Abstracts and Reports

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Regional Meeting on Behavioral Interventions for STD and AIDS Prevention

Sexually transmitted diseases (STDs) can lead to serious consequences that interfere with the social functioning and quality of life of afflicted individuals. Long-term complications include physical and/or mental incapacity, reduced fertility, and even fatal illness. Nevertheless, public attitudes and beliefs tend to impede efforts to interrupt the transmission of these diseases, since those at risk may disregard preventive measures, neglect to seek appropriate treatment, or even consider an STD as a sign of virility. In addition, traditional taboos surrounding sexuality and misleading information about available treatments compel a large proportion of STD patients to resort to inadequate self-treatment or rely on the help of traditional healers, drug vendors, and others outside the official public health sector.

A major transmission route of the human immunodeficiency virus (HIV) is through unprotected sexual activity. In addition, evidence exists that STDs such as genital ulcer diseases, gonorrhea, trichomoniasis, and chlamydia infection may constitute serious risk factors for HIV transmission.

To strengthen and coordinate efforts to reduce the incidence of these diseases, a Regional Meeting on Behavioral Interventions for the Prevention of STD and HIV/AIDS was held in Kingston, Jamaica, from 11 to 14 December 1990. The event was sponsored by the Pan American Health Organization/World Health Organization and cosponsored by the Ministry of Health of Jamaica and the Federal Centre for AIDS of the Ministry of Health and Welfare, Canada. It was attended by 185 behavioral scientists, educators, epidemiologists, program managers, clinicians, and other health personnel from 33 countries and territories of the Americas.

Specific objectives of the meeting were the following:

- to assess existing STD intervention programs in the Americas aimed either at the general population or at specific groups (such as migrant workers, IV drug users, sex workers);
- to stimulate coordination of health promotion approaches for the prevention of STDs and HIV infection;
- to review data collected from recent surveys of knowledge, attitudes, and practices and other behavioral research, and to discuss their impli-

Source: PAHO/WHO Program for the Prevention and Control of AIDS in the Americas, "Report of the Regional Meeting on Behavioral Interventions for the Prevention of STD and HIV/AIDS—Challenges and Choices for the 1990s, Kingston, Jamaica, 11-14 December 1990" (Washington, D.C.: PAHO, March 1991 [mimeo]).

cations for behavioral interventions to prevent STD/HIV transmission;

- to outline procedures for evaluating the effectiveness of proposed health promotion programs;
- to develop guidelines for the prevention and control of STD/HIV and regional strategies for behavioral interventions.

CONTENT OF THE MEETING

The conference consisted of an inaugural session, 11 plenary sessions, and poster presentations on 10 topics. The inaugural session featured an overview of behavioral interventions for STD and AIDS prevention, which examined the rationale for coordinating HIV/STD programs in the Americas and how that coordination can be developed. The point was made that the further spread of AIDS can be minimized not only through programs specifically to prevent HIV transmission but also through programs designed to combat other STDs. Conversely, the lessons learned through fighting AIDS can be adapted for the fight against STDs. The urgency of the AIDS problem has opened the door to candid discussion of issues that were previously discussed mostly in private and in vague language. This new candor has led to better public understanding of AIDS, sexuality, and disease processes, as well as to behavioral research of greater depth and sensitivity. With closer coordination, this candor can be extended to the discussion of all STDs.

Another advantage of coordination is the more efficient use of scarce resources. Owing to their common transmission route and shared at-risk population segments, the campaigns against HIV/AIDS and STDs already share many of the same strategies and resources.

Coordination can take different forms in different countries, depending on resources, epidemiological patterns, and other factors. Thus, there can be no single coordination strategy, but rather coordination options. These include 1) at a minimum, the sharing of information on prevention strategies, so that lessons learned about STD prevention can be applied immediately to HIV/AIDS, and vice versa; 2) joint planning and provision of services, such as serological testing and counseling; and 3) full integration of HIV/AIDS and STD prevention, which includes not only planning and services but also administration, personnel, and infrastructure.

Current STD control efforts often focus on acute clinical diseases caused by easily diagnosed bacterial infections. As a result, available resources are spent on diagnosis, treatment, and contact tracing for diseases like gonorrhea and syphilis, while primary prevention and many other STDs remain unaddressed. It was emphasized that increased attention should be given to the less easily detectable and treatable STDs, to primary prevention, and to promotion of long-term behavior change. The coordination of HIV/AIDS and STD control is but one step in the broader effort to coordinate these programs with other health care activities, such as family planning, maternal and child health, tuberculosis control, and substance abuse services, as well as with other public policy sectors, such as education and nutrition.

The plenary sessions on the first day included presentations by experts on the various types of STDs and their economic and societal impact. The epidemiology of STDs and HIV/AIDS in the Americas was reviewed by speakers from Antigua, Argentina, Honduras, and Mexico. The impact of these diseases on physical and mental well-being was explored, and the importance of nongovernmental organizations (NGOs) in the fight against AIDS

was stressed. Speakers highlighted the use of peer educators among hard-to-reach groups and the utilization of diverse educational methods.

Day two of the meeting opened with a session devoted to opportunities and needs for behavioral interventions. Most of the speakers, who represented the Andean subregion, the Caribbean, Central America, Chile, Mexico, and the United States, reported rapid increases in the prevalence of HIV infection, and several referred to recent increases in congenital syphilis and recurrent infections with other STD agents.

Many different kinds of interventions were described, including mass media techniques, formal educational approaches in schools, and individual techniques, such as psychotherapy. Given that each type of intervention has its weaknesses and strengths, most speakers supported the use of overlapping intervention schemes. Mass media campaigns were seen as relatively inexpensive and particularly effective in conveying a simple message to young people and in countering the negative messages that were also transmitted via the media. Formal educational programs could convey more complex information and skills training than mass media, but most current school curricula were considered completely inadequate. Several speakers emphasized that curricula should cover ethical and psychological issues along with the usual biological information. Individual interventions, such as counseling and psychotherapy, were seen as most appropriate for adult target populations, among whom these techniques were capable of producing changes in personal attitudes and behavior. Such services were also the least dependent on societal sanctions, but were expensive since they required the time of highly trained personnel.

Two main target audiences were cited: 1) groups at a high risk of transmitting or contracting HIV infection and STDs, such as homosexual and bisexual males, sex workers, drug users, migrant workers, and prisoners; and 2) populations just beginning to face the risk of STD/HIV, such as teens or children. The interventions directed at these groups should encourage beneficial behavior changes, such as using condoms, seeking medical care for STDs, and decreasing the number of sex partners, and, ideally, should also reduce stigmatization of STDs, eliminate myths, and lead to a better overall understanding of sexuality.

Most speakers noted the difficulty of gaining acceptance and support for STD/HIV and sex education intervention programs owing to the controversial nature of the subject matter. Public opinion and societal norms could undermine these health programs, and religious objections were a common problem in the Americas. Strategies for handling these problems included emphasizing generally accepted cultural values, such as monogamy; handling emotionally laden material in a matter-of-fact manner and incorporating it into the general health education curriculum; and accepting controversy, since it could contribute to the rapid dissemination of information by increasing public attention. The speakers also discussed the need for careful evaluation of the efficiency and cost-effectiveness of behavioral interventions.

The remaining three plenary sessions of the day dealt with condom promotion and procurement issues, the role and training of primary health care workers in the prevention of STD/HIV transmission, and counseling and partner notification.

The final day of the meeting began with a session on the development of methods and materials for coordinated STD/HIV interventions. Four different approaches were discussed: interventions directed at the general public; those offered through

STD services; outreach programs; and interventions directed at youth, both in and out of school. It was stressed that cultural and socioeconomic factors that differ between countries help define the approaches used in reaching the general public. Various media channels included T-shirts with printed messages, stickers, comic books, songs, pamphlets, and telephone hotlines. Participants mentioned the risk of creating confusion and stigmatization when campaigns against STDs are joined with those against HIV/AIDS, since many STDs are curable, while HIV infection is not.

The meeting then turned to the topic of interventions directed at women, specifically sex workers, with presentations that focused on studies of their knowledge, attitudes, and practices related to STDs and HIV/AIDS. Among the conclusions were that ministries of health must seek the help of NGOs in reaching this marginalized group of women and that promotion of correct condom use should be continued, even though that approach by itself was insufficient since some clients refused to use condoms.

The final plenary session dealt with a variety of programming and planning issues, including management, training, evaluation, and funding. A 1989 study shed light on the current situation of STD and AIDS programs and the possibilities for their integration. Some of its findings were the following:

- Eight countries had allocated no funds for programs or activities directly related to STD control. A specific budget existed in only six of the countries and territories surveyed, while funds for STD prevention and control came from other programs' budgets in 20 countries.
- Eight countries had one full-time person in charge of STD control activities; in 17 countries, the director of STD control activities also had responsibilities in other health areas; and four countries had no one, full-time or part-time, with this responsibility.
- Only two countries had fully integrated STD and HIV/AIDS programs. In 11 countries there was some degree of cooperation between these programs, while in four others the STD and AIDS programs were completely separate. Five countries had AIDS-related activities as part of the STD program, and seven had STD-related activities as part of the AIDS program.

KINGSTON DECLARATION

After review and discussion of country experiences, methodologies, and intervention approaches, the participants agreed on the "Kingston Declaration on Behavioral Interventions for the Prevention of STD and HIV/AIDS." This declaration provides a framework within which governments, community groups, NGOs, and others can develop an agenda for action. It states that interventions for the prevention of HIV infection should be coordinated or combined with those aimed at preventing other STDs in order to achieve optimal effectiveness and the most efficient use of limited resources. These combined programs should promote the overall concept of sexual health. Behavioral interventions should focus on youth (in and out of school) and groups with high-risk behavior (sex workers, substance abusers) as priorities. The resources of governments, NGOs, community groups, and religious groups should be utilized. Successful implementation of behavioral interventions ultimately requires the empowerment of women, strengthened and expanded STD services, strengthened management of program components concerned with

behavioral interventions, and improvements in research and training.

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Throughout the meeting, the participants emphasized that education and prevention programs must be accessible, targeted to specific groups, culturally sensitive, and locally designed. Such programs should make appropriate use of the media and integrate HIV/AIDS activities with other health and social initiatives. The conclusions and recommendations stemming from this meeting will serve as a springboard for a renewed effort in the 1990s to stem the spread of STD and HIV/AIDS in the Americas.

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Role of Nongovernmental Organizations in Health Activities in Trinidad and Tobago

As countries throughout Latin America and the Caribbean confront a deepening economic crisis, nongovernmental organizations (NGOs) have gained importance as service providers. This heightened role of NGOs has been acutely felt in the field of health as the public health sector struggles to cope with the twin constraints of diminishing resources and increased demand.

In Trinidad and Tobago, an effort was undertaken to assess the number of nongovernmental organizations working in the delivery of health and health-related services in the country and to analyze the scope of their work. This, in turn, was part of a broader strategy for strengthening the contributions of these NGOs.

This report summarizes the methodology, analysis, and conclusions of a survey of the country's NGOs working in health and highlights the outcomes and recommendations that emerged from a national NGO conference. The lessons learned in Trinidad and Tobago may prove useful to other countries in the Region and stimulate reflection on the capabilities and limitations of NGOs as resources for national health development.

SURVEY OF NONGOVERNMENTAL ORGANIZATIONS

During 1988–1989, a PAHO/WHO-sponsored survey was conducted among Trinidad and Tobago's nongovernmental organizations providing health or health-related services. This survey was part of an effort to analyze the capabilities of these NGOs to work within the seven priorities of the Caribbean Cooperation in Health (CCH) initiative: environmental protection, including vector control; human resources development; prevention of chronic noncommunicable diseases and accidents; strengthening of health systems; food and nutrition programs; maternal and child health and

Source: Condensed from the document "Nongovernmental Organizations in Trinidad and Tobago and the Caribbean Cooperation in Health (CCH) Initiative—A Case Study," prepared by Mrs. Joaquin St. Cyr for the PAHO/WHO Representation in Trinidad and Tobago; and from recommendations of the conference "Strengthening Nongovernmental Organizations—A Strategy for Cooperation in Health," May 1989, Trinidad and Tobago.