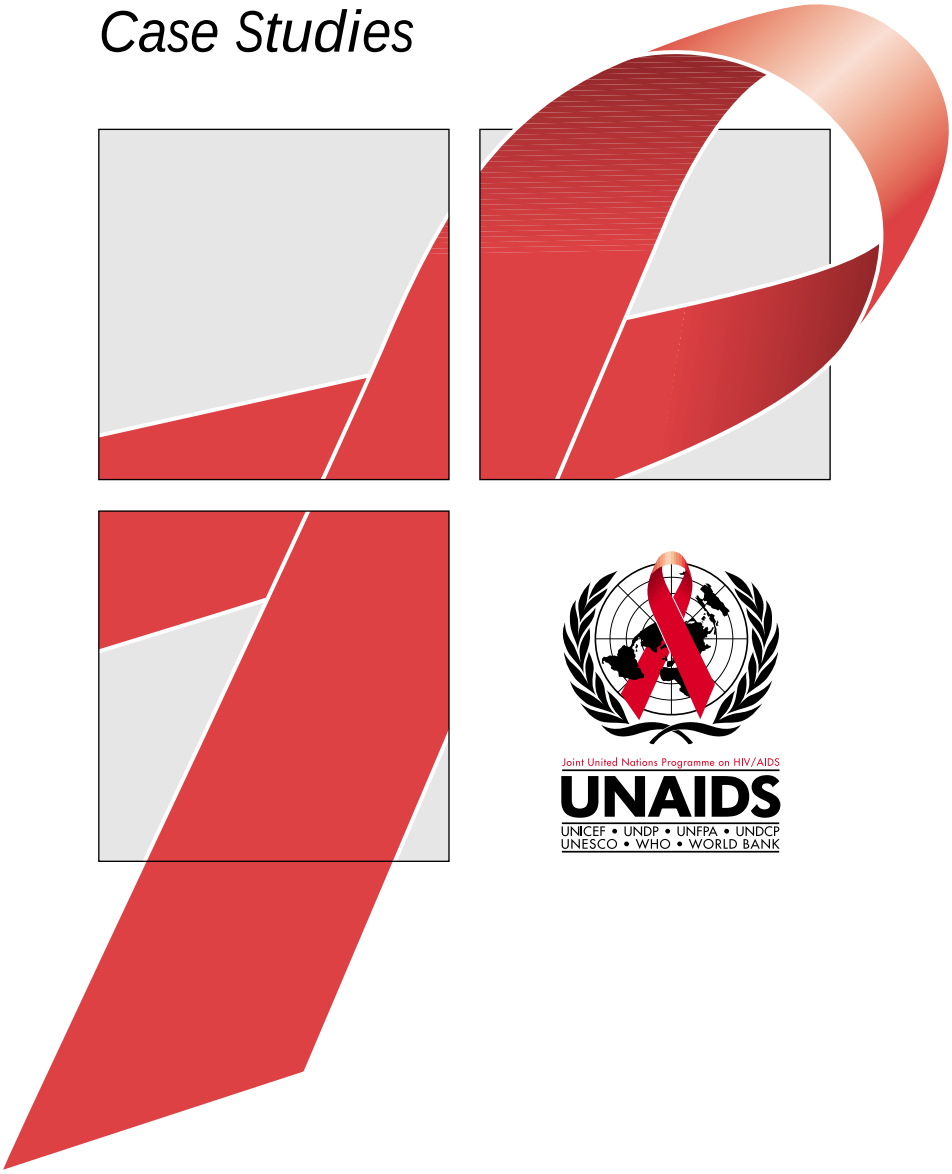
Innovative Approaches to HIV Prevention

Selected Case Studies



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Innovative Approaches to HIV Prevention

INTRODUCTION

By the end of 1999, there were an estimated 34.3 million adults and children living with HIV/AIDS in the world and there had been some 18.8 million deaths. Sub-Saharan Africa remains the centre of the epidemic, with nearly 25 million men, women and children infected with HIV/AIDS. In Asia, an estimated 7 million people are infected, and rates are increasing in countries such as India and China. Parts of Central and Eastern Europe are also witnessing an alarming increase in HIV infection rates (UNAIDS, 2000).

Over the last two decades, much has been learned about HIV prevention. Some of this new knowledge comes from carefully conducted evaluation studies, programme reviews, the documentation of existing good practices (UNAIDS, 1999), meta-analyses and reviews (e.g. Gibney, DiClemente & Vermund, 1999), and the observations of field workers, nongovernmental organizations (NGOs) and health promotion practitioners.

All of these information sources have proved to be valuable in indicating the most appropriate and promising interventions. By providing different kinds of information – for example, indicating changes in the prevalence and incidence of infection; changes in reported behaviours; increases in related service utilization or condom sales; or improved HIV-related knowledge, beliefs, attitudes and skills – each contributes to our understanding of what can 'work' in HIV prevention.

The following five criteria are particularly valuable when evaluating HIV prevention programmes:

1) Relevance
   - perception as relevant by target groups
   - cultural and contextual relevance
2) Efficiency
   - well coordinated planning and implementation
   - reach
3) Impact
   - impact on reported rates of STD and HIV
   - impact on HIV and AIDS-related knowledge, beliefs and attitudes
   - impact on safer sex practices and safer forms of drug use
4) Sustainability
   - generalizability to other contexts
   - cost-effectiveness
5) Ethical soundness

It is important to note, however, that the success of any intervention will depend to a large degree on the appropriateness of what has been done. Every intervention occurs within a specific context, and local context as well as the stage of the epidemic must be taken into account when planning, designing and implementing HIV prevention programmes. It is also critical to remember that interventions at *multiple levels* are nearly always needed in order to encourage people to adopt and sustain safe sex and drug use practices, as well as to establish the enabling and supportive environments necessary for reducing vulnerability to HIV infection.

METHODOLOGY

The identification of a number of innovative and promising interventions was achieved through consultations with various experts in the field of HIV/AIDS prevention at the international, regional and local levels, as well as through reviews of published literature. A parallel project supported by UNAIDS, and based within the East-West Center in Hawaii, has recently established an archive of HIV prevention studies. The aim of this report is to complement this and similar reviews.

Information was sought from key individuals working in international agencies and charitable foundations at headquarters, and when necessary, followed-up at the regional level. Information was also gathered from individuals within UNAIDS and cosponsoring agencies at headquarters as well as at regional and national levels. A standard *pro forma* was used to alert individuals to the nature of the project's work and to invite collaboration and participation. Copies of this *pro forma* were subsequently sent by e-mail, fax or post to named individual contacts at intercountry and country level. This invited the nomination of local programmes, projects and activities to be considered for inclusion in this review.

Contact was then made with individual projects via their manager or coordinator and descriptions of their ongoing work were elicited under a series of headings. These included:

- the location of the project, contact details and the funding agency;
- an overall description of the work of the project;
- a statement of project activities and outputs to date;
- information about evaluation and project outcomes;
- a description of any innovative aspects of the work;
- a statement of constraints/obstacles affecting local activities and the success of the interventions.

The activities undertaken as part of this work should not be regarded as comprehensive. Rather, the aim is to identify key studies and investigations on HIV prevention interventions beyond information dissemination. Thus, this work provides a set of intervention examples for HIV prevention and highlights some of the key issues to consider when designing, implementing and evaluating HIV programmes.

WHAT WORKS IN HIV PREVENTION?

Over the last two decades, a great deal has been learned regarding effective interventions for HIV prevention. When the first cases of AIDS were reported in the early 1980s, individuals and groups acted to alert people to this dangerous new disease and the steps that could be taken to protect against it. Even before HIV was isolated, safer sex and safer drug use guidelines had been developed based upon epidemiological evidence concerning patterns of transmission. However, providing people with information about how to protect against infection has proven to be insufficient in and of itself. People require enabling environments that will reduce their susceptibility and vulnerability, and allow them to modify their behaviour based on their knowledge gained through information provision.

National level

At the national level, political commitment at all levels has been shown to be essential for programme success. Multi-level interventions that seek to involve a variety of partners in co-ordinated action have been shown to be more successful than those that work in isolation (UNAIDS, 1998a, 1998b, 1998c, 1999). Furthermore, coordinated economic, political and social effort are required to reduce societal vulnerability alongside programmes and interventions operating at individual and community levels (UNAIDS, 1998d).

Global experience has shown the following elements to be among those central for effective national HIV prevention efforts:

- *general awareness-raising activities* to provide information and counter negative reactions among the population at large;
- *focused persuasive action* to meet the needs of specially vulnerable groups and communities, with steadily expanding coverage;
- *multi-sectoral and multi-level partnerships* to deliver programmes and services across a range of contexts;
- *community involvement* in programme and intervention development, and building upon the will of groups and individuals to contribute to national HIV prevention efforts;
- greater *integration between prevention and care* to reduce costs and to reduce levels of discrimination and stigmatization;
- action to build *societal resistance* to HIV transmission and reduce the systematic vulnerability of particular individuals, groups and sections of society.

(Piot and Aggleton, 1998)

Community level

Following a recent review of successful community-based projects and activities (UNAIDS, 1999), a further set of principles has been identified outlining some of the factors that need to

be taken into account if community-based prevention activities are to be effective. These include:

- *engaging the community* through existing organizations, groups and structures for education and support;
- *building partnership* and trust through communication, networking and collaboration;
- *including people with HIV and AIDS* at all stages of the process so as to enhance visibility and benefit from their skills and experiences;
- creating *an accepting community environment* in which HIV and AIDS are acknowledged to be everyone's concern.

Beyond these principles, community-based approaches need to make certain that resources are directed towards community capacity-building in order to ensure sustainability.

Programme/project level

At the programme/project level, the following factors are central to programme success when adequately operationalized.

- the provision of *information* in culturally appropriate ways about how HIV is and is not transmitted;
- the inclusion of *activities* that encourage people (both as individuals and communities) to appraise the risks that face them personally;
- the provision of *training* in skills for communication and (where it is feasible) sexual negotiation;
- the provision of enhanced *access* to resources such as condoms and appropriate and affordable health services, including those for the early detection and treatment of sexually transmitted diseases (STDs).
- the *participation* of target groups at all stages of design, implementation and evaluation;
- the *monitoring* of programmes/projects at all stages of development and implementation.

Group level

Prevention approaches need to be tailored to the needs of particular groups.

When working with ***young people***, for example, it is important to:

- take into account the *diversity* of young people and their needs;
- encourage *youth participation* in project design and implementation;
- work in a climate of *openness* that recognizes and respects the realities that young people face;

- focus on *young men's sexual health*, as well as sexual health issues relating to *young women*;
- examine the *positive* aspects of sexual health;
- promote greater awareness of *sexual and reproductive rights*;
- provide opportunities to address issues of *gender*, social status and sexuality;
- undertake work with *young men* to enable them to think about their role in relation to both their sexual health and that of their partners;
- promote greater awareness of the *structural issues* affecting the sexual and reproductive health of young people, including the need for improved rights and protection for young people;
- improve access to basic *education* and timely sex and HIV-related education;
- provide access to *voluntary counselling and testing services*, along with appropriate referrals;
- increase access to *youth-friendly health services.*

When working with ***women,*** it is important to:

- use a *multifaceted approach* that addresses economic and other needs which may take priority over HIV/AIDS in the daily lives of women living in poverty in developing countries;
- focus on *improving communication between sexual partners* which acknowledges the difficulties women encounter in talking and negotiating with men about sex;
- increase awareness of the importance of *including men* in work for the prevention of HIV among men, women and children;
- address the need for improved *health services* for women;
- acknowledge the importance of a *gendered approach* to HIV prevention work, which includes discussions of power relations between men and women;
- provide access to *voluntary counselling and testing services*, along with appropriate referrals;
- acknowledge the *support* that women can provide to each other through open discussion and the development of networks.

When working with ***people who inject drugs,*** it is important to:

- focus on *harm reduction* as well as *rehabilitation*;
- *advocate* to protect the rights of people who inject drugs;
- adopt a *multi-pronged approach* including needle and syringe exchange and the provision of drug treatment, including detoxification, substitution pharmacotherapy, HIV/AIDS care and social network interventions;

- provide *drop-in services*, mobile services and outreach work;
- work to improve the *sexual health* and sexual practices of people who inject drugs;
- undertake HIV prevention activities when *seroprevalence is still low*;
- establish *trust* between people who inject drugs and health workers through outreach work;
- provide good access to *sterile injecting equipment* and condoms;
- provide access to *voluntary counselling and testing services*, along with appropriate referrals;
- establish high levels of *knowledge* about HIV infection and modes of transmission among people who inject drugs.

When working with ***men who have sex with men,*** it is important to:

- *acknowledge the wider concerns of MSM in developing countries*, including issues such as harassment, poverty and responsibilities towards family members;
- recognize the importance of *raising public awareness* about issues concerning MSM, countering prejudice and discrimination, and the promotion of human rights;
- provide *training for professionals* working with MSM, including health workers, teachers and prison officers;
- *address homophobia*, including internalized homophobia;
- help MSM develop *support networks*;
- provide access to *voluntary counselling and testing services*, along with appropriate referrals;
- acknowledge the *diversity* of MSM in developing and developed countries.

When working with ***sex workers,*** it is important to:

- *acknowledge the wider concerns* and priorities of sex workers, which include social, legal and economic issues as well as concern for their families and children;
- address the *prejudice* and stigmatization that sex workers face;
- acknowledge the importance of helping to *empower* sex workers;
- provide improved and more accessible *health services*, most especially for the diagnosis and treatment of STDs;
- seek the cooperation and *support of gatekeepers* in the sex industry, including brothel owners and bar owners as well as employers of potential clients of sex workers;
- legitimize the role of *sex workers as educators*, providing them with the respect of their peers;
- acknowledge the importance of providing sex workers with financial incentives for *peer-led work*;

- work, where possible, with men as well as women through a *focus on clients* and, in some cases, *boyfriends.* This is important given the prevalent power relations between both men and women and clients and sex workers.

SOURCES OF EVIDENCE

There are clearly a number of different ways of generating knowledge about HIV prevention methods and their effects. All rely to some extent upon observation and the amassing of information, but each differs according to the rigour with which data and information are collected and made sense of. The kinds of relatively casual observations that contribute to intuitions and gut reactions are different in kind from the more systematic approaches used in observation studies and objectives-based evaluations. These in turn differ from the approaches often used in more formally conducted experimental and comparative evaluations.

It is crucial to bear in mind the strengths and limitations of different kinds of approaches (and different kinds of evidence) when making judgements about what works, and what might prove to be a promising approach, in HIV prevention. By itself, no one approach can answer all the questions we may have about appropriateness and effectiveness. Taken together, different kinds of evidence, and different kinds of methodology, can be persuasive in helping us identify the most useful approaches to adopt in particular circumstances and with particular groups.

The following sections provide case study examples of interventions conducted for the prevention of HIV/AIDS for the aforementioned most vulnerable groups, and describe promising HIV prevention interventions geared to addressing their specific needs.

WHAT WORKS WITH YOUNG PEOPLE?

Approximately half of all people who acquire HIV become infected before they turn 25. Thus, it is crucial that work be undertaken to help young people protect their sexual health. However, there has been a great deal of uncertainty about how to approach HIV and AIDS prevention with young people. For example, there continues to be widespread concern that 'too much' sex education will encourage young people to become prematurely sexually active. Consequently, many sex education programmes have focused solely upon abstinence. Several studies have shown, however, that well-designed programmes of sex education, combining messages about safer sex as well as abstinence, may delay sexual debut, as well as increase preventive behaviours among those young people who are already sexually active (Grunseit, 1997). Where they have been able to access appropriate knowledge, skills and means, young people have shown a remarkable propensity to adopt safer behaviour.

The experiences of young people vary according to social and cultural context, gender, socioeconomic status and sexuality. In order to be successful, HIV prevention programmes need to abandon stereotyped images of young people and take full account of their diversity while recognizing that all young people need accurate information. However, it is important to be aware that young people, especially girls in developing countries, do not always have the freedom to make their own choices about sexual behaviour. They may, for example, be vulnerable to forced or coercive sex, and may sell or exchange sex to ensure their economic survival, or to gain the protection of adults. Young people in developing countries often have immediate needs for shelter, food and clothes which take priority over the threat of a disease which may or may not kill them in years to come (Swart-Kruger & Richter, 1997).

It is important that programmes take into account these structural constraints, barriers and challenges for daily survival which young people face. In addition, it is critical that a dialogue begin with policy-makers to make certain that the rights of young people are ensured, and that governments and international agencies work to address the specific needs of young people in especially vulnerable circumstances. It is also important to remember that, while young people may be at special risk of HIV infection, they also present an opportunity for halting the epidemic, since their sexual and other habits may not yet be firmly established.

YOUTH CASE STUDY 1

Setting: University

Country: Kenya

Intervention: Peer-led education

Sponsoring institution/organization: Family Planning Private Sector (an NGO)

The ***Kenyan*** NGO, Family Planning Private Sector (FPPS) initiated a peer education project for sexual and reproductive health in collaboration with staff and students in nine institutions of higher education. Students' representatives and Deans from all the institutions were brought together in order to develop an outline curriculum. As a result, student leaders established 'AIDS Awareness Clubs' which became the main coordinating bodies for activities. Peer educators organized a variety of activities, including condom distribution and the publication of newsletters. Qualitative evaluation carried out in five of the institutions by FPPS and Family Health International along with an external consultant during March-April 1997, revealed that approximately 19 000 students were reached through the programme, and the project substantially increased students' access to services as well as information. Among the most innovative aspects of the work was the way in which the project team secured the support of the colleges' administration. Additionally, the initiative's success stemmed largely from the fact that young people themselves were involved in all aspects of project design and implementation.

YOUTH CASE STUDY 2

Setting: Community: out-of-school youth

Country: Peru

Intervention: Advocacy, information dissemination, and youth empowerment

Sponsoring institution/organization: Institute of Population Studies at Cayetano Heredia University

During 1995-1997, the Institute of Population Studies at Cayetano Heredia University in ***Peru*** designed, implemented and evaluated a community-based programme in youth and sexual and reproductive health in two neighbourhoods in Peru. Programme staff aimed first to mobilize community resources in order to improve the quality and dissemination of information on related issues. Second, they aimed to promote more democratic models for sexual health promotion which respect the rights of young people. Third, they aimed to empower young people in identifying and seeking solutions to their own sexual and reproductive health (SRH) problems. In addition, the project sought to motivate local municipalities, education and health sectors, youth groups and community-based organizations to direct more resources towards youth SRH services.

In a preparatory phase, information on the perceptions and needs of local young people was obtained. A survey of a representative sample of 800 young people was undertaken, along with focus group discussions, interviews with key members of the community and a rapid assessment of health services within the area. An advisory committee comprising representatives from governmental, nongovernmental, community and youth organizations was established. Subsequently, training programmes were designed and implemented with health workers, teachers and youth and school peer promoters. Additionally, a directory of reference services in youth health was compiled. The major output of the programme was the design and implementation of a campaign for improved sexual health among young people.

Qualitative and quantitative evaluation activities included the collection of data through activity records, individual and group interviews with key members of the community, post-workshop surveys and observations to assess the educational impact of SRH workshops. In addition, data were collected on the functioning of the health service network and the referral system. Young people assessed the educational workshops positively since they were participatory, entertaining and centred on their own problems and perspectives. The young people were genuinely committed to the programme strategy, as shown by their level of voluntary involvement as peer promoters. The level of involvement and support to the project from key people in the diverse working networks increased significantly. The evaluation concluded that the project strategy has high potential to impact on the SRH of young people, and to become established within the community.

YOUTH CASE STUDY 3

Setting: Mass media

Country: Dominican Republic

Intervention: Communications campaign using radio, print and television

Sponsoring institution/organization: Dominican Republic National HIV/AIDS Prevention Programme in collaboration with 20 government organizations and NGOs

During 1994-1997, a media prevention campaign aimed at young people was developed via collaboration between the ***Dominican Republic's*** National HIV/STD Prevention Programme and twenty governmental and nongovernmental organizations. Before the media campaign, extensive research, including a KABP survey, was carried out in order to establish a profile of the young people at whom the intervention was aimed. Appropriate messages about HIV/AIDS were then developed and disseminated through radio, television and print media in three phases. The first phase was designed to increase awareness. The second phase attempted to ensure consistency in messages from different sources, and included the production of a manual for teachers and youth workers. The third phase concentrated on making young people aware of how to protect themselves from HIV infection and providing information about where they could access services and support.

An evaluation conducted in 1996, which involved focus group discussions with young people, revealed that the messages were perceived as well targeted, creative and imaginative. Young people reported that the messages had promoted discussion and helped them reflect on their behaviour. However, young people also reported that more work was needed in order to encourage better communication between parents and children. The overall approach has now been replicated in Guatemala, and other countries in the region are also looking at how the method can be adapted for their own use.

YOUTH CASE STUDY 4

Setting: Community: sexually exploited youth

Country: Nepal

Intervention: 'Camps' or shelters

Sponsoring institution/organization: Maiti Project

In ***Nepal***, the Maiti Project has targeted young people subjected to sexual exploitation and abuse, including young women who are at risk of being sold into prostitution in India. The project has undertaken a diverse range of activities, the focus of which is the establishment of camps in high-risk areas. Each of the camps functions as a shelter for approximately thirty girls who have been rescued from traffickers or who are in danger of being sold. The camps provide education and vocational training, as well as support and counselling. The project has worked closely with colleges, local pressure groups, village leaders, medical officers, lawyers and police. Evaluation suggests that the Maiti Project has prevented approximately 180 girls from being sold into brothels in India each year. In addition, 105 people have been imprisoned as a result of the project's efforts to expose child traffickers. In 1997 alone, 60 girls were repatriated from India and 75% of these were subsequently reunited with their families. The project is most remarkable in its integrated approach to meeting the needs of young people, and the ways in which it takes account of the complex social and economic circumstances of vulnerable young people.

YOUTH CASE STUDY 5

Setting: Community

Country: Haiti

Intervention: Health services and training for young people, families and teachers

Sponsoring institution/organization: Fondation pour la Santé Reproductive et l'Education Familiale (FOSREF)

In ***Haiti***, the Fondation pour la Santé Reproductive et l'Education Familiale (FOSREF) has attempted to ensure the provision of reproductive health services directly designed for young people. Two large medical centres designed specifically for young people have been established. The project has also provided technical support to staff working in other clinical settings to enable them to cater more effectively to the needs of young people. Other related project work has included the training of teachers and parents in order to expand the support network available to young people. Project staff have also played a central role in lobbying for national support for the creation of reproductive health services which adequately respond to the needs of young people. The participation of young people has been encouraged at every stage of development, management and implementation. In addition, an extensive peer education programme with young people adopting the roles of trainers and health promoters was established.

FOSREF staff carried out an evaluation in 1997 assisted by an external consultant. By that time, more than 125 000 young people had been reached through the project. More than 4 000 had received training in family life and reproductive health, including 300 specializing in STD/HIV prevention. Two hundred schools, within the geographical area of the project, were regularly visited by the peer educators. The training of peer educators was carried out by 18 youth specialist facilitators and assistant facilitators. More than 15 000 young people regularly attended the youth medical centres where they received a range of services including contraceptive counselling, prevention of STD/HIV, specialized HIV/AIDS counselling, antenatal care and support services. In addition to this formal evaluation, two studies were carried by young people themselves to assess the appropriateness and acceptability of the services from the point of view of the target group.

YOUTH CASE STUDY 6

Setting: Community households

Country: Egypt

Intervention: Telephone hotline

Sponsoring institution/organization: Ministry of Health and private sponsors

An AIDS hotline and counselling service evolved out of a trial telephone counselling service established during the early 1990s in ***Egypt***. It was an attempt to provide a channel for people to discuss issues surrounding sex and sexuality within a context where cultural taboos prohibit their open discussion in public. Even with limited advertising, people began to call, and an evident need for the service was identified. In September 1996, after securing personnel and office space from the Ministry of Health (MoH), and funding from the Ford Foundation, the hotline was opened. Counsellors were appointed by the MoH and underwent an intensive 4-week training. The objectives of the project are to provide accurate information about HIV/AIDS to the general public, including young people, and to provide confidential and anonymous HIV/AIDS counselling services.

A team of trained counsellors answer all calls, and callers can choose whether to speak to a woman or a man. The hotline is advertised on bulletin boards, trains, metros, buses, and in Arabic newspapers. Supervisory monitoring of the calls is conducted, to ensure the quality of the information and services provided. Evaluation has taken the form of monitoring the services and gathering basic demographic data on the callers using the service. Questions are asked to determine the level of education of each caller, how they learned about the hotline, whether or not they are married and from where they are calling. The volume of calls is monitored and daily statistics on the numbers of callers, their gender breakdown and the sorts of questions asked are recorded. Between September 1996 and May 1998, 18 628 calls were made, averaging around 1 000 per month. More than 50% of callers are between the ages of 13 and 25 years, and 70% are unmarried. Most callers have had a high school or university education, and less than 20% are women. Although the project originally focused on Greater Cairo, calls are also made from rural settings and from other countries where Arabic newspapers are read.

The number of calls made to the hotline has surpassed all expectations. The anonymity of the hotline appears to have provided a vital link to information and counselling services that would otherwise not be available. Through the hotline, people are able to discuss issues such as sexuality, condom use, pre-marital sex and homosexuality, which are rarely addressed in public forums. At the time of its operation, this was the only HIV/AIDS Hotline run by a government service in the Middle East.

YOUTH CASE STUDY 7

Setting: Schools

Country: Viet Nam

Intervention: Skills-based HIV/AIDS and STD prevention

Sponsoring institution/organization: UNICEF and the Vietnam Ministry of Education and Training (MOET)

In ***Vietnam***, a skills-based HIV/AIDS/STD prevention project was begun as a UNICEF-assisted HIV/AIDS prevention project of the Vietnam Ministry of Education and Training (MOET) in 1997. The primary goal of the project was to work with schools to equip young people with information and skills required for promoting healthy behaviour, and avoiding risky situations, especially related to HIV/AIDS. The major focus was on student knowledge, attitudes and values and behaviours. An anticipated secondary outcome was a similar impact on teaching staff.

The project trained teachers in skills-based health education for HIV/AIDS and other STD prevention, and supported them in implementing the new approach in the classroom. Skills-based HIV/AIDS/STD-related lessons were developed for grades 1-12 and integrated into the existing curriculum. New teachers' guidebooks and student worksheets were developed by those trained. In the initial implementation year, a total of 300 teachers implemented and 15 000 students studied life skills and HIV/AIDS prevention. Another 5 000 young people studied life skills and other topics with 140 Viet Nam Red Cross trainers supported by UNICEF.

YOUTH CASE STUDY 8

Setting: Schools

Country: Uganda

Intervention: School health education

Sponsoring institution/organization: Uganda AIDS Commission

A school health education programme in primary schools aimed at AIDS prevention in the Soroti district of ***Uganda*** emphasized improved access to information and other resources for healthy sexual behaviour decision-making; improved peer interaction regarding information and decision-making related to HIV/AIDS, sexuality and health; and improved quality of performance of the existing school health education system. A cross-sectional sample of students, average age 14 years, in their final year of primary school was surveyed before and after 2 years of interventions. The percentage of students who stated they had been sexually active fell from 42.9% (123 out of 287) to 11.1% (31 out of 280) in the intervention group, while no significant change was recorded in a control group. The changes remained significant when segregated by gender or rural and urban location. Students in the intervention group tended to speak to peers and teachers more often about sexual matters. Over the study period, these students became more likely to give as reasons for abstaining from sex those associated with a rational decision-making model rather than a punishment model. A primary school health education programme which emphasizes social interaction methods can be effective in increasing sexual abstinence among school-going adolescents in Uganda. The programme does not have to be expensive and can be implemented with staff present in most districts in the region.

WHAT WORKS WITH WOMEN AND MEN?

It has been estimated that about 55% of all adults living with HIV/AIDS are women, with the difference between men and women being most pronounced in those under the age of 25 (MAP, 2000). Not only have women been reported as having a heightened physiological susceptibility to HIV infection (International Center for Research on Women, 1999), they also have an increased social vulnerability (Goodridge & Lamptey, 1999). Women have unequal access to education and economic resources. They wield less power than men in social and sexual relations (Mane, Gupta & Weiss, 1994). Entrenched stereotypes and differences in role expectations between the sexes also mean that women often have less say in decisions about when and how intercourse takes place, including whether or not a condom will be used (Davies, Dominy & Peters *et al*, 1996). What is more, women are more likely than men to experience rape and sexual coercion, and are sometimes forced to sell or exchange sex for their economic survival. In addition to their own increased risk of HIV infection, women also carry the lion's share of the social burden of the epidemic (Goodridge & Lamptey, 1999) in terms of providing the care for relatives with AIDS (Crawford, Lawless & Kippax (1997). Women with HIV infection also often experience more social blame and stigma than men in the same position.

Gallois, Statham & Smith (1992) have argued that women do not constitute a 'risk group' for HIV infection in the usual sense of the term because women do not usually infect each other, but instead acquire HIV mainly through their relationships with men. Research in a variety of contexts shows that women's attitudes towards sex and sexual behaviour differ considerably from those of men. Women report a preference for sexual relations based on mutual fidelity, intimacy and open communication (Long & Ankrah, 1996). They have fewer sexual partners than men and a great many more women than men report having only one lifetime sexual partner (Giffin, 1998). When women do express a desire for safer sex, men are often obstructive. Perhaps not surprisingly, therefore, the major HIV risk for women is their regular sexual partner or husband (Goodridge & Lamptey, 1999). Dominant ideologies of masculinity on the other hand promote the display of sexual prowess, and encourage men to have multiple partners (Rivers and Aggleton, 1999).

Many existing HIV prevention programmes fail to take adequate account of the social vulnerability of women or the unequal power relations which make it difficult for women to influence decision-making in their sexual relationships. The key elements of many programmes – partner reduction, condom use and STD treatment – are not necessarily appropriate for women, who do not have multiple partners, cannot always influence the decision to use condoms, and may be asymptomatic for STDs (Goodridge & Lamptey, 1999). Indeed, open and honest verbal communication is one of the most difficult aspects of heterosexual relationships (Rivers *et al*, 1998).

There is now increasing recognition that prevailing ideologies of masculinity and femininity facilitate HIV transmission. There is also widespread agreement that the promotion of more equal gender roles is the key to preventing infection. It is crucial therefore not only to address stereotyped gender roles, but also to redress some of the stark structural inequalities between men and women, including the unequal distribution of economic resources and differentials in access to education and health provision. Women's empowerment, however, cannot be achieved by women alone but requires the support of men for its successful realization (Gupta, Weiss & Mane, 1996).

GENERAL POPULATION CASE STUDY 1

Setting: Community: women hawkers

Country: Namibia

Intervention: Prevention education

Sponsoring institution/organization: Okatumbatumba Hawkers Association (a CBO)

The Okatumbatumba Hawkers Association was established in 1989 in ***Namibia*** to support street sellers in their work. Initially, literacy and English courses were organized alongside training for effective negotiation with business establishments since these were the expressed needs of its members. More recently, work has been extended to include HIV/AIDS, which the hawkers themselves raised concerns about. In October 1994, a training programme was designed and a group of 16 women hawkers were trained in basic HIV prevention work. The overall aim of the programme was to increase HIV/AIDS awareness and condom use among the community of Windhoek and neighbouring regions. An interactive, visual story-telling technique was the main learning tool used, and enabled people of all levels of literacy to participate in the programme.

Prevention activities were carried out in *cuca* shops (informal/unlicensed drinking establishments), street markets, churches, local businesses and government agencies. Condoms and information leaflets were distributed from these venues and the owners became informal information/support resources within their communities. Trained hawkers from Windhoek subsequently travelled to other regions where they trained their counterparts to provide local HIV prevention education in local languages. A training of trainers programme was subsequently established in 7 of the 13 administrative regions of Namibia. This programme enabled the Hawkers Association to address the concerns of hawkers in other regions and to extend its business training, bulk purchasing and loan and savings programme to meet the demands of hawkers who were reached through the AIDS awareness campaign.

In total, an estimated 11 000 people participated in education sessions. Follow-up visits have revealed a huge demand from local communities for further education. In addition, church leaders were very responsive to the initiative and expressed a wish to extend their role in terms of support to people living with HIV/AIDS. Evaluation has revealed an increase in knowledge about HIV and an increased awareness of the need to change sexual behaviours. Groups visited during evaluation talked about how they had communicated the information they had received to their children and families. The effectiveness of face-to-face interaction was noted repeatedly. A further external evaluation of the work has been carried out by the regional directorate of the Ministry of Health, through observations of the intervention in the field. This revealed a reported high degree of effectiveness in terms of communicating accurate information, credibility and acceptance within the community.

The project's greatest innovation has been to build on the extensive social and interactive contact that street-sellers have every day with their customers. The success of the project as a community-based initiative is significant. It offers a clear illustration of how simply designed programmes can prove successful when appropriate strategies and acceptable and established channels are employed.

GENERAL POPULATION CASE STUDY 2

Setting: Family planning associations

Country: Jamaica, Honduras, Brazil

Intervention: Integrated prevention education and health service provision

Sponsoring institution/organization: International Planned Parenthood Federation Western Hemisphere Region (IPPF/WHR)

In 1992, International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) developed a pilot project to integrate HIV/AIDS prevention into the programmes and services of family planning associations (FPAs) in ***Jamaica***, ***Honduras*** and ***Brazil***. The result has been a shift of emphasis from the delivery of contraceptive services towards a more holistic approach that promotes sexual as well as reproductive health. However, the goal of the programme was not just to 'add on' HIV/AIDS as an extra component, but rather to improve the overall quality of services by changing the manner in which they are provided, and effecting changes in interaction between clients and providers of these services.

Initially, interviews were conducted with staff and clients, and observations were made at counselling sessions. As a result, staff were trained in basic information about HIV/AIDS and sexual health, counselling skills, communication skills, issues relating to gender and power, and the development of skills to train clients in more effective negotiation with their sexual partners. Specific training according to professional needs was also provided – for example STD management for physicians, and group facilitation skills for staff working with groups. Each FPA then adopted policies and practice to support the required changes in the provision of services.

Evaluation revealed that work with clients had broadened from helping with contraception to more detailed discussion of risk behaviours, sexual relationships and power within relationships. Service providers changed the way in which they discussed family planning methods and now discussed each in relation to HIV/AIDS. Whereas before the intervention, staff at all three FPAs expressed resistance to condoms, they subsequently not only discussed the role of condoms in terms of disease prevention but developed innovative ways of promoting their potential for enhancing sexual pleasure and destroying prejudices associated with their use.

In addition, whereas before there was a focus on the biological mechanics of preventing pregnancy, staff later discussed a wide range of sexual issues that were previously considered taboo subjects. In response to this new approach, clients began to discuss with FPA staff previously sensitive subjects such as homosexuality, anal or oral sex, extramarital affairs, impotence, premature ejaculation, sexual abuse and domestic violence.

GENERAL POPULATION CASE STUDY 3

Setting: Community

Country: Zambia

Intervention: Support and counselling services

Sponsoring institution/organization: Society for Women and AIDS in Zambia (an NGO)

Established in 1989, the Society for Women and AIDS in ***Zambia*** (SWAAZ) represents an attempt to respond to the multiple problems facing a society with a high prevalence and incidence of HIV/AIDS. The overall aim of this initiative was to strengthen the capacity of women, families and communities to respond to HIV/AIDS in Zambia. In Lusaka, SWAAZ is best known for the establishment of four family support homes in low-income communities providing a wide range of services to women, young people, orphans, widows and people living with HIV/AIDS. Activities vary within each home, but include preschool and feeding programmes for orphans, women and youth clubs, small income-generating projects, such as baking, knitting, sewing, gardening and carpentry, and community HIV prevention programmes.

An evaluation was carried out in late 1997 to access the impact of activities in Lusaka. The review team visited the four Family Support Homes in Bauleni, Chawama, Mtendere amd Mandevu townships. In Bauleni, preschool provision and the programme for feeding orphans had a very positive impact, providing services to children which they would not otherwise have received. Other activities, including the income-generating projects, had not yet taken off. In Chawama, preschool provision afforded opportunities for orphans to receive preschool education. A Community Prevention Team (CPT) was using counselling as a method for controlling and preventing HIV/AIDS in the surrounding community. However, the review revealed that the Family Support Home at Chawama was not economically sustainable, being totally dependent on outside funding. At Mtendere, the pre-school project was highly successful and economically self-sustaining. In addition, a Youth Drama Club had been effective not only in its HIV prevention work but also in campaigning against poverty and raising awareness about mental health issues. The club generates income for itself and helps to subsidize the other activities of the support homes. In Mandevu, the preschool project was the most successful and economically viable of all activities.

SWAAZ is respected for the innovative and multi-faceted nature of its interventions, addressing a wide range of economic and social needs within communities affected by HIV/AIDS. Through close collaboration with other governmental and nongovernmental organizations, SWAAZ has managed to sustain its work at times when this might not otherwise have been possible.

GENERAL POPULATION CASE STUDY 4

Setting: Various organizations

Country: Uganda

Intervention: Participatory education and training

Sponsoring institution/organization: ActionAID

The Stepping Stones (SS) project was designed to promote participatory education and training around the world. SS materials were originally designed for use in sub-Saharan Africa but have since been adapted and used in many other parts of the world. While focusing on the needs and special vulnerability of women, SS workshops also involve men. The aim is to help women and men explore their needs, analyse their sexual health problems and look at and practise different ways of behaving in relationships. The approach is highly participatory, using methods not requiring literacy. Workshop sessions are described in detail in a manual along with training guidelines. Sessions guide participants through building group trust, exploring issues to do with HIV and safer sex, analysing behaviour patterns, improving communication skills, and devising ways to change. Role-play, drama and drawing, along with other interactive methods, are used.

In 1997, the project completed a survey of people who had received training, with positive results. In 1998, a more in-depth review was carried out with four organizations and two communities in ***Uganda*** in which the SS approach had been implemented. A review team comprising representatives from international NGOs, local NGOs, health and education departments, and members of the Kabanga and Nabirumba villages where the training programme had been run, worked together to design the evaluation tools. Participatory meetings, using rapid appraisal techniques, were held with representatives of communities that had undergone training using SS, as well as those which had not received any training.

The participatory learning methods promoted by the project were highly valued, as was the good facilitation and the relevance of the content of the sessions. In terms of impact, the group receiving SS demonstrated an increase in the use of condoms, fewer sexual partners, improved relationships with partners, children and friends and an increased ability to refuse unwanted sex. In addition, the project had a positive impact on other aspects of participants' life and reportedly reduced the incidence of alcohol misuse, encouraged the sharing of money in the home, and promoted more positive attitudes towards caring for those who are sick. Outcomes of the review have been used to further adapt the SS resource, and have been shared globally with those interested in participatory models of monitoring and evaluation.

The positive impacts brought about by the effective use of SS go beyond decreasing vulnerability to HIV infection and improving other aspects of women's lives. The programme challenges the notion that gender relationships within the household are not relevant to broader issues of development, and illustrates how personal issues impinge on the quality of life of individuals.

WHAT WORKS WITH PEOPLE WHO INJECT DRUGS?

It has been estimated that between 6 and 10 million people throughout the world inject drugs. High rates of HIV infection among people who inject drugs have been found in countries as diverse as Brazil, Thailand, India and Myanmar (Abdul-Quader *et al,* 1999). In many parts of the developing world, injecting drugs has become the most common risk behaviour associated with HIV infection (Abdul-Quader *et al,* 1999) and HIV infection can spread very rapidly this way. For example, during 1985-1987 HIV prevalence among people who injected drugs in Bangkok was 1%. By the end of 1988, however, this figure had increased to around 40% (Stimson, 1994).

People who inject drugs risk HIV infection in two main ways: first, through the sharing of syringes and other injecting equipment; and second, like other sexually active people, through unprotected sex with infected partners. Those designing HIV-related programmes, aimed at people who inject drugs, face a number of challenges, not least the common fixed ideas about people who use drugs. Also, in many countries drug use is socially sanctioned, stigmatized and illegal (Stimson, 1995). Not surprisingly, drug use generally, and injecting drug use in particular, is often hidden. People who inject drugs are often marginalized, which means that they may find it difficult to access services and resources that might help them to protect their health. Some legal restrictions may serve as barriers to HIV prevention, by prohibiting the open provision of sterile injecting equipment for example (Abdul-Quader *et al*, 1999).

Evidence from Europe, North America and Australia suggests that people who inject drugs can make considerable changes to their behaviour so as to reduce the risk of HIV infection (Stimson, 1995). There is clear evidence that in developed countries participation in prevention programmes also leads to a reduction of risk behaviour among people who inject drugs. However, in developing countries there is highly variable access to appropriate information, education and services for people who inject drugs (Abdul-Quader *et al*, 1999).

IDU CASE STUDY 1

Setting: Existing health and education service sites

Country: India

Intervention: Counselling and condom/bleach distribution

Sponsoring institution/organization: SAHAI Trust (an NGO)

Outreach services for people who inject drugs were established in 1993 in Vepery and Royapuram, ***India*** by the SAHAI Trust, a nongovernmental organization involved in prevention and treatment of drug use. A comprehensive assessment of HIV risk behaviour among people who inject drugs was conducted in 1994 and identified an increase in the number of drug users injecting opiates as well as synthetic opioids such as buprenorphine. The research suggested that the sharing of syringes and needles as well as other injecting equipment was very common, as were high-risk sexual practices. Findings from this assessment provided the basis for the design of the outreach project. A team consisting of ex-users and professional social workers provided education, counselling and support, as well as distributing condoms and bleach, to injecting drug users who were not reached through existing services or through traditional health education channels.

Evaluation has involved the collection of baseline data from 125 people who inject drugs and a follow-up assessment of 161 users eighteen months after the outreach intervention was introduced. Findings were compared with a control group of 87 drug users from locations where there were no outreach services. The comparison at follow-up revealed that participants from the outreach locations had adopted significant protective and risk-reduction behaviours. Nearly 47% of participants reported decreased sharing of needles and syringes compared to only 35.5% from control locations. Almost 30% of users from outreach locations always cleaned syringes, compared to only 10.3% of the control group. There was no significant difference between the two groups in terms of reported sexual risk behaviour.

IDU CASE STUDY 2

Setting: Community

Country: India

Intervention: Outreach and drop-in services including drug substitution

Sponsoring institution/organization: SHARAN (an NGO)

SHARAN has undertaken outreach work with people who inject drugs in the slum areas of New Delhi, ***India***. The project began work in 1993 as a pilot drug substitution programme and, as a result of its success, was funded in 1995 to introduce an expanded programme using sublingual buprenorphine tablets. A drop-in centre was established in a slum area (Nizammuddin), to serve the drug-using population from the poorest localities in Delhi. The long-term objective of the project was to produce absolute reductions in levels of heroin and injecting drug use in New Delhi. It aimed to achieve this through providing accessible health and harm reduction services to people who inject drugs whilst simultaneously providing information on drug use and HIV/AIDS to their communities.

The establishment of a drop-in centre providing medical care and a substitution programme has been complemented by the provision of outreach and community-based detoxification services. A specialized staff-training programme has increased the capacity of the centre to address the needs of people who inject drugs. Appropriate action, research, and the production and distribution of IEC materials are additional project outputs.

Initial baseline surveys were carried out to inform the project design. Some original materials for awareness campaigns were created such as posters and street plays. Specialized training was provided to staff to develop counselling skills, and to increase technical knowledge of drug use and HIV/AIDS. With the establishment of the drop-in centre, drug substitution treatment using sublingual buprenorphine, medical treatment including referrals to other services, and specialized care for tuberculosis, STD and HIV/AIDS management were introduced. In addition, the centre provides free needles, syringes and condoms.

Outreach activities conducted by teams of peer educators include educational sessions on safer drug use and safer sex, referrals to relevant services, STD and tuberculosis treatment, and abscess management. Detoxification camps and home-based detoxification (including the training of family and other community members) are further components of the project's work. These activities are supported through follow-up home visits to affected families, providing information and counselling.

An external mid-term evaluation of the programme was carried out in August 1996 by two senior researchers from the Indian Council of Medical Research Unit on HIV/AIDS and Substance Abuse. In addition, at the end of the first year, an evaluation of client responses was carried out by a private agency. Internal evaluations are also conducted to assess both the quality of life of clients (monthly) and the working of the programme (yearly). The mid-term external evaluation

noted two major achievements. First, the programme has achieved a high degree of 'user-friendliness' and, as a result, the number of clients using the service has risen rapidly. Second, the evaluation concluded that, as a trial of bupronorphine substitution, the programme had been very successful in proving its safety.

During the three years of its functioning, the project reached 1 611 clients, and 356 of these used the service on a regular basis (the centre had originally been contracted to service just 300 users). One hundred and fifty people who injected drugs had stopped injecting altogether and 58% had considerably reduced heroin use. There was a clear reduction in the number of clients appearing with injecting-related abscesses, cellulitis, sinuses and thrombophlebitis coupled with an increased HIV/AIDS awareness. During its initial phase of operation, the project thus had a major positive impact on reducing the extent of heroin and injecting drug use in this area of New Delhi.

IDU CASE STUDY 3

Setting: Community drop-in centres

Country: Ukraine

Intervention: Information provision and condom/needle supply

Sponsoring institution/organization: Vera, Nadezhda, Lubov (a CBO)

In response to the increasing number of people injecting drugs in the ***Ukraine***, a project was begun in December 1996. Two stationary drop-in centres and one mobile outreach service were initially created to provide free and anonymous services to people who inject drugs. Teams of three or four volunteer workers provided services, with each team including a volunteer who is medically trained, and a person who injects drugs. Services have included the supply of clean needles and syringes, condom distribution, information and counselling on HIV and production and distribution of leaflets. Services have been extended to include young men and women who sell sex. Although the initial impetus for the project came from the Southern Branch of the Ukranian AIDS Centre, in May 1997 the community organization Vera, Nadezhda, Lubov took over responsibility for the implementation of the project.

Records of attendance at centres together with daily project records, provide important evaluation material. During the first four months of the centre's opening (up to April 1997), 4 889 visits from 1 216 people who inject drugs were recorded. It has been estimated that contacts with the outreach service exceeded the total number of client contacts within the two drop-in centres. During the first six months of 1997, 114 000 syringes and 36 000 condoms were distributed. Between July and mid-October 1997, about 3 000 injecting drug users were reported to have had contact with the service.

Pre- and post-intervention studies provide additional important evaluation data. The first survey (conducted in August 1996) involved 511 people who injected drugs and showed a high level of risk behaviours among respondents (58% of whom were under 25 years old). Only 43% reported using their own needles for injection, and condom use was reported as low as 16%. In April 1997, a new sample of 200 people who injected drugs, recruited at drop-in centres and the outreach post, showed a much lower level of both injecting and sexual risk behaviour.

This project has remained a community-based project and, despite major external difficulties, has managed to maintain a continuous service. It is run exclusively by volunteers who have other occupations as their means of income. The close involvement of people who inject drugs in programme design and implementation ensures a high degree of acceptability. Project activities have had a positive impact on the reduction of risk behaviours. However, unfavourable political and organizational conditions have been a major constraint. This, coupled with a shortage of basic resources including syringes and educational booklets and a dependence on volunteer involvement are limiting factors, together with severe financial shortages.

IDU CASE STUDY 4

Setting: Prisons and community

Country: Mexico

Intervention: Harm reduction and rehabilitation

Sponsoring institution/organization: Compañeros A.C. (an NGO) with the support of the Pan American Health Organization and Mexican National AIDS Programme

Since 1987, the nongovernmental organization Compañeros A.C. in Northern ***Mexico*** has been developing and evaluating prevention strategies among people who inject drugs. In 1994, with funding from the Pan American Health Organization and with the support of Mexican National AIDS Programme, a strategy for the introduction of harm reduction was initiated based on Prochaska's model of 'stages of change'. This highlights the stages a drug user may go through before ceasing substance use. The project promotes detoxification and rehabilitation alongside harm reduction. The overall objective of the work is to bring about changes in behaviour ranging from giving up the use of injected drugs, to gradual changes in behaviour, which minimize harm to those who continue injecting. Ex-injecting drug users are involved in outreach work. People who are at a perceived 'action' stage (a stage at which they have a strong intention to minimize harm or to stop using drugs) are identified by field workers and presented with a range of intervention options.

Fieldwork is carried out in prisons as well as in the wider community, and people who inject drugs repeatedly come into contact with project workers. Information leaflets are produced and distributed by the field workers. Rehabilitation services provided by the project incorporate complementary treatments such as acupuncture and herbal medicine. Education and support is provided to the families and partners of people who inject drugs.

Records detailing the type and extent of services provided to people using the project, together with follow-up surveys carried out six months after a person enrols in the programme, provide the core of evaluation data. In addition, baseline data have been collected at the time of enrolment. These include demographic information and data on educational and social background and the age at which individuals began using drugs. By mid-1997, Compañeros had delivered the following harm reduction services: community outreach services to 1 380 people who inject drugs; distribution of 55 373 harm reduction packets (including condoms, bleach and education leaflets); and 239 skills-building sessions with social networks of people injecting drugs, as well as 2 872 individual skill-building sessions. Between 1992 and September 1997, 928 heroin users enrolled in the rehabilitation programme.

Since the introduction in 1995 of a specific focus on young people (under 20 years), the percentage of young people making use of the harm minimization services has risen from 20% to 32% of the population group. Six months after completion of rehabilitation treatment, there was a 25% decrease in the reported use of marijuana, heroin and speedball. Amongst those who continue using drugs, there has been change towards using drugs that are not injected. The extensive field and outreach work of the project, together with the focus on individual assessment and support, offers a personalized intervention approach. Identifying injecting drug users at stages when they are positively disposed to behavioural modification causes interventions to be better targeted.

IDU CASE STUDY 5

Setting: Community

Country: Belarus

Intervention: Outreach and needle exchange

Sponsoring institution/organization: Parents for the Future of their Children (an NGO) with the support of WHO and UNAIDS

Established in mid-1996 and funded by WHO and UNAIDS, a project was developed in ***Belarus.*** It was the result of an initiative from a group of Svetlogorsk residents who were concerned about the level of injecting drug use within their community, and the consequent risk of HIV infection from high-risk injecting and sexual behaviours. The group evolved into an NGO called 'Parents for the Future of their Children'. Svetlogorsk City authorities and the Republic AIDS Prevention Centre have also participated in the initiative.

A needle exchange service is run at two exchange points. Disinfectant, condoms and brochures on safe behaviour and HIV/AIDS prevention are also made available. Information materials for the families of people who inject drugs are produced and distributed. Volunteers provide outreach education services to 'difficult to reach' groups. Former injecting drug users voluntarily clean the area around the syringe exchange points. Since October 1997, a professional lawyer has offered free legal consultations to drug users. Anonymous diagnosis and treatment for STDs is carried out at gynaecological centres by doctors who are specially trained and sensitive to the needs of people who inject drugs. Thirty peer educators have also been trained and a peer education project established.

Daily monitoring of services, together with behavioural studies and a final project assessment carried out in April 1998, form the core of evaluations to date. In addition, and for the first time in the country, a method of sentinel surveillance using the blood residues in syringes was introduced. The syringe exchange points have consistently provided services to a minimum of 300 and a maximum of 700 people who inject drugs each month. The final assessment, conducted by a commission of international, regional and national experts, together with a second behavioural study, have detected a consistent behavioural change towards less risky practices among people who inject drugs coming into contact with the project. The primary behavioural study showed that 92% of respondents had a high degree of risk of HIV infection. The secondary study showed this indicator to be reduced to 43%. The number of representatives of the target group who did not use condoms likewise decreased from 71% (pre-intervention) to 30%.

The quality and scope of the information and educational work were positively assessed. The fact that this project was initiated at community level has given it a strong impetus and afforded it a high level of acceptance. Its focus on the close involvement of people who inject drugs in a range of project activities has rendered it highly accessible to members of the target group. The project has had an additional impact on promoting a positive attitude towards preventive interventions on the part of local authorities and the population of the city. There is a plan to reproduce the positive experience of the Svetlogorsk project in other regions of the country.

WHAT WORKS WITH MEN WHO HAVE SEX WITH MEN?

In many developed countries, gay and other men who have sex with men were among the first to be affected by HIV, and continue to bear the brunt of the epidemic. In developing countries the situation is quite different. In many such countries heterosexual transmission accounts for the vast majority of reported cases. However, it is not clear whether or not this is an accurate reflection of the real situation. In many developing countries, male-to-male sex is highly stigmatized, and in some it is legally prohibited. This can cause governments, political leaders and the public at large to believe that homosexual transmission does not exist, when in fact it is simply hidden (National Research Council, 1996).

As time has passed, a new willingness to 'lift the veil' on hitherto stigmatized and denied behaviours has come about. In sub-Saharan Africa, for example, where virtually no cases of homosexual transmission were initially reported, there is now a growing body of literature to suggest that same-sex contacts are far more common than previously thought (see Aggleton, Khan & Parker, 1999 for a review). It is now clear that across a variety of countries in both the developed and developing world men who have sex with men (MSM) are made more vulnerable to HIV infection because of the clandestine nature of their relationships, and the marginalization and discrimination they face (McKenna, 1996; Aggleton, Khan & Parker, 1999). The challenge now is to expand on the limited number of innovative programmes for men who have sex with men, and to address the structural factors that promote this discrimination and stigmatization.

MSM CASE STUDY 1

Setting: Community

Country: Chile

Intervention: IEC campaign and training of health professionals

Sponsoring institution/organization: The Lambda Centre (a CBO)

A project initiated in 1995 by the Lambda Centre, a gay association in Santiago, ***Chile*** in collaboration with other nongovernmental organizations (NGOs) and some universities aimed to address the high incidence of HIV infection amongst homosexually active men who then accounted for 82% of all sexually transmitted HIV infections. Homosexual behaviour remains a criminal offence in Chile and the political climate up until democratization in 1990 has made work with gay men difficult in Chile. Nonetheless, a series of workshops with gay-identified men were held to promote open discussion and encourage the development of social networks, alongside the training of health and other professionals on sexuality and discrimination issues. Posters were produced and distributed, along with condoms and information on services. Work was carried out in relation to the defence of human rights and wider legal issues affecting gay men. A strategy to develop a network of supportive individuals and institutions, including those within the public health system, was also developed.

Over a five-year period, workshop content has been adapted and modified and tested out within different cultures and age groups in a variety of geographical locations. Efforts have been made to raise the profile of gay communities through their participation in public activities such as World AIDS Day events, Gay Pride marches and candlelight memorials. A strategy to raise awareness within the public health system was employed to make care and support programmes more appropriate and accessible to MSM. This included the training of health workers on issues of sexuality and homosexuality. Other activities included the distribution of condoms, information leaflets and advice on where good-quality HIV counselling and testing services were available. In addition, work has been carried out in relation to the defence of human rights and wider legal issues affecting gay men.

Process evaluations were conducted at each of the workshop sessions using an open-ended questionnaire format. The outcomes of this evaluation identified a felt need among gay men for social forums where they can communicate openly on issues affecting them, and derive support for the difficulties they face. Evaluation data were also collected to assess the extent and scope of the work. Between 1995 and 1997, 172 activities were implemented involving 1576 people in seven Chilean cities. Groundwork has been laid for the development of a more systematic approach to HIV prevention for men who have sex with men, which can be consolidated upon and expanded in the future. The project has been particularly innovative given the prevailing political climate, with gay organizations taking the lead in lobbying for changes in health care services, legal, civil and human rights and attitudes towards homosexuality.

MSM CASE STUDY 2

Setting: Community

Country: Jamaica

Intervention: Counselling, education and outreach activities

Sponsoring institution/organization: Jamaica AIDS Support (an NGO)

A project was designed and implemented by ***Jamaica*** AIDS Support (JAS), a nongovernmental volunteer-based support and education group for men who have sex with men (MSM). Widespread discrimination against MSM has made it difficult to implement HIV prevention work in Jamaica, and as men with HIV became unwell, very limited support has been available for them and their families. The specific purpose of the outreach and risk reduction project was to increase JAS's capacity to support risk reduction among MSM in three discrete geographical areas. Comprising 80 volunteers, JAS met weekly and held educational outreach events and provided support to people living with HIV/AIDS. Peer counselling was carried out to promote self-esteem, a positive attitude towards sexual health, and lasting behavioural change. Peer counsellors provided education to men who have sex with men and to their families, including 24-hour support for families of people living with AIDS. Regular support group meetings have explored topics such as safer sex, gay relationships, prostitution, education, homophobia and strengthening the gay community. Long-term counselling and support services for people living with HIV/AIDS have included telephone counselling and, importantly, the provision of home-based and hospice care at the 'Life' hospice established by JAS with financial support from their funders AIDSCAP. Monthly special events included parties, which featured safer sex skits and information booths. Condoms were distributed free of charge along with information leaflets and educational materials. Workshops were held with drag performers to help them improve their ability to relay prevention messages through art.

Up until August 1998, a total of 106 support group meetings were held nationally, and many more subgroups have met to discuss issues more intimately. A peer-counselling network has now been expanded from Kingston to two other cities, and four additional towns have been identified for outreach activities. A total of 149 support groups of people living with AIDS have reached 737 attendees. Two KABP surveys were conducted in December 1995 and August 1996 and comparisons made. Eighty-five per cent of those surveyed in 1996 now reported knowledge of prevention practices and appropriate perceptions of risk of HIV infection. A 40% increase in the use of condoms and a 30% reduction in self-reported high-risk behaviour was reported. The project is striking in its attempt to provide wide-ranging support for MSM including those living with HIV/AIDS. The holistic nature of the prevention education workshops and the emphasis on counselling and peer support has been well received by MSM. The extension of the work from Kingston to other major towns and cities demonstrates the potential transferability of this style of work. The project has grown out of a self-help community initiative and this adds to its credibility among members of the target group.

MSM CASE STUDY 3

Setting: Prisons

Country: Costa Rica

Intervention: Condom promotion and counselling

Sponsoring institution/organization: ILPES (an NGO) with the support of the Costa Rican Ministry of Justice

The Instituto Latinoamericano de Prevención y Educación en Salud (ILPES) established a programme with men who have sex with men in ***Costa Rican*** prisons. In 1990, a study undertaken among inmates of La Reforma Correctional Centre, the country's largest penitentiary, revealed a high proportion of HIV infection. No clear policy on prison-based prevention measures had been formulated, despite general recognition of the fact that sexual activity is common among inmates. Previously, there were no HIV awareness programmes directed towards the prison population, and access to HIV antibody tests was limited.

In 1992, ILPES, in collaboration with the Ministry of Justice, began developing a Holistic AIDS Prevention Programme for inmates of Costa Rican correctional facilities. The central objective of this work has been to promote changes in attitude towards HIV/AIDS on the part of inmates, but the approach also addressed the attitudes of correctional personnel. HIV prevention workshops were designed to explore and focus upon the multiple factors that contribute to or inhibit HIV prevention within prisons. To date, these have included work on power; AIDS and safe sex; anger management; sexuality; self-esteem; alcoholism and substance abuse; and holistic health. Workshops use a participatory methodology in which all members take part on equal terms with one another, devising among themselves a system of horizontal communication through such tools as games, exercises, role-play and meditation. Workshops have also been conducted with prison personnel to increase awareness of HIV/AIDS related issues.

Evaluation, conducted during 1995, focused on the outcomes of workshops for prison inmates. By this time, a total of 453 prisoners had participated in the programme and almost all the country's correctional facilities had taken part. A total of 188 individuals who took part in the programme during the first six months of 1995 were chosen to participate in the evaluation. A questionnaire was distributed to each of them before and after the experience, and changes in responses were systematically recorded. The percentage of inmates who proved knowledgeable about HIV/AIDS increased from 69% before the intervention to 79% post-intervention. In addition, the ability of respondents to communicate effectively with their sexual partners was reportedly enhanced by the workshops. There was a rise in the proportion of respondents who felt able to tell their partner what they liked from 56% to 66%, and a fall in the number of participants who stated that they never communicate with their partner about sexual preferences from 24% to 12%. In terms of condom use and attitudes towards condoms, the proportion of respondents who never used condoms decreased from 51% to 36%, and the number of respondents indicating that they found condoms enjoyable to use rose from 8% to 19%. The holistic workshops had a significant effect on helping inmates feel better about themselves and as a result, a marked improvement in the social atmosphere in the prisons was observed. The uniqueness of conducting a project of this nature within state correctional services, particularly through a process of NGO/governmental collaboration should be noted.

MSM CASE STUDY 4

Setting: Community

Country: Bangladesh

Intervention: Condom promotion and counselling

Sponsoring institution/organization: The Bandhu Social Welfare Society (an NGO)

The Bandhu Social Welfare Society in Dhaka, ***Bangladesh,*** began its community-based work in October 1997. MSM are central to the project management and service provision. A preliminary ethnographic study, together with a risk and needs assessment, was carried out in order to build a clearer profile of male-to-male sex networks. The programme was then designed on the basis of these findings. Primarily, the project has sought to develop and strengthen informal, friendship networks outside of the sexual environment. These are then used to address social concerns such as harassment and police victimization and other personal concerns that the men experience. Outreach activities included an interactive approach to promoting condoms, encouraging discussion and sharing of experiences; the social marketing of condoms; ensuring referral to sensitive and appropriate STD treatment services; and networking with women's sexual health agencies so as to build appropriate referrals for female partners. By providing opportunities for the men to explore other expressed interests such as dance, fashion design, learning English and vernacular literacy skills, the project aims to enhance its acceptability and encourage longer-term attachment on the part of members of the target group.

Since the project is still relatively new, evaluation to date has largely involved monitoring of service provision and usage. Between October 1997 and January 1998, the Bandhu project received a total number of 960 visits (12 group meetings and 500 individual visits). Over 4 500 condoms were distributed and 1 900 contacts established at public sex environments. Overall, there are clear indications that a socializing/community building/friendship framework is more effective in this context than a more traditional peer education model.

Various aspects of the project's work have been important to its early success. The fact that the project is beneficiary-led is significant, affording it a high degree of acceptability and ensuring an ethical base for project activities. Similar projects employing this model of intervention have now been established in Lucknow and in New Delhi. This demonstrates the project's transferability to other regional contexts. The holistic approach adopted, with an emphasis on developing extensive social and support networks, offers a non-clinical style of intervention and acknowledges the wider concerns of the target group. Outreach work, with its focus on friendship building rather than on condom distribution, is an approach that is well received by the target group. HIV/AIDS is still considered to be of relatively low importance, compared with other priority concerns of MSM including family, marriage, employment, income and harassment.

MSM CASE STUDY 5

Setting: Community

Country: South Africa

Intervention: Telephone service

Sponsoring institution/organization: Triangle Project (an NGO)

A project which has existed in various guises for the past 15 years, and which is now called the Triangle Project, works to meet the education and support needs of gay men in Cape Town, ***South Africa.*** The primary assumption of the project is that men are better prepared to protect themselves and partners in the context of HIV if they have a strong gay identity. To this end, the project works not only with gay men, but also attempts to address homophobia within the wider community, as well as to create safer and more accessible health and school environments and provide support and counselling services.

A baseline needs analysis for gay men was carried out initially. Printed information was developed and distributed along with condoms and lubricants in bars and clubs. Outreach education on safer sex and empowerment was carried out in the form of participatory workshops in bars, clubs and other gay venues. Counselling services were provided by telephone and face-to face by a team of trained volunteers. The project trains external groups such as teachers and nurses on issues related to homosexuality. More recently, training has been provided to counterpart agencies elsewhere in Southern Africa (such as GALZ in Zimbabwe). There is a strong focus on training volunteers in order to expand the capacity of the organization to address the needs of gay men. The project is currently completing focus group research examining issues of sexual identity, self-esteem, health-seeking and risk-taking behaviours.

Between June 1997 and June 1998, 236 200 condoms were distributed at urban, township and cruising venues, along with 30 000 sachets of lubricant. Thirty-seven thousand leaflets on safer sex, alcohol and drug use, relationships, 'coming out', STDs and hepatitis B have been produced and distributed. A wide variety of people have undergone training on issues such as safer sex and attitudes towards homosexuality. Post-course workshop evaluations indicate increased knowledge and changed attitudes. Participants report valuing the non-didactic and non-prescriptive approach adopted during workshops. The project team is now in the process of developing and applying more systematic evaluation models. The project's focus on challenging negative attitudes to homosexuality has led to improvements in health service delivery and in education. Through nurturing a strong gay identity, the project has increased the accessibility of HIV prevention, education and support services to gay men in South Africa. However, government funding was cut by 90% in 1997 when prevention of HIV within the heterosexual population was designated a priority.

WHAT WORKS WITH SEX WORKERS AND THEIR CLIENTS?

Early in the epidemic, sex workers were recognized as a key group to involve in HIV-prevention work (Wellings & Field, 1996). However sex workers have been difficult to fully involve in HIV prevention, since the illegality of prostitution in many countries means that women and men who exchange sex for money may not always be visible or accessible. Sex work is also highly stigmatized in many societies and, in early reports about AIDS, the mass media often presented sex workers unhelpfully as 'conduits of infection' rather than as individuals who might be especially vulnerable and/or who have a key role to play in HIV prevention (Alexander, 1996).

In developing countries, most female sex workers are characteristically poor, without formal education and relatively powerless (Ngugi, Branigan & Jackson, 1999). Often, individuals engage in sex work to determine their own economic survival and, in many cases, that of their children and other family members. Rural to urban migration in many developing countries ensures both a large number of sex workers in cities and a ready clientèle. A number of the clients of sex workers are men who have left their families behind to seek work in large cities (Aggleton & Rivers, 1999). In some cultural contexts, sex before or outside of marriage regularly involves the exchange of money or goods. Importantly, existing HIV prevention programmes have rarely focused on the male clients of sex workers (Rivers & Aggleton, 1999).

Sex workers are often highly mobile, making grassroots organization and HIV-preventive programming difficult. Additionally, while many sex workers do, or would wish to, use condoms, the largely illicit and sometimes illegal nature of sex work enhances vulnerability. In contexts where soliciting for clients is illegal, carrying a large number of condoms may lead to arrest and fines. Similarly, the hidden nature of sex work may render sex workers vulnerable to rape and sexual coercion (Alexander, 1996)

In prevention planning and programming it must be remembered that sex workers, like other groups, are far from homogeneous. They include women and men, those who identify as gay or bisexual, and young people, who may be relatively powerless and particularly vulnerable to exploitation and injecting drug users. There are a variety of contexts in which sex work takes place: for example, in brothels, bars, on the streets and through broker-mediated encounters.

SEX WORKERS CASE STUDY 1

Setting: Community: male sex workers

Country: Morocco

Intervention: Peer education and outreach

Sponsoring institution/organization: Association de Lutte contre le SIDA (an NGO)

The Association de Lutte contre le SIDA (ALCS) developed a project to focus on male sex workers in covert settings in Casablanca and Marrakesh in ***Morocco***. The overall aim was to reduce the risks of STDs and HIV infection among male sex workers, their clients and their clients' partners. The project has also sought to meet the wider care and support needs of socially marginalized sex workers. Between 1993 and 1994, observations and interviews were carried out with members of the target group in Casablanca and Marrakesh. In 1995, a structured behavioural survey was conducted with a sample of 172 men to provide baseline data for the intervention. Peer outreach workers were then recruited and trained. The outreach workers began by making regular contacts at venues (around three times a week during 1995 in Casablanca) with male sex workers. They provided peer education and counselling, condoms, and referrals to local health services for STD diagnosis and treatment and HIV counselling and testing. A drop-in service was established along with a telephone hotline and discussion group. The project has begun to establish contacts in other cities where men are involved in sex work such as Tangier and Agadir.

In collaboration with WHO, an initial baseline evaluation was conducted in 1995 using questionnaires, interviews and a review of existing data. Behavioural change was measured by making comparisons with data collected earlier in 1993-1994. Additional process indicators provided data on the number of outreach contacts, the number and type of referrals, numbers of condoms distributed, etc. In terms of the acceptability of the project and the strategies employed, respondents had a positive attitude towards the outreach work and valued the opportunity to discuss issues related to sexual behaviour, health and HIV/AIDS. Ninety-three per cent of those surveyed preferred to access condoms though outreach workers rather than through more conventional sources. Increases in the numbers of men seeking voluntary counselling and testing were noted. Seventeen thousand individual contacts were made over a period of 10 months in 1995, reaching an estimated 530 persons (84% of these engaged in sex work). Within a short period of time, reported regular use of condoms has increased. Detailed baseline research prior to the intervention, by interviewers who were familiar with the milieu of the target group, has confirmed the existence of situations of HIV/AIDS risk and vulnerability. The project has managed to set a precedent both within the country and the North African region in demonstrating the feasibility of successful outreach HIV prevention work with marginalized and clandestine populations.

SEX WORKERS CASE STUDY 2

Setting: Sex workers

Country: Venezuela

Intervention: Peer education

Sponsoring institution/organization: Asociación de Mujeres por el Bienestar y Asistencia Recíproca (an NGO)

A project implemented by the Asociación de Mujeres por el Bienestar y Asistencia Recíproca (AMBAR) in Caracas, ***Venezuela*** aimed to improve the quality of life of female sex workers through strategies which protect their health and at the same time guarantee their human and civil rights. Initially, a group of 40 sex workers were recruited to be trained as health promoters. Inclusion criteria used to identify potential health promoters included credibility and respect among their peers. After training, the women were able to provide education on human rights, self-esteem, sexuality and reproductive health, prevention of STD/HIV and the effective use of condoms. Materials such as posters, leaflets and bulletins were distributed in establishments and public places frequented by sex workers. A manual and set of visual training materials have also been produced for use by peer health promoters when conducting talks and workshops.

Outreach work is carried out both at working sites and at STD health services. Managers and the owners of clubs, hotels and bars where sex work takes place have participated in the project by assisting in the social marketing of condoms and the distribution of information. Weekly meetings have been held with health promoters to plan the peer education work, along with supervision and support sessions. Every Tuesday, free condoms have been distributed from AMBAR headquarters to sex workers who participate in the promotion activities. Legal and psychological consultations have been made available alongside a programme to ensure that claims of violations of human rights brought forward by sex workers are channelled through organizations competent to deal with them effectively.

When the project began in 1995, 13 000 sex workers were registered with the Ministry of Health and Social Services. Subsequently, a register of 25 000 women using health and support services was established. Not a single case of HIV infection has been reported among those in contact with the project since 1995. Every Tuesday, a large number of sex workers come to AMBAR headquarters to receive free condoms and to take part in educational activities. Police harassment has decreased as a result of the complaints processed by AMBAR. The social marketing of condoms has been a success, with sex workers assuming control of the market, and owners and managers selling condoms in their establishments at affordable prices. Through successfully tackling human rights and health concerns, the project has gained a high degree of acceptance, verified by the extent of participation in the intervention. The project has achieved its goal of improving the quality of life of women involved in sex work and has significantly reduced the risk of HIV infection.

SEX WORKERS CASE STUDY 3

Setting: Community: sex workers

Country: Cameroon

Intervention: Peer outreach in urban areas

Sponsoring institution/organization: AIDSCAP

Between 1993 and 1996, AIDSCAP supported a project for sex workers and their clients in six urban areas of ***Cameroon***. Trained peer educators worked in pairs to provide weekly education sessions in bars, brothels, STD clinics, neighbourhoods and other sites where people were known to practise high-risk sexual behaviours. In addition, educational sessions were held in prisons on request. Sex workers distributed condoms free of charge as a promotional activity and then sold condoms to peers and clients once demand had been established. A theatre group comprised of sex workers performed interactive and humorous dramas at outreach venues where sex workers and their clients meet. Between 1993 and 1996, 200 peer educators and coordinators were trained and in turn conducted more than 5 000 education sessions in community and clinic-based settings. An estimated 500 000 contacts were made through educational sessions including 52 workshops held at the central prison of Yaoundé.

Evaluation of the results and impact of the activities has been conducted through baseline and follow-up KABP surveys collecting both quantitative and qualitative data. At baseline, information was elicited from 800 sex workers, 800 clients and 200 people being treated for STDs. Follow-up data were collected from 818 sex workers and 661 clients. The percentage of the target population able to identify at least two means of HIV prevention rose from 40.2% (sex workers) and 49.8% (clients) at base line, to 85.6% and 85.6% respectively at follow-up. There was a decrease of 10-20 percentage points in the proportion of the target population reporting an STD in the three months immediately preceding the follow-up survey, coupled with an increase by 10 percentage points in the number having access to adequate treatment for their last STD. The percentage of sex workers reporting having ever used a condom rose steadily from 28.3% in 1988, to 88% in 1996. Among clients, this percentage rose from 55.5% in 1990, to 81% in 1996. Consistent condom use by sex workers with non-regular clients rose from 52% in 1994, to 75% in 1996.

A comprehensive assessment of the work already carried out during the preceding phase allowed this project to build on the strengths of an existing programme. As a result, project activities have been sustained over a substantial period of time, and the potential impact of the intervention has been maximized. Using drama as the main means of HIV prevention communication has made it possible to reach many people in an entertaining way within settings where they are most likely to engage in high-risk sexual behaviour. Sex workers have proved highly successful in the effective marketing of condoms. Indeed, the sale of condoms has become the main source of income for some women who are now wholesalers.

SEX WORKERS CASE STUDY 4

Setting: Community

Country: Papua New Guinea

Intervention: Outreach

Sponsoring institution/organization: Papua New Guinea Institute of Medical Research

Research by the ***Papua New Guinea*** Institute of Medical Research in the early 1990s established that sex workers and their clients, mostly transport workers, were particularly vulnerable to HIV infection. In 1994, an ethnographical situation assessment was carried out with transport workers and the women that sell them sex. Outreach work began even during the initial baseline surveys when informants were given basic information on HIV/AIDS, provided with condoms and shown how to use them. Training modules were developed and produced for sex workers and each of the target client groups. Workplace policy workshops were held with shipping firms, police, security firms and trucking firms in order to secure their support. Activities were designed to reduce the incidence of police 'line-ups' or group rape sessions to which sex workers in custody were subjected. Outreach work was carried out with truck drivers at rest stops and through workplace training sessions, and with sailors and dock workers on wharves and aboard ships. A clinic providing confidential STD services for sex workers was established in Port Moresby. In Lae, sex workers could receive HIV testing and counselling at the project site, followed up, if necessary, with referral to local clinics for STD treatment. Theatre and music groups attached to the project also helped disseminate HIV/AIDS prevention messages. Additionally, a drop-in centre provided literacy and vocational training by the YWCA. A telephone Hotline provided counselling services for sex workers and clients.

Formative research and ongoing monitoring have provided some clear indictors of success to date. By mid-1998, in Port Moresby 403 peer educators had completed their training. This included 75 sex workers, 36 policemen, 16 policewomen, 14 wives of policemen, 20 security men, 163 sailors (from 24 ships), 65 dock workers and 14 hotel workers. In Lae, by March 1997 a total of 125 peer educators had been trained including sex workers, dock workers, sailors and truckers. Among sex workers, quantitative evidence for increased condom use can be found in the progressive stages of baseline data, indicating a rapid increase in condom use from the point at which the project was started. Efforts to reduce the incidence of line-ups have been successful, with reported involvement by police officers in a line-up during the previous week being reduced from 10% pre-intervention, to 4.2% post-intervention. In addition, the first successful prosecutions of police officers involved have occurred and the incidence of sexual harassment reported by sex workers has diminished. Demand for condoms has been steadily rising and in Port Moresby five condom depots have been set up on the wharves. During 1996-1997, between 1.5 and 2 million male condoms and 5 000 female condoms were distributed.

Extensive formative research on the real contexts of risk-taking in vulnerable groups has provided guidance for the overall development of the project. The extent of involvement by a wide range of agencies is unique and was achieved by encouraging the highest level of participation in the project by a diverse range of related agencies, at every stage of its development. Addressing the human rights of sex workers has been of paramount importance.

ANNEX. SUMMARY OF CASE STUDY RESULTS

What Works With Young People?

	Setting	Country	Intervention	Reach	Sponsoring agency	Outcome/comments
1	University	Kenya	Peer-led education "AIDS Awareness Clubs", condom distribution, publication of newsletters	19 000 students reached in 9 institutions via 251 trained peer educators	Family Planning Private Sector (FPPS)	X: Joint involvement of students and colleges administration in design and implementation of the school-based curriculum was found effective
2	Community	Peru	1) Advocacy 2) Youth empowerment training * information and education plus community advocacy for sexual and reproductive health services for young people	800+ young people	Institute of Population Studies, Cayetano Heredia University	X: Successful local campaign for young people's sexual health
3	Mass media	Dominican Republic	Combined radio, television and print media intervention	National	Dominican Republic National HIV/AIDS Prevention Programme & 20 government organizations and NGOs	X: Mass media linked to HIV/AIDS education in other settings can change social norms and attitudes, thus helping prevent HIV
4	Community	Nepal	'Camps' or shelters *provide a safe space for girls who are the subjects of sexual trafficking * provide educational/vocational training, counselling and support	Prevents 180 girls per year from being sold to brothels. Reunites families.	Maiti Project	X: A multi-faceted project incorporating shelter, food, health care, legal protection and HIV/AIDS education can improve the quality of life foryoung women involved in prostitution
5	Community	Haiti	1) Youth advocacy 2) Peer-led education * founded two large medical centres & peer, family and teachers training so as to widen the network of support for young people.	125 000 young people reached 4 000 young people received training in family life and reproductive health	Fondation pour la Santé Reproductive et l' Education Familiale (FOSREF)	X: Access to youth-friendly health services is an important part of HIV/AIDS prevention X: Participation of young people in project development and implementation leads to beneficial outcomes
6	Telephone Hotline	Egypt	1) Counselling 2) Information	Average of 1 000 calls per/ month received	Ministry of Health & private sponsors	X: The anonymity of an AIDS Hotline can help people access information and counselling around the culturally taboo topics of sex and sexuality
7	Schools	Vietnam	Skills-based HIV/AIDS and STD prevention *emphasis on changing knowledge, attitudes values and behaviours *work in school to equip young people with lifeskills needed to avoid risky situations and practise safer behaviour	Skills-based lessons developed for 1-12 grade 300 teachers and 15 000 15 000 students involved in year one. 5 000 students studied with Red Cross trainers.	Vietnam Ministry of Education and Training (MOET) with support of UNICEF	X: Life skills approaches can enhance students, knowledge, attitudes and behaviours so as to lead to risk reduction. X: Life skills programmes may have beneficial effects for teachers as well
8	School	Uganda	1) Peer-led education 2) Curriculum: school health 3) Improved access to information	Students in Soroti district	Uganda AIDS Commission African Medical and Research Foundation Soroti District Administration	X: Three-part intervention increased reports of abstinence amongst Ugandan students X: Outcomes attributable to the interactive nature of the intervention, not simply the provision of information X: Combining together of intervention elements helped students process the information of a family member becoming HIV-positive in a way which led to positive behaviour change.

	Setting	Country	Intervention	Reach	Sponsoring agency	Outcome/comments
1	Community: women hawkers	Namibia	1) Prevention education *interactive visual story telling technique *condoms and information distribution 2) Peer-led education *hawkers trained in basic HIV prevention	Hawkers and hawkers' clients. Training of trainers in 7 of the 13 administrative regions in Namibia. 11 000 people participated in education sessions	Okatumbatumba Hawkers Association (a CBO)	X: Increase in knowledge about HIV and need to change sexual behaviors: X: Evaluation revealed high effectiveness in communicating accurate information, credibility, and acceptance within the community.
2	Family Planning Associations	Jamaica Honduras Brazil	Integrated prevention education and health service provision *staff trained in HIV/AIDS and sexual health,counselling, communication skills,issues relating to gender power and skills to help clients negotiate with their sexual partners	FPA clients and staff	International Planned Parenthood Association	X: Issues of sexuality and HIV/AIDS more frequently discussed with staff X: Staff more likely to recommend the use of condoms as a means of preventing HIV transmission
3	Community (family support homes)	Zambia	Support and counselling *establish 4 family-support homes *high school drama club *preschool project *income generation	Mothers, infants, preschool children	Society for Women and AIDS in Zambia (SWAAZ)	X: Innovative and multi-faceted approach to HIV/AIDS prevention.
4	Various organizations	Uganda	Participatory education and training The Stepping Stones Project *focus on needs and vulnerability of women, but also including men *group work, role play, participatory education	Local organizations and communities in Uganda	ActionAID	X: Participants showed increased use of condoms, fewer sexual partners, and increased ability to refuse unwanted sex X: Reduction in incidence of alcohol misuse encouraged sharing of money in the home, and care for those who are sick

What Works With People Who Inject Drugs?

	Setting	Country	Intervention	Reach	Sponsoring agency	Outcome/comments
1	Existing health and education services	India	1) Counselling 2) Condom/bleach distribution *ex-users & social workers provide: education, counselling and support	Drug injectors in Vepery and Royapuram	SAHAI Trust (NGO)	X: At 18-month follow-up, 47% of IDUs in intervention group reported reduction in needle and syringe sharing (cf. 35% in controls) X: At 18-month follow-up, 30% of IDUs reported always cleaning syringes (cf. 10% in controls)
2	Community	India	1) Outreach education 2) Detoxification clinics 3) Drug substitution * integrated service provision including prevention education, harm reduction and service referral * drop-in centre	New Delhi. 1 611 clients (including 356 regular users) over three-year period	SHARAN (NGO)	X: In course of three years, reported 58% reduction in heroin use and 30% reduction in injection practices
3	Community drop-in centres	Ukraine	1) Community outreach 2) Condom/needle supply *two drop-in centres and one mobile outreach centre	4 889 visits from 1 216 people recorded during first 4 months 114 000 syringes and 36 000 condoms distributed in first six months	Vera, Nadezhda, Lubov (CBO)	X: At 9 month follow-up, reported decrease in high risk behaviour amongst the clients. X: Shortages of resources and organizational constraints have limited the effectiveness of the project
4	Prisons and wider community	Mexico	1) Harm reduction and education 2) Rehabilitation *Outreach education *Harm reduction (condoms, bleach) *Rehabilitation	1 380 people who inject drugs reached 55 373 harm reduction packs distributed	Campañeros A.C. (NGO), Pan American Health Organization, Mexican National AIDS Programme	X: 25% decrease in use of marijuana, heroin and speedball, six months after rehabilitation
5	Community	Belarus	1) Outreach education 2) Needle exchange * disinfectant, condoms, and brochures on safe behaviour and HIV/AIDS prevention *free legal advice to drug users *anonymous diagnosis and treatment for STDs	Between 300 and 700 people per month visiting syringe exchange points Lowered risk of infection among service users	Parents for the Future of their Children (NGO), WHO & UNAIDS	X: Consistent behavioural change towards less risky behaviours

What Works With Men Who Have Sex With Men?

	Setting	Country	Intervention	Reach	Sponsoring agency	Outcome/comments
1	Community	Chile	1) IEC campaign 2) Training of health professionals * a series of workshops open to gay men to promote open discussions and encourage the development of support networks. * posters, condoms, and information distributed * work on legal and human rights for gay men	During 1995-1997, 1 576 people participated in 172 activities	The Lambda Centre (NGO)	X: Raised profile of gay communities in a context where homosexuality remains illegal X: Enhanced awareness of human rights
2	Community	Jamaica	1) Counselling 2) Education 3) Outreach activities * to support risk reduction amongst MSM 4) Peer-led education/counselling * counselling available 24 hrs a day for MSM and their families. * long-term hospice care, workshops	149 support groups reached 737 attendees by August 1998	Jamaica AIDS Support (NGO)	X: 85% of participants reported improved knowledge of prevention practices and appropriate risk perception X: 40% increase in reported use of condoms, 30% reduction in high-risk behaviour X : programme effectiveness attributed to the holistic nature of the intervention
3	Prisons	Costa Rica	1) Holistic workshops 2) Counselling * promote behaviour change amongst inmates, and attitude change amongst correctional personnel. *games, exercises, role-play and meditation to help the inmates communicate during workshops	By 1995, almost all prisons in Costa Rica participating in programme	ILPES (NGO) and Ministry of Justice	X: Increased knowledge of HIV/AIDS prevention, and enhanced ability to communicate with sexual partners. X: Increased reported condom use and marked improvement in social atmosphere of prisons
4	Community	Bangladesh	1) Condom promotion/outreach 2) Counselling *strengthen informal social networks outside of the sexual environment *interactive approach to education, health	October 1997 - January 1998: 960 client visits, 4 500 condoms distributed, 1 900 contacts in public sex environments	The Bandhu Social Welfare Society (NGO)	X: Demonstrated clear value of friendship/ social network approach. X: Holistic, non-clinical approach valued by clients
5	Community	South Africa	1) Telephone counselling 2) Outreach work and condom distribution *organized on philosphy that strengthening gay identity and combating homophobia are essential to successful HIV prevention	June 1997- June 1998: 236 200 condoms, 30 000 sachets of lubricant and 37 000 leaflets distributed	Triangle Project (NGO)	X: Increased knowledge and changes in attitudes towards homosexuality. X: Improved education and health service delivery for gay men

What Works With Sex Workers and Their Clients?

	Setting	Country	Intervention	Reach	Sponsoring agency	Outcome/comments
1	Community. Male sex workers	Morocco	1) Peer education 2) Outreach work *Peer education, counselling, condom distribution, referrals to local health services for STD diagnosis and treatment, HIV testing and counselling	17 000 individual contacts over 10-month period in 1995	Association de Lutte contre le SIDA (ALCS)	X: Reported increases in regular use of condoms X: Increased use of counselling and testing services
2	Community. Female sex workers	Venezuela	Peer education *improve quality of life and defend sex workers' civil and human rights *promote self-esteem, sexual and reproductive health, STD/HIV prevention, condom use	25 000 women sex workers in Caracas	Asociación de Mujeres por el Bienestar y Asistencia Recíproca (NGO)	X: Improved quality of life for sex workers. X: Increased awareness of civil and human rights X: Reduced risk of HIV infection
3	Community. Female sex workers	Cameroon	1) Outreach in urban areas 2) Peer-led education *weekly education sessions in bars, brothels, STD clinics, neighbourhoods *condom distribution *theatre performances	During 1993-1996, 200 peer educators trained, 5 000 educational sessions held and estimated 500 000 contacts.	AIDSCAP	X: Increased knowledge of prevention X: Increased condom use, reduction in group rapes X: Decreased levels of infection
4	Community. Female sex workers	Papua New Guinea	1) Outreach work 2) Heallth policy workshops 3) HIV counselling and testing *Outreach education/condom distribution *Policy workshops to reduce "police line-ups" and group rapes *Establishment of a clinic for sex workers offering HIV testing and counselling *theatre and music groups to help spread information	During 1996-1997, 1.5 - 2 million male condoms and 5 000 female condoms distributed. By-mid 1998, 403 peer educators trained.	Papua New Guinea Institute of Medical Research	X: Increased demand for condoms X: Increased reported condom use X: Fewer 'line-ups' and group rapes X: Lowered levels of sexual harassment

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