HIV prevention programs of nongovernmental organizations in Latin America and the Caribbean: the Global AIDS Intervention Network project

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ABSTRACT

Objective. *The objective of this paper is to describe HIV prevention programs conducted by nongovernmental organizations (NGO) that are meeting this challenge.*

Methods. *One NGO undertaking HIV prevention programs was evaluated in each of the 23 countries participating in the Global AIDS Intervention Network (GAIN) Project throughout Latin America and the Caribbean. A two-stage selection process was used: (1) a search in databases and other information sources; (2) identification of NGOs that were best established and most actively engaged in HIV prevention activity. Executive directors were questioned about staffing, budget issues, populations served and barriers faced by these entities.*

Results. *The 23 NGOs conducted 58 direct-service programs and had been conducting HIV prevention activities for a mean of 8 years (SD = 4.45; range 1–18 years). Average annual program budget was US$ 205 393 (range: US$ 10 000 to US$ 1 440 000). The NGOs reported a mean of 4.5 full-time employees (range 0–15, SD = 4.7). Many relied on volunteers (median = 10, mean = 51, range 0–700, SD = 150) to conduct HIV prevention activities. The NGOs provided prevention services for the general community (82.6%), children and adolescents (34.8%) and men who have sex with men (30.4%). Activities conducted by NGOs included train-the-trainer activities (43.5%) and face-to-face prevention activities (34.8%). Obstacles cited included lack of funding (60.9%) and HIV-related stigma and discrimination (56.5%).*

Conclusion. *The strategies used by NGOs to overcome barriers to prevention are a testament to their ingenuity and commitment, and serve as examples for NGOs in other world regions.*

Key words AIDS, prevention and control, Latin America, nongovernmental organizations.

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Although the impact of the HIV/AIDS epidemic in Latin America and the Caribbean (LAC) has not yet reached the magnitude evident in Africa, HIV is well established and in danger of spreading rapidly in the absence of effective responses. An esti-

mated 1.7 million adults and children with HIV/AIDS live in Latin America, and an additional 440 000 live in the Caribbean. In LAC, the number of deaths attributable to AIDS in 2004 exceeded 100 000. Adult HIV prevalence rates in several Caribbean Basin countries (e.g., Haiti and the Dominican Republic) average 2.3%, and are surpassed only by those in Sub-Saharan Africa, making this the second most affected region in the world (1, 2).

The HIV/AIDS epidemic in LAC has been characterized as an "epidemic with many faces" (3). There are important variations in the epidemiologic patterns of spread observed in different subregions and countries (e.g., Andean, Southern Cone, Brazil, Central America, Mexico, and Caribbean Basin) (1). Male homosexual and bisexual contact is a primary route of transmission in Mexico as well as in many South American countries (4). For instance, 46.4% of the cumulative cases in the Andean subregion were transmitted by homosexual or bisexual contact, whereas only 12% of the cumulative cases in the Caribbean and 13.5% of the cases in Central America were attributed to this mode of transmission (2, 5). Studies have found HIV prevalence rates of 14% in Lima, Peru, 20% in Santa Fe de Bogotá, Colombia, and 28% in Guayaquil, Ecuador, among men who have sex with men (2). Furthermore, this population group may contribute to the growing rates of HIV infection among women in LAC since studies have demonstrated that a large proportion of men who have sex with men also have sex with women (6).

Heterosexual transmission plays a prominent role in the spread of HIV, and the proportion of AIDS cases due to heterosexual transmission is 78.9% in Central America, 35.9% in Brazil, and 76.8% to 79.3% in the Caribbean Basin (5). In the past 5 years, HIV infection prevalence rates in antenatal clinics are reportedly 0.4% to 2% in Guatemala, 7.1% in Guyana, 2% to 3.8% in Belize, 3.6% in the Bahamas and 13% in different sites in Haiti, the most heavily impacted country in the Region (4, 7, 8). The prevalence rate at prenatal clinics in the Dominican Republic has stabilized at less than 2% after rapid increases in the 1990s (9).

Injection drug use represents a significant mode of HIV transmission in the Southern Cone countries, Brazil, and the northern part of Mexico (4). The highest prevalence rates among injection drug users range between 21% and 52% (10). In 1997, HIV infection prevalence rates among injection drug users varied from 4.4% in Peru and 18% in Uruguay to 40% in Brazil. AIDS case reporting indicates that injection drug use is also a major source of HIV infection in Argentina, where 40% of all cases are attributable to this mode of transmission (3). There is some evidence that HIV transmission from drug use is increasing in many of the Caribbean countries that serve as "bridges" for the export of illegal substances to the United States (11).

In addition to the challenges posed by the varied epidemiologic patterns of spread and high seroprevalence rates, preventive efforts in LAC are impacted by economic, political and sociocultural factors (4, 6, 12). Unequal economic development in the Region, coupled with the perception that HIV was not a serious problem, led to a slow governmental response to the HIV epidemic in many LAC countries (4). Although some data are available, the Region lacks a well-functioning surveillance system that could be used to track the current dynamics of the epidemic and effectively plan prevention efforts (13). Political instability, high levels of unemployment, guerrilla warfare, and the extreme poverty of many LAC countries have spurred population mobility, a significant factor in the spread of HIV (1). Furthermore, diverse cultural and religious beliefs regarding homosexuality and condom use, the cultural meanings of penetrative and receptive sexual roles, manliness, and sexual identity, as well as unequal power dynamics resulting from cultural and structural differences have hampered HIV prevention efforts in the Region (4, 6, 14).

In most LAC countries, particularly in the capital cities, activities oriented towards HIV prevention or mitigation of its social impact have been initiated by gay and non-gay-oriented, community-based, nongovernmental organizations (NGOs) (6, 15). Although anecdotal information on the quality, sustainability and reach of these efforts exists, little has been documented or published, and even fewer programs have been evaluated (6). As an important first step in this process, the goal of the present study was to obtain detailed information about prevention programs being carried out by 23 NGOs in 23 LAC that participate in the Global AIDS Intervention Network (GAIN) Project. The goal of the GAIN Project is to compare the effectiveness of different consultation strategies to promote the adoption of a successful HIV prevention intervention, the "popular opinion leader," by NGOs in 4 regions of the world: Africa, Eastern Europe/Central Asia, Latin America and the Caribbean (16, 17). In this report we use information from in-depth structured interviews conducted at the start of the study with each NGO's Director or Prevention Director, to categorize the major types of prevention programs being offered in LAC and the populations being served. We describe challenges and barriers to effective prevention efforts, and highlight—through three case studies—innovative programs for combating the further spread of HIV in the Region.

METHODS

Identification and selection of participating NGOs

Using the methodology described by Kelly et al. (18), we recruited one NGO that was undertaking HIV prevention programs in each of 23 LAC countries during 2000–2001 (Table 1). A two-stage selection process was used to obtain the study sample. First we searched the directories and data bases of Joint United Nations Programme on HIV/AIDS (UNAIDS), the International Council of AIDS Service Organizations (ICASO), United Nations Education, Scientific and Cultural Organization (UNESCO), and others. We also examined compilations of NGOs presentations made at

TABLE 1. Cities and countries in Latin American and the Caribbean represented in the 2001 Global AIDS Intervention Network (GAIN) Project

St. John's, Antigua and Barbuda
Buenos Aires, Argentina
Nassau, Bahamas
Belize City, Belize
La Paz, Bolivia
Rio de Janeiro, Brazil
Grand Cayman, Cayman Islands
Santiago, Chile
Santa Fe de Bogotá, Colombia
Havana, Cuba
Santo Domingo, Dominican Republic
Quito, Ecuador
Georgetown, Guyana
Port-au-Prince, Haiti
Mexico D.F., Mexico
Managua, Nicaragua
Asunción, Paraguay
Lima, Peru
Basseterre, St. Kitts and Nevis
Kingstown, St. Vincent and the Grenadines
Paramaribo, Suriname
Montevideo, Uruguay
Caracas, Venezuela

AIDS conferences, and lists of NGOs participating in regional AIDS consortia and networks. We then used expert recommendations from national and international sources to identify which NGO was best established and had the greatest scale of direct service HIV prevention activity in each country. Once the NGOs were identified, we contacted the Executive Directors and invited them to participate in the project. An overwhelming majority of NGOs contacted agreed to participate. The cities and countries that participated in the study are listed in Table 1.

Data collection

Social scientists experienced in HIV prevention and the Region's cultures conducted telephone interviews in Spanish, English, or French with the Director or Prevention Director of each NGO in late 2001 to early 2002. Interviews followed a standardized script and included both open- and closed-ended questions as well as probes designed to elicit fuller responses. As described by Kelly et al. (18), these in-depth structured interviews were designed to obtain information on two aspects: (1) organizational and program characteristics of the NGOs, and (2) the presence of core elements of popular opinion leader programs in prevention activities being conducted by the NGOs. Because the ultimate goal of the study was to measure the adoption of the popular opinion leader program, it was important to assess these core elements at baseline (see Kelly et al. (18) for a full description of the main trial). Copies of the questionnaire were mailed before the interview to facilitate administration and to permit the NGO to gather the necessary data. Informed consent was obtained prior to conducting the interviews. Interviews lasted 2 to 4 hours. Each NGO was given US$ 500 as compensation for their time. The following areas were assessed:

Organizational characteristics. Directors indicated the number of full-time and part-time staff and volunteers, the year in which the NGO began to provide HIV prevention services, the annual budget (later converted to US dollar equivalents to facilitate comparisons), and the percentage of the total budget devoted to HIV prevention work. Directors stated whether or not their NGO provided services other than HIV prevention and whether or not their NGO had been involved in research efforts.

Current HIV prevention programs. Directors identified the NGO's three largest HIV prevention programs. If an NGO offered fewer than three programs, only the programs offered were described. For each program identified, the Director responded to a series of open-ended questions and probes intended to provide a detailed picture of the program's methods, goals, and operation (e.g., "Please tell me how the program is implemented, the people it reaches and how it works"; "What exactly is done in this program?"; and "What is the goal of the program and how often is it offered?"). Using a scale from 1 to 10, Directors rated the perceived success of each program and indicated whether or not they took steps to evaluate each program's effectiveness.

Client populations served. The Director reported which community populations were served by the three largest programs, and listed all other populations served during the past six months.

Barriers faced by the NGO. The Director ranked, in order of importance, the three greatest barriers faced by the NGO during implementation of HIV prevention programs.

Interview coding

All interviews were audio-recorded. Interviewers wrote summaries of the responses for each question referring to the audio-tapes as necessary. The interviewers then translated these summaries into English. These translations were then coded by an experienced team of prevention researchers into previously developed categories for types of program, populations served, and barriers to prevention.

RESULTS

Organizational characteristics

The NGOs we surveyed have been conducting HIV prevention activities for a mean of 8 years (SD = 4.45; range 1–18 years). Thirty percent (7/23) had initiated prevention efforts from 1983 to 1990, 44% (10/23) from 1991 to 1995, and 26% (6/23) from 1996 to 2000. There was wide variability in the average size of the annual budgets, which ranged from US$ 10 000 to $1 440 000 (mean = $205 393; median = $120 000). Thirty-nine percent (9/23) of the NGOs had annual budgets ranging from $10 000 to $46 000, 30% (7/23) had budgets ranging from $83 333 to $180 000, 22% (5/23) had budgets ranging from $200 000 to $400 000, and 9% (2/23) had a budget of $668 151 or $1 440 000. However, the

median annual budget dedicated to HIV prevention efforts was $78 000 (range $3 992 to $367 483).

Similarly, there was wide variation in the number of paid staff and volunteers conducting HIV prevention activities, with most NGOs having a larger number of volunteers than paid employees. The mean number of full-time employees was 4.5 (range 0–15, SD = 4.7). The number of part-time paid staff ranged from 0 to 11 with a mean of 2.4 (SD = 3.3). Thirty percent of the NGOs had no full-time paid staff and 47.8% had no part-time staff dedicated to prevention efforts. Many NGOs had volunteers engaged in HIV prevention activities. The median number of volunteers was 10, and the mean was 51 (range 0–700, SD = 150). Ninety-one percent (21/23) of the NGOs provided a variety of services other than HIV prevention, and 78% had participated in research at some point in their history.

TABLE 2. Types of HIV/AIDS prevention programs conducted by nongovernmental organizations (NGOs) in Latin America and the Caribbean surveyed in 2001 and 2002

	NGO (n = 23)	Percent of cases
Capacity building and train-the-trainer activities	10	43.5
Individual and small group face-to-face programs	8	34.8
Small, mass and electronic media campaigns	6	26.1
Outreach at the individual and community level	6	26.1
Peer education	5	21.7
AIDS 101 presentations	5	21.7
Support and prevention services for HIV-positive people	4	17.4
Political action programs	3	13.0
Informational resource centers	3	13.0
AIDS hotlines	2	8.7
Condom distribution	2	8.7
HIV testing and counseling	2	8.7
Production of materials	1	4.3
Life skills training	1	4.3

TABLE 3. Populations served by Latin American and Caribbean nongovernmental organizations (NGOs) surveyed in 2001 and 2002

	NGO (n = 23)	Percent of cases
General population/Community	19	82.6
Children/Adolescents	8	34.8
Men who have sex with men	7	30.4
HIV-positive persons and their families	5	21.7
Other nongovernmental organizations	5	21.7
Governmental organizations	4	17.4
Medical and nonmedical service personnel	4	17.4
Commercial sex workers	3	13.0
Intravenous drug users	2	8.7
Women at risk	1	4.3

Types of prevention programs

Fifty-eight direct-service HIV prevention programs serving different at-risk populations were described. Program types were coded into one of 14 categories (Table 2). The three most frequently reported program types were: (1) organizational capacity building or train-the-trainer activities (43.5% 10/23), (2) small-group or individual face-to-face prevention activities (34.8%, 8/23), and (3) information dissemination campaigns that included print, mass (e.g., billboards and posters) and electronic media (26.1%, 6/23).

Populations served

Table 3 summarizes the community populations served by the NGOs. Because most NGOs served more than one population, the percentages do not add up to 100%. The most frequently reported service populations were: general community (82.6%), children and adolescents 34.8%, and men who have sex with men (30.4%). Almost 22% (5/23) served persons who had HIV infection and their families.

Barriers to HIV prevention

Many barriers to the delivery of HIV prevention services were identified. The three most frequently cited barriers were: (1) Lack of funding (60.9%); (2) HIV-related stigma and discrimination (56.5%) ; and (3) reported religious, cultural and secular beliefs regarding condom use, homosexuality, and AIDS (43.4%) (Table 4).

Case studies

Despite the difficulties encountered in mounting effective prevention efforts, many NGOs have used innovation, science, and creativity to develop programs to curb the further spread of HIV in the Region. In order to highlight the innovative responses adopted by many NGOs to counteract the socioeconomic, political, and cultural barriers to prevention efforts in the area, we selected three organizations as case studies for the present paper. These organizations were selected because they varied in terms of size, budget, years in operation, mission, and the approaches used to provide information about prevention, and we wanted to present a broad spectrum of prevention approaches. The Bolivia Harm Reduction Network is a single-program NGO, whereas *Visión Mundial* is an international agency with affiliates in more than 140 coun-

TABLE 4. Barriers to HIV/AIDS prevention services reported by Latin American and Caribbean nongovernmental organizations (NGOs) surveyed in 2001 and 2002

Barrier	NGOs (n = 23)	Percent of cases
Lack of funding	14	60.9
Discrimination and stigma about HIV	13	56.5
Religious, cultural and secular beliefs	10	43.4
Lack of infrastructure support and qualified personnel	6	26.1
Governmental indifference or neglect	5	21.7
Social discomfort/reluctance in discussing sex and sexuality	5	21.7
Low community perception of risk	2	8.7
Economic and social problems (other than HIV)	2	8.7
Gender inequality	1	4.3

tries. The *Liga Colombiana de Lucha Contra el SIDA* is a grass roots, AIDS service organization similar in activities and scope to AIDS service organizations in the United States (Table 5).

El Museo de la Coca, *Bolivia Harm Reduction Network, La Paz, Bolivia*

Background. The program implemented at the *Museo de la Coca* is based on a harm reduction model that emphasizes stopping substance use and, for those who cannot or will not stop, reducing risks associated with drug use. It also aims to reduce the risk of HIV infection and other sexually transmitted infections (STI) by explaining the connection between sexual behavior, drug use (especially cocaine) and HIV infection.

Program description. The program takes the form of museum exhibits that trace the history and use of the coca plant in the Andean subregion. Trained volunteers guided small groups of visitors, many of whom are tourists, through the exhibits. Because the museum draws many visitors who are cocaine users or who are experimenting with the drug, the exhibits are designed to engage them in prevention-relevant conversations. Volunteers are trained to use a client-centered approach for tailoring the prevention information to the specific circumstances of the individual visitors and making referrals to drug treatment or other services as necessary.

Staff and volunteer training. Staff and volunteers participate in an intensive three-step training program that lasts up to 3 months. The first component consists of traditional AIDS education (e.g., transmission, prevention, treatment) as well as a desensitization and personalization process. In addition to didactic lessons and group discussions on a variety of topic areas, the training includes daily interactions with persons who have HIV and visiting AIDS treatment centers. This component helps trainees to understand the real issues of HIV disease, and to dispel myths and misconceptions regarding HIV and individuals living with HIV. The second component teaches effective prevention messages and communication skills regarding sex, drugs, and HIV infection. Trainees practice engaging individuals in prevention dialogues and using the exhibits to initiate these conversations. They also learn to observe body language and to generate probes that could trigger further prevention con-

TABLE 5. Summary of organizational characteristics of the three nongovernmental organizations described in the case studies

Name		
El Museo de la Coca Bolivia Harm Reduction Network	*Visión Mundial*'s *Iniciativa Esperanza*	*Liga Colombiana de Lucha contra el SIDA*
Location		
La Paz, Bolivia	Santo Domingo, Dominican Republic	Santa Fe de Bogotá, Colombia
Background		
The program uses a harm reduction approach to the prevention of cocaine use.	*Iniciativa Esperanza* incorporates HIV prevention and care activities into their broader health promotion and disease prevention program.	This organization began as a grass-roots effort to provide hospice care for terminally ill AIDS patients.
Program description		
Program takes the guise of a "museum exhibit" that traces the history and use of the coca plant. Prevention education is provided as part of these exhibits.	*Iniciativa Esperanza* conducts activities geared towards influencing, empowering and training community members to become health advocates.	Program activities consist of distributing HIV/AIDS information, sexual health workshops, peer outreach and HIV testing.
Staff		
Staff and volunteers participate in a three-step training program lasting three months.	The agency has one full-time employee (FTE) fully dedicated to HIV/STI prevention. Twenty FTEs dedicate 30% of their effort to HIV/STI[a] prevention.	Program staff consists of both paid employees and volunteers. All go through an intensive 3-month training program.
Intervention		
The intervention is delivered as part of the conversations that ensue while visitors are being guided through the museum.	HIV/STI prevention efforts are presented within each of the agency's health promotion and disease prevention activities.	Interventions are implemented based on the identified needs of the target population and availability of trained staff.

[a] STI = sexually transmitted infection.

versations. The last component is considered the apprentice period, where the trainee first observes a fully trained volunteer conducting the prevention activities (e.g., guiding a group of visitors through the museum) and then conducts the prevention activity until he or she has mastered the skill.

Intervention delivery. The intervention is delivered as part of the conversations that ensue while visitors are being guided through the museum. Using a client-centered approach, volunteers and staff engage visitors in a variety of prevention topics that include basic information about HIV, the link between substance abuse and HIV infection, and the link between risky sexual behavior, substance use, and HIV. Staff and volunteers are trained to skillfully steer these conversations so that effective prevention messages can be delivered and the visitors remain receptive to these messages. Prevention conversations are tailored to the specific situation of the visitor. During the course of these conversations, visitors often admit to using or experimenting with cocaine. They are encouraged to quit and are offered and referred to drug treatment serves. In addition, those who are interested in a less harmful alternative to cocaine powder are offered free lessons in chewing coca leaves. Psychiatric, psychological and other professional referrals are also made on a case-by-case basis.

Visión Mundial, *Santo Domingo, Dominican Republic*

Background. *Visión Mundial* (World Vision) is an international, Christian relief and development organization founded in 1950 with affiliates in 140 countries. Its mission is to serve the world's poorest children and families. Although its scope is international, the affiliates in each country perceive themselves to be a national NGO. *Visión Mundial* Dominican Republic was established in 1988 with the mission of conducting health promotion activities to improve the lives of children and families. Approximately 5%–10% of the agency's resources are dedicated specifically to HIV prevention.

As a response to the HIV/AIDS epidemic, World Vision launched the Hope Initiative with the goal of reducing the impact of HIV and AIDS on children and families through prevention, care, and advocacy. In the Dominican Republic, the Hope Initiative (or *Iniciativa Esperanza*) was initiated in 1997. In December 2000, they made the programmatic decision to incorporate HIV prevention and care activities into their broader health promotion and disease prevention agenda.

Program description. Using a community mobilization approach, the NGO conducts activities geared towards influencing, empowering, and training community members to become health promotion advocates in their respective communities. The programs are family-focused and work through the existing social, religious, and civic institutions. To gain credibility in each community, the NGO identifies and gains support from formal and informal community leaders and establishes collaborations with public and private entities in each community. It then works with these leaders to conduct a community needs assessment to determine the type of health promotion and disease prevention activities that are most needed. A plan of operation is developed and revised annually. These plans are typically organized around four components: (1) *Prevención* (prevention); (2) *Atención* (attention/care); (3) *Mitigación* (mitigation); and (4) *Defensoría* (advocacy). Although each component targets different sectors or individuals in each community, these components are intended to work synergistically to advance the goal of community-wide health promotion and disease prevention. HIV prevention activities are woven into each component.

The prevention component is geared towards developing and promoting healthy families. Families participate in train-the-trainer activities in which community members are trained to disseminate health promotion and disease prevention information on a wide range of health promotion topics. HIV and STI prevention information is embedded within this broader curriculum.

The second component, attention/care, is directed at promoting access and linking individuals and families to existing community resources, and facilitating the coordination of service delivery through case management, counseling, and other services. The NGO aims to create a culture of care for people living with HIV/AIDS and the orphans and vulnerable children impacted by the disease.

The mitigation component targets health care workers and other allied health professionals. It seeks to develop alliances with these individuals and to assist them to more effectively conduct their day-to-day activities by providing information and access to available resources. The advocacy component focuses on mobilizing political forces and creating the political will to promote health and reduce diseases. Activities included are: (1) working with the political process to pass antidiscrimination laws or laws that protect the civil rights of all individuals, (2) mounting community-wide information efforts to reduce discrimination and stigmatization of certain diseases, including HIV infection, and (3) mobilizing political forces to increase access to health services. In the HIV arena, advocacy efforts have been directed at promoting public policies and programs that prevent new infections and provide maximum care for those living with or affected by HIV. Efforts include promoting access to antiretroviral drugs and reducing discrimination towards persons who have HIV/AIDS.

Staffing. The agency has only one full-time employee dedicated 100% to HIV/STI prevention. Twenty additional full-time employees dedicate approximately 30% of their time to prevention efforts. The Hope Initiative is run by a combination of agency staff and community members and is designed to be self-sustaining, with periodic assistance from the NGO.

Intervention delivery. HIV/STI prevention efforts are embedded within the broader, overarching agency mission of health promotion and disease prevention. HIV and STI are included as target diseases in the NGO's mission to promote healthy communities.

Liga Colombiana de Lucha Contra el SIDA, *Santa Fe de Bogotá, Colombia*

Background. The *Liga Colombiana de Lucha Contra el SIDA,* Santa Fe de Bogotá, Colombia, began as a grass-roots effort in 1983 to provide a place where terminally ill AIDS patients, primarily gay men, could live and die. The NGO is one of the largest AIDS service organizations in Bogotá and has expanded its service populations to include women infected with and affected by HIV, sex workers, and young people. Approximately 75% of agency resources are dedicated to HIV prevention services.

Program description. Started in 1993, Project Lambda, a multidimensional HIV prevention program for MSM, is one of the NGO's most enduring programs. Annual funding for the project has varied from US$ 500 to $60 000. Venues (e.g., saunas, baths, bars, clubs, public areas, and others) frequented by men who have sex with men are "mapped" continuously with observational techniques and informal discussions with the target community. Anonymous surveys of patrons of these venues are conducted regularly to identify prevention strategies, develop effective messages, and discover other factors that could be used to build a multidimensional prevention program. From these data, the NGO crafts culturally-sensitive prevention brochures, flyers and videos; develops prevention workshops; structures discussion groups; and designs an outreach program.

Program activities consist of: (1) distribution of brochures, flyers, and videos, (2) sexual health promotion workshops, (3) discussion groups that focus on sexuality and sexual health, (4) peer outreach in public venues (e.g., bars, clubs), and (5) sexual health and HIV prevention counseling, including HIV testing. The timing and delivery of these activities varies according to identified need and available resources.

Staffing. The program is staffed by both paid employees and trained volunteers. Most interventionists are volunteers. The NGO has a rigorous protocol for identifying and training volunteers: all interested parties first complete a paper and pencil survey whose results are analyzed by NGO staff. Selected individuals undergo an intensive, multidimensional training program lasting up to 3 months. Training includes seminars, workshops, and skill building sessions followed by an apprentice period.

Intervention delivery. Not all of the prevention activities are delivered simultaneously. Some activities such as workshops, discussion groups and outreach efforts occur more often than others. Although a monthly schedule of intervention activities is drafted, final decisions are often based on the identified needs of the target population and the availability of trained staff to deliver the program.

DISCUSSION

The diverse characteristics of the HIV epidemic in LAC—coupled with the region's economic, political, and social circumstances—present many challenges for prevention. Although the epidemic in much of the Region remains concentrated primarily among men who have sex with men and injection drug users, there has been a slow but continuous increase in HIV prevalence rates among the general population and vulnerable groups. Adult prevalence rates in a few countries are surpassed only by those seen in Sub-Saharan Africa; nevertheless, there is still the promise that large epidemics can be averted in many other countries. Some of the most significant efforts to prevent or mitigate the impact of HIV in LAC are being conducted by NGOs. Yet these efforts have rarely been documented or published. This paper represents an important first step in this process.

One of the most interesting findings, which we highlight in the case studies presented above, is that many NGOs, particularly those in Spanish-speaking countries, have chosen to integrate HIV prevention within a broader context of sexual/reproductive health and a health promotion agenda. It is possible that NGOs adopted this approach to overcome some of the barriers hampering prevention efforts in the Region. Nonetheless, the merit of using a more comprehensive approach and the possible influence that this could have on the maintenance of intervention effects should be recognized. In the past few years many researchers have called for more holistic prevention programs (19, 20). It is encouraging to note that these efforts are already in place in many LAC countries. Studies to evaluate the effectiveness of this approach are needed.

There was great variation in the organizational characteristics of the NGOs in the sample. The NGOs with the larger budgets were located in countries where the prevalence of HIV is highest, such as Brazil, the Dominican Republic, Guyana, and Haiti. Organizations with a longer history of providing HIV prevention programs (e.g., *Liga Colombiana de Lucha Contra el SIDA*, *Asociação Brasilera Interdisciplinar de AIDS*, or *Corporación Chilena de Prevención del SIDA*) were those whose initial efforts were directed towards men who have sex with men, the population group that was initially the most clearly affected. Although most NGOs reported directing prevention services towards the general population or the community, few NGOs served this group exclusively. In short, the populations served by the NGOs tended to reflect the characteristics of the epidemic in their respective countries.

The most frequent type of prevention program offered by NGOs focused on building capacity in other organizations or individuals to provide prevention services. This type of program was particularly prevalent among NGOs from Spanish-speaking

countries such as Paraguay, Uruguay, Nicaragua, and the Dominican Republic, one of the case studies highlighted in this paper. Organizations whose target populations included young people or men who have sex with men tended to provide prevention services which included individual and small-group programs, peer education, and outreach. In countries where the prevalence of HIV is high and epidemics have lasted longer (e.g., Brazil and Haiti), NGOs offered prevention services to persons with HIV/AIDS.

The NGOs identified a number of barriers to the delivery of HIV prevention services. Insufficient funding, discrimination and stigma related with HIV, and religious, cultural, and secular beliefs were the three most frequently cited barriers to prevention. Interestingly, NGOs from English- or French-speaking countries (n = 9) ranked the importance of these barriers differently than NGOs from Spanish-speaking nations (n = 14). For instance, all NGOs in English- or French-speaking nations reported lack of funding as the most important barrier to prevention, yet only 35.7% of NGOs from Spanish-speaking nations did so. Our data indicate that several NGOs in Spanish-speaking countries developed innovative strategies for obtaining program funding, and this could have reduced the salience of this factor as an impediment to prevention. For instance, *Acción por Solidaridad* (Venezuela) has an established group of private supporters who make monthly contributions through automatic charges to their credit card. Others, such as the *Museo de la Coca*, developed ways to be self-sustaining through admission fees and proceeds from the museum store. It is possible that the relatively low levels of international funding available for prevention in many LAC countries spurred these organizations towards innovation in fund-raising.

The two most important barriers to prevention efforts cited by NGOs from Spanish-speaking countries were (1) discrimination and stigma (64.3%), and (2) religious, cultural and secular beliefs (64.3%). These barriers highlight some of the sociocultural issues that prevention providers must overcome in these countries. In particular, many NGOs cited the pervasive power and influence of the Catholic Church and its views on homosexuality and condom use as formidable challenges that, with time and effort, are beginning to be creatively addressed. On the other hand, 44.4% of NGOs in English- or French-speaking countries cited discrimination and stigma as barriers, and only one NGO in these countries cited religious, cultural and secular beliefs as impediments to prevention. These findings highlight the need to tailor prevention services to the social, cultural and political realities of individual nations. Future studies should explore these differences.

Because only one major NGO in each country's capital or large city was included in the sample, our findings do not necessarily mean that the activities or programs of the NGOs in this study are representative of other NGOs in the Region. Studies that use probabilistic sampling methods to select NGOs are needed to provide a more representative picture of prevention programs and activities offered in the Region.

This paper is one of the first attempts to systematically categorize HIV prevention services offered by NGOs in LAC and to describe the barriers to prevention efforts as perceived by these organizations. The diversity of programs offered and populations served underscores the many faces of the epidemic in the Region. Furthermore, the strategies used by NGOs to overcome barriers to prevention are a testament to their ingenuity and commitment. These approaches could serve as examples for NGO in other world regions and should be studied further. Because many countries in the LAC have smaller numbers of HIV/AIDS cases, the Region offers the opportunity for primary prevention efforts to impact the future growth of the HIV epidemic. International funders should direct resources and provide technical assistance to governmental and nongovernmental organizations in LAC countries. Of particular importance is the development of effective surveillance systems that could be used to better monitor epidemiologic trends, and to improve and direct primary prevention services in the Region. Efforts to evaluate the effectiveness of prevention services and support the sustainability of successful programs should also be increased. A concerted international response will help to contain the future spread of HIV in Latin America and the Caribbean.

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RESUMEN

Programas de prevención de VIH de organizaciones no gubernamentales en América Latina y el Caribe. El proyecto Global AIDS Intervention Network

Objetivo. Describir los programas de prevención de la infección por VIH y el sida de algunas organizaciones no gubernamentales (ONG).

Métodos. Estudiamos, en cada una de los 23 países que participan en el proyecto Global AIDS Intervention Network (GAIN) en América Latina y el Caribe, una ONG que lleva a cabo programas de prevención. La muestra se seleccionó mediante un proceso bietápico: 1) una búsqueda en bases de datos y otras fuentes; 2) la identificación de las ONG mejor establecidas y más activas en el campo de la prevención de la infección por VIH, según fuentes autorizadas. A los directores ejecutivos se les hizo preguntas acerca de los programas de prevención, el personal, los presupuestos, las poblaciones con las que trabajaban y las barreras a su trabajo.

Resultados. Las 23 ONG llevaban a cabo 58 programas de servicio directo y tenían un promedio de 8 años de estar proveyendo programas de prevención. El promedio anual del presupuesto era de US$ 205 393 (intervalo de US$ 10 000 a US$ 1 440 000), y el número promedio de empleados a tiempo completo era de 4,5 (intervalo de 0–15, DE = 4,7.) Muchas ONG dependían de los voluntarios para los programas de prevención (mediana = 10, promedio = 51, intervalo de 0–700, DE = 150). Las ONG ofrecían programas de prevención dedicados a la comunidad en general (82,6%), a jóvenes y adolescentes (34,8%), y a hombres que tienen relaciones sexuales con otros hombres (30,4%). Las actividades de las ONG consistían en entrenar a los entrenadores para todo tipo de actividades (43,5%) y en realizar programas de prevención cara a cara con los participantes (34,8%). Se citaron como obstáculos la falta de fondos (60,9%) y la discriminación y estigma relacionados con la infección por el VIH (56,5%).

Conclusiones. Las estrategias que emplean estas ONG para sobrepasar las barreras a la prevención son prueba de su inventiva y dedicación y sirven como ejemplo para las ONG en otras regiones del mundo.

Palabras clave SIDA, prevención y control, América Latina, organizaciones no gubernamentales.