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HIV Behavior Change Communications Program for High Prevalence Sites in Mexico

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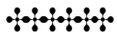
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ACRONYMS

ABC	Abstinence, Be Faithful, Condoms
ARV	Anti-Retroviral
BCC	Behavior Change Communication
CENSIDA	Centro Nacional para la prevención y el control del VIH
CSM	Condom Social Marketing
FSW	Female Sex Worker
FY	Fiscal Year
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NSP	Needle exchange and Syringe Program
PEPFAR	President's Emergency Plan For AIDS Response
PSI	Population Services International
PWID	People Who Inject Drugs
PwP	Prevention with Positives
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
ZM	Zona Metropolitana (Metropolitan Zone)

EXECUTIVE SUMMARY

For over 10 years, the U.S. Agency for International Development (USAID) has implemented a program to address Mexico's HIV/AIDS epidemic, in support of the common interests of the governments of the United States and Mexico. The objectives of this study are to present the basic factors driving the Mexican epidemic, to analyze the USAID HIV/AIDS prevention program objectives and implementation practices during the period 2005-2009, and to provide recommendations for future prevention priorities.

As of March 31, 2009, 130,969 cumulative AIDS cases had been registered in Mexico; 82.4 percent of the cases were men, with a man-to-woman ratio of 4.7. (CENSIDA, 2009) The government of Mexico's 2007-2012 strategic plan for HIV/AIDS and STIs identifies a concentration of the epidemic in key populations: MSM, FSW and MSW, and PWID. (Secretaría de Salud, 2008) Several studies provide compelling evidence for a targeted response to the epidemic.

The USAID program for Mexico focuses on reduction in the risk of HIV transmission in vulnerable populations with high prevalence by supporting behavior change activities and commercial condom distribution. Additionally, it promotes positive political change, multi-sectoral participation, stigma reduction, and equitable policies in the workplace. These activities have been designed and implemented in accordance with the priorities and strategies of CENSIDA.

During 2005-2009, USAID implemented HIV prevention activities through two projects. The first, called Behavior Change in High-Prevalence and Vulnerable HIV/AIDS Populations in Mexico, is a BCC program implemented by PSI. A second project, called Condom Availability in Private Sector High-Risk Outlet Project in Mexico, is a small targeted condom social marketing (CSM) program implemented by Abt. Associates (under a sub-agreement with PSI.) The BCC program was designed to support the following prevention objectives:

- Change behaviors in order to reduce the transmission of HIV and other STIs, including the reduction of sexual risk behaviors, and to increase risk perception in populations with high prevalence using strategies based on the ABC focus; and
- Increase coordination of prevention services for populations with high prevalence of HIV between public and private institutions that provide voluntary counseling and testing and care for other STIs with an aim of increasing the demand for both

Grounded in BCC best practices, the USAID BCC program adapted a series of interventions and messages to the Mexican context. Through the program, USAID implemented prevention strategies and messages that supported policies promoted by Mexican authorities. The prevention interventions can be grouped into six categories: individual outreach, group outreach, multi-session activities, support groups, event-based activities, and communication campaigns. The individual, small group, and multi-session behavior change interventions were designed using the Stages of Change theory. (Prochaska et al., 1997)

The implementation strategy included a focus on reaching the highest possible coverage of target populations in high-risk areas. Experience in the field, paralleled with local research results, brought about several programmatic changes over the course of implementation, improving the interventions for the target populations. In 2005, the BCC program began operating in 11 cities located in eight states and expanded to 24 cities in 15 states by 2006. In 2008, a strategic decision was made to decrease the program's geographic coverage to eight cities in seven states, with a slight decrease in the number of activities implemented and people reached.

The USAID BCC program implemented approximately 57,000 activities between fiscal years 2005 and 2009. Throughout the project, the individual intervention called *Salvando VIHdas* was the predominant program activity, representing over 70 percent of all BCC activities (figure 4). From 2005 to 2008 fiscal years, there was a steady increase in the number of individual interventions and a decrease in the number of small group interventions.

An analysis of 2009 PSI survey with MSM, was done to learn if exposure to select BCC activities has driven changes in behavior. In general, exposure to the HIV prevention program was associated with:

- Reduced number of sexual partners among MSM:
- Increased condom use in the 12 months prior to the MSM survey
- Increased probability of having used a condom during their last sexual encounter
- Increased probability of carrying a condom at the time of the survey
- Increased the number of times that an individual had tested for HIV

The Condom Availability in Private Sector High-Risk Outlet Project in Mexico was designed to increase the availability and promotion of condoms in non-traditional venues (bars, discos, brothels, grocery stores, etc.). Work on establishing condom availability in non-traditional venues began in 2006 through the CSM program, although actual sales distribution did not begin until 2008. At the time the fieldwork for this study (2008-2009) was conducted, records showed that the program's condom sales totaled approximately 1,700 boxes of condoms, with 3 condoms per box. Subsequent program reports showed that a total of approximately 38,000 branded condom units were sold by the final project year (2009). All lubricant sales (120 units) for the CSM program took place in Cancún.

This paper makes the following recommendations:

Innovative intervention strategies: Consider new strategies and best practices. For example, a mobile clinic for sex workers supported by the University of California showed promise in Mexicali. Explore key structural interventions such as removing the obligatory HIV testing for sex workers. Removing obligatory testing may promote voluntary counseling and testing among this population. Always look for proactive ways to adapt prevention strategies, such as the Tom Patterson's motivational interviewing technique used in northern border cities in Mexico or the PEER Methodology used in Central America and the Caribbean.

Feasibility study for needle exchange programs: In July 2010, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) issued new guidance for HIV prevention among PWID. The new guidance encourages a "comprehensive HIV prevention package" for PWID including needle and syringe programs and harm reduction strategies previously prohibited by PEPFAR. According to the revised guidance "needle exchange and syringe programs (NSPs) do not increase the numbers of persons who begin to inject drugs or increase the frequency of drug use" and "studies have shown that NSPs result in decreases in drug-related risk behavior." (PEPFAR, 2010) Future programming in Mexico should use the change in guidance as an opportunity to explore the feasibility USAID-funded NSPs.

Develop appropriate goal behaviors and BCC messages for targeted high risk groups: In 2005, PEPFAR introduced a new rule that at least two-thirds of all funds for preventing sexual transmission of HIV should be spent on promoting AB messages. The remaining one third of money for preventing sexual transmission was to be spent on condoms and related activities.

These spending requirements led to the inappropriate use of AB messages with high risk populations in Mexico as described above and in table 6. Seventy-one percent of the people reached with BCC activities between 2007 and 2009 were reached with messages such as correct and consistent condom use, use of water-based lubricants, using clean needles, and getting an HIV test, while the remaining program activities focused on AB messages for high-risk groups.

Messages tailored to high-risk sexual behaviors should be increased to 100% of all program activities and supported by adequate condom distribution. Harm reduction and clean needle messages now can be supported by the provision of needle exchange and syringe programs. Future HIV prevention programs for high-risk populations, such as sex workers, MSM, and IDU, should choose evidence-based strategies and locally appropriate messages that are unhindered by outdated or ineffective approaches.

Evaluate the condom availability in non-traditional venues program: The program to increase private non-traditional condom outlets and the BCC program to change risky behaviors of people most at risk for HIV infection, including CSM, were implemented in parallel, but were not coordinated. This management practice has been noted in USAID programs in more than one country. Further evaluation of these two condom promotion strategies and how they might be implemented as one strategy in Mexico would be useful to future planning.

Program monitoring and evaluation: Better program record keeping should be mandated. Routine program data quality checks should be implemented by USAID for the next HIV prevention program. Baseline and end-line behavior surveys should be well planned and well-funded at the start of the program, in order to allow for comparison. Clearly defined target populations, well designed sampling methodology, and HIV testing will allow the next prevention program to be evaluated using behavioral surveys.

Program coverage: According to anecdotal evidence, the BCC program was reaching the same individuals with the same materials over and over, which can lead to a saturation of

the message. In order to increase the quality of the interventions, future programs should use the strong relationships with previously identified target populations to introduce new prevention strategies, new materials, and new messages that are tailored to each local population as stated in the first recommendation. Once quality programming and strong monitoring and evaluation have been established in key sites, geographic expansion is possible.

Local and national governments have suggested the following proposals: in the state of Veracruz, increase the reach of the program to Boca del Río, which is part of the metropolitan area of the city of Veracruz, and consider the incorporation of Coatzacoalcos, San Andrés, Cosamaloapan, and Tierra Blanca. Starting from the work based in Mexicali, consider the inclusion of Kilometer 53, which is on the border with Sonora. With the Mexico City base, consider changing the interventions toward missions further away from the center of the city and with a smaller presence of other organizations, and incorporating surrounding municipalities in the state of Mexico where organizations are not working (or agree upon associations with the existing organizations in order to avoid overlap in the work being done).

Target populations: Prioritize PLWHA, SWs, MSM, and IDU. Consider expanding programs to transgender communities and incarcerated populations, but keep in mind new prevention strategies are required for new target populations.

PLWHA: Programs for PLWHA must include comprehensive support services. PEPFAR uses the term “prevention with positives” (PwP) to describe a minimum package of services. PwP includes providing HIV-positive individuals with information about ways they can protect their own health, encouraging and counseling HIV-positive persons to prevent transmission of HIV, promoting and providing condoms to sexually active HIV-positive individuals, developing strategies to increase adherence to prevention of mother-to-child transmission of HIV and therapeutic treatment regimens, discussing with all HIV-positive persons strategies for disclosing one’s HIV status to sex partners, and offering confidential HIV testing to the sex partners of and children born to all individuals who are living with HIV/AIDS.

Field research on transgender populations: In order to explore the need and feasibility of work with transgender populations, small-scale, qualitative research should be considered.

Adolescents and young people: It is not recommended for USAID programs to direct efforts toward these vulnerable populations because other agencies are providing programming for them. When working with a broad general population, significant resources are required to obtain evident changes in behavior and HIV prevalence.

Relations with national, state, and local HIV/AIDS authorities: With a goal of better utilizing resources to provide maximum coverage and quality, it is highly recommended that the implementing partner charged with conducting activities is empowered and required to coordinate with the local and national governments. Host country government authorities have better knowledge of the characteristics of the epidemic, the needs of the population, and the corresponding prevention work being done by other organizations. Additionally,

coordinated work will permit the agency that is conducting the activities to diminish problems with police and business owners. A strong relationship with the health services authorities will provide proper referrals.

1. INTRODUCTION

For over 10 years, the U.S. Agency for International Development (USAID) has implemented a program to address Mexico's HIV/AIDS epidemic, in support of the common interests of the governments of the United States and Mexico. The objectives of this study are to present the basic factors driving the Mexican epidemic, to analyze the USAID HIV/AIDS prevention program objectives and implementation practices during the period 2005-2009, and to provide recommendations for future prevention priorities.

Between July 1 and September 15, 2009, approximately 700 documents from USAID, Population Services International (PSI), and the MEASURE Evaluation project were reviewed. In order to describe the activities carried out by USAID/Mexico, a database was developed from monthly program records. Using data a 2009 survey of men who have sex with men (MSM) in three cities, (PSI Mexico, 2009) impact evaluation models (propensity score matching) were designed to measure the impact of interventions on several key behavior indicators (number of sex partners, condom use with casual partners, carrying a condom, taking an HIV test). Field visits in Mexico City, Mexicali, and Veracruz included interviews with program managers and observation of behavior change communication (BCC) program activities directed toward female and transgender sex workers, MSM, incarcerated men, and people who inject drugs (PWID). Visits to non-traditional sites for condom sales through the social condom distribution program in Veracruz were also conducted.

2. THE HIV/AIDS EPIDEMIC IN MEXICO

According to a 2005 census, Mexico's population in its 32 states is about 103 million. Because of the flow of people between Mexico and the United States, HIV/AIDS has been a joint health priority for the two countries since the beginning of the epidemic. Bi-national cooperation has been considered essential for the development of prevention and care interventions. As of March 31, 2009, 130,969 cumulative AIDS cases had been registered in Mexico; 82.4 percent of the cases were men, with a man-to-woman ratio of 4.7.^a (CENSIDA, 2009)

The decentralization of health care services in Mexico mandated that prevention and control of HIV/AIDS and other sexually transmitted infections (STI) fell under the responsibility of each of the 32 states, many of which maintained a focus on medical care. As part of the federal response, the National Center for Prevention and Control of HIV/AIDS (CENSIDA) supported human rights programs, activities to diminish stigma and discrimination, communication campaigns focusing on HIV prevention and condom use, plans focused on gender, and self-help groups. By the end of 2003, Mexico reached the goal of universal access to antiretroviral (ARV) treatment; and in 2007, almost 20,000 people living with HIV/AIDS (PLWHA) who had no health insurance received treatment. (Secretaría de Salud, 2007) In 2006, the federal government supported HIV prevention projects that targeted key

^a The under-registration of cases and delay in notification are factors that must be considered.

populations and were developed by civil society organizations. In this period, a harm reduction program for the PWID was launched.

Mexico's HIV epidemic is considered to be concentrated among specific populations, including MSM, male and female sex workers (MSW and FSW), PWID, and incarcerated men. Several studies provide compelling evidence for a targeted response to the epidemic.

Researchers have found HIV prevalence in MSM populations that range from 8.9 percent to 20.5 percent.^b (Magis-Rodríguez et al., 2008; Gayet et al., 2007; Ritieni et al., 2006; Ruiz et al., 2005) A 2001 study in Tijuana found a prevalence of 20.5 percent in a sample of MSM, of whom 41 percent reported using injection drugs. In MSW populations, the HIV prevalence ranges from 12 to 25.5 percent.^c Among FSW, the HIV prevalence ranges from one to 6.4 percent.^d Injection drug use was common among the six percent of HIV-positive FSW in Tijuana and Ciudad Juárez between 2004 and 2006. An investigation conducted in Tijuana between 2006 and 2007 found an HIV prevalence of 4 percent among clients of sex workers, which was also associated with injection drug use. A review of various publications gives a range of HIV prevalence between 2.3 percent and 6.5 percent for PWID in Mexico. (Magis-Rodríguez, 2009) There are few studies on the prevalence of HIV among incarcerated populations. Prevalence rates published for various incarcerated populations range from 0.6 to 2.8 percent.^e (Zárraga et al., 2009; Alvarado-Esquivel et al., 2005; Flores-Sánchez et al., 2005) A recent study shows that 76 percent of PWID had a history of incarceration, of which 61 percent injected while in prison and 75 percent shared syringes. (Pollini et al., 2009)

USAID/Mexico has conducted studies with target populations to establish basic behavior indicators. Ideally, surveys would have been conducted prior to the start of a 2005-2009 prevention program. The studies presented below were completed in 2007 and 2008 and used to design preventive interventions in 2008 and 2009. The results can also serve as baselines for future interventions.

^b MSM prevalence studies (Magis-Rodríguez et al., 2008; Gayet et al., 2007) include the following results: 13.8 percent in Guadalajara, Jalisco in 2003; 9.3 percent in Acapulco, Guerrero in 2005; 10.8 percent in Monterrey, Nuevo León in 2005; 10.5 percent in Nezahualcóyotl, Estado de México in 2005; 8.9 percent in Tampico, Tamaulipas in 2006. In the city of Mexicali, a prevalence of 10 percent was found in a study carried out between 2003 and 2005 (Ritieni, A., et al., 2005), while in Tijuana a prevalence of 20.5 percent was found in 2001, in a sample of MSM of whom 41 percent reporting using injection drugs (Ruiz, J.D. et al., 2006).

^c MSW prevalence studies (Magis-Rodríguez et al., 2008) included the following results: 18.7 percent in Guadalajara, Jalisco in 2003; 21.1 percent in Mexico City, Distrito Federal in 2003; 25.5 percent in Monterrey, Nuevo León in 2005; and 12 percent in Nezahualcóyotl, Estado de México in 2005.

^d These findings included 4.2 percent in Veracruz and Boca del Río, Veracruz in 2003; 1 percent in Acapulco in 2005; and 1 percent in Monterrey in 2005. In cities on the border between Mexico and the United States, many studies have been conducted in order to determine the HIV prevalence in this population. A prevalence of 6.4 percent was found in Tijuana, Baja California in 2003; a prevalence of 6 percent was found in Tijuana and Ciudad Juárez between 2004 and 2006, which was significantly associated with injection drug use. An investigation conducted in Tijuana between 2006 and 2007 (Patterson et al., 2009) found an HIV prevalence of 4 percent among clients of sex workers, also associated with injection drug use.

^e In Nuevo León in 2008, a prevalence of 2.8 percent was published in a small purposive sample that used rapid testing. In the first half of 2006, health authorities in the city of Veracruz determined an estimated prevalence of 1.6 percent. (Zárraga, et al., 2009) An HIV prevalence of 0.6 percent was found in inmates in Durango. In the year 2002, a prevalence of 1.8 percent was found in Nuevo Laredo, Tamaulipas. (Alvarado-Esquivel, C., 2005; Flores-Sánchez, et al., 2002)

A 2007 survey of MSM (PSI Mexico, 2007) showed that condom use in the last sexual encounter with a casual partner was high (77 percent), yet insufficient (table 1). Only half of the respondents indicated condom use with their last regular partner. A high proportion had ever taken an HIV test (96 percent), but a lower proportion had taken one in the last year (70 percent).

Table 1: Sexual Risk Behaviors among MSM in Five Mexican Cities⁺

(N=904)	Condom use in the last sexual encounter with a casual partner	Condom use at last sexual encounter with a regular partner	Condom use at last sexual encounter with a woman	More than one partner in the last 12 months	Has ever been tested for HIV and received the results	Tested for HIV in the last 12 months
Percent	77.4**	49.9	61.1	51.1	95.8	70.4
Number of respondents	(n=871)	(n=611)	(n=178)	(n= 904)	(n=588)	(n= 588)

⁺ Ciudad de México, Mérida, Mexicali, Tapachula, and Veracruz.

* Excludes sex workers

** Confidential question

A survey conducted with primarily males who inject drugs examined sexual as well as injection behaviors (table 2).(PSI Mexico, 2008) The results indicate that the majority (66 percent) reported never using a condom with a stable partner. In the case of occasional partners, 57 percent indicated that they always used a condom. The proportion is higher for commercial partners, with 62 percent of PWID stating that they always used condoms. Only 15 percent of the respondents said that they always used new syringes. Forty-six percent stated that they injected with used needles or syringes more than half of the time, and 49 percent said that they always shared needles or syringes in the last month. Seven out of ten IDU reported sharing syringes or needles more than half of the time or always in the last month.

Among incarcerated men, condom use is notably low (table 3) (PSI Mexico, 2008). About 8 percent of incarcerated men interviewed reported having sexual encounters with men in the last 12 months and 57 percent of those respondents reported using a condom in the last sexual encounter with a man. Ninety-seven percent of incarcerated men reported having sexual encounters with women in the last 12 months and 33 percent of those respondents reported using a condom at their last encounter with a woman. Twenty percent indicated having injected some form of drug, medication, vitamin or nutritional supplements in the last year. Of this proportion, nearly all (97 percent) reported using a new syringe.

Table 2: Sexual and Drug Risk Behaviors of PWID in Mexicali and San Luis Rio Colorado

(Total sample N=125)	Condom use with stable partners in the last 3 months % (n=56)	Condom use with casual partners in the last 3 months % (n=44)	Condom use w/ CSWs in the last 3 months % (n=21)	New needles used in the last month % (n=123)	Used needles used in the last month % (n=124)	Shared needles used in the last month % (n=124)	Used needle was utilized the last time they injected % (N=125)
Total							64.0
Never	66.1	29.5	23.8	4.9	8.1	15.3	---
Less than half of the time	10.7	6.8	4.8	39.9	25.0	14.5	---
More than half of the time	5.4	6.8	9.5	39.9	46.0	21.8	---
Always	17.9	56.8	61.9	15.4	21.0	48.8	---

Table 3: Behavior Indicators of Incarcerated Populations in Four Mexican Cities (2008)[^]

	Condom use in last sexual encounter with a man					Condom use in last sexual encounter with a woman		Injected drugs, medication, vitamins or food supplements in the last 12 months		Used new syringe last time injected drugs, medication, vitamins or food supplements		Used friend's syringe last time injected drugs, medication, vitamins or food supplements	
	N	%	n	%	n	%	n	%	n	%	n		
Total	877	57.0	75	33.0	848	20.0	177	97.0	169	5.0	8		
DF. Rec. Norte	304	55.0	16	31.0	89	25.2	77	97.0	74	2.7	2		
DF. Rec. Oriente	304	59.0	17	32.0	93	18.0	54	96.0	51	8.0	4		
Guadalajara	217	59.0	17	32.0	93	18.0	54	96.0	51	8.0	4		
Mexicali	24	--	--	35.0	4	45.0	7	--	--	--	--		
Veracruz	24	--	--	65.0	13	45.0	7	--	--	--	--		

[^]Data is missing for these variables in the report.

3. THE NATIONAL RESPONSE

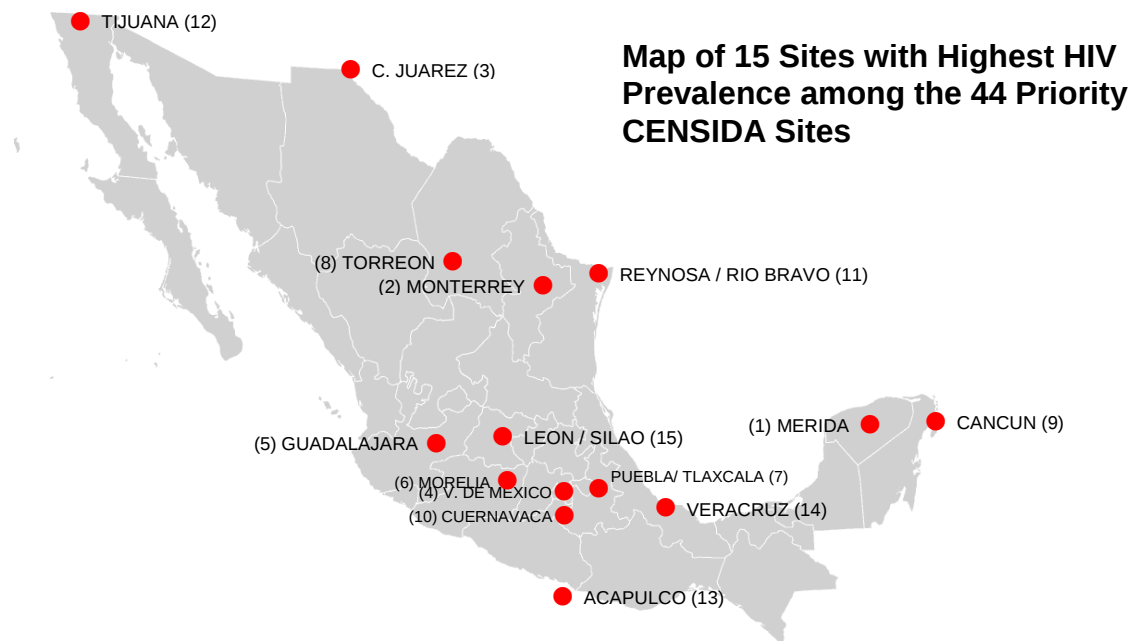
The government of Mexico's 2007-2012 program plan for responding to HIV/AIDS and STIs identifies a concentration of the epidemic in key populations: MSM, FSW and MSW, and PWID. (Secretaría de Salud, 2008) The plan includes prevention of HIV transmission and control of the AIDS epidemic as a strategy, including the following action items:

- Focused strategies for prevention of sexual transmission, taking into account the needs of key populations, which include access to condoms, lubricant, HIV and STI diagnostic tests, and sex education;
- Harm reduction programs associated with HIV transmission through drug use in the states with higher prevalence;
- Social marketing of male and female condoms;
- Preventive programs based at the ambulatory centers for prevention and treatment of AIDS and STIs throughout Mexico;
- Observance of blood safety guidelines for hemoderivatives and transplants, regarding HIV, syphilis, and hepatitis B;
- Field investigation on human sexuality in order to prevent HIV/AIDS and STIs; and
- Technical competence of civil society organizations working on HIV/AIDS.

Since Mexico has an urban epidemic, CENSIDA has identified 44 metropolitan areas as priority sites. These 44 cities were selected because they rank higher in an ordinal index that considers the city's size, HIV prevalence, and percentage of the country's MSM population.^f All states, with the exception of one (Zacatecas), have one or more cities on the list. Together, these cities contain 72 percent of recent AIDS cases among MSM in Mexico (2003-2008). (CENSIDA, 2009) Although there are PWID scattered throughout the country, based on service reports provided by institutions under the Epidemiological Surveillance System for Addictions (SISVEA), it is estimated that 45 percent of the PWID is concentrated in four cities: Tijuana, Ciudad Juarez, Hermosillo and Guadalajara.^g (CENSIDA, 2009) These cities account for 50 percent of the recent cases of AIDS in PWID. The national program has identified 15 cities that have the highest HIV prevalence, accounting for 53 percent of the reported AIDS cases in MSM in 2003-2008. Figure 1 provides a map of the 15 sites with the highest HIV prevalence and a list of all 44 CENSIDA priority sites.

^f See Round 9 Global Fund Proposal Annex No. 4.P.

^g See Round 9 Global Fund Proposal Annex No. 4.P.



List of the 44 priority sites determined by CENSIDA

1 ZM Mérida	12 ZM Tijuana (+IDU)	23 Mazatlán	34 ZM Poza Rica
2 ZM Monterrey	13 ZM Acapulco	24 ZM Tepic-Xalisco	35 ZM Aguascalientes
3 ZM Juárez (+IDU)	14 ZM Veracruz	25 Hermosillo (+IDU)	36 ZM Saltillo
4 ZM Valle de México	15 ZM León / Silao	26 ZM Pachuca	37 Chetumal
5 ZM Guadalajara (+IDU)	16 ZM Toluca	27 ZM Villahermosa	38 ZM Tuxtla Gutierrez
6 ZM Morelia	17 ZM Colima	28 Mexicali	39 Campeche
7 ZM Puebla-Tlaxcala	18 ZM Chihuahua	29 Durango	40 ZM Xalapa
8 ZM Torreón-GP	19 ZM Tampico	30 ZM Tehuantepec/Juchitán	41 Culiacán
9 ZM Cancún	20 ZM San Luis Potosí	31 Matamoros	42 Tapachula
10 ZM Cuernavaca	21 ZM Oaxaca	32 ZM Coatzacoalcos	43 Puerto Vallarta
11 ZM Reynosa-R. Bravo	22 ZM Querétaro	33 Cdad. del Carmen	44 La Paz

Figure 1: CENSIDA sites for HIV prevention among MSM and IDU.[]

4. USAID SUPPORT TO THE NATIONAL RESPONSE

The USAID program for Mexico focuses on reduction in the risk of HIV transmission in vulnerable populations with high prevalence by supporting behavior change activities and commercial condom distribution. Additionally, it promotes positive political change, multi-sectoral participation, stigma reduction, and equitable policies in the workplace. These activities have been designed and implemented in accordance with the priorities and strategies of CENSIDA. The general objective of this cooperation is to strengthen overall national capacity to respond to the epidemic.

A project called Behavior Change in High-Prevalence and Vulnerable HIV/AIDS Populations in Mexico is a BCC program implemented by PSI. A second project, called Condom Availability in Private Sector High-Risk Outlet Project in Mexico, is a small targeted condom social marketing (CSM) program implemented by Abt. Associates through PSI. The BCC program was designed to support the following prevention objectives:

- Change behaviors in order to reduce the transmission of HIV and other STIs, including the reduction of sexual risk behaviors, and to increase risk perception in populations with high prevalence using strategies based on the ABC^h focus; and
- Increase coordination of prevention services for populations with high prevalence of HIV between public and private institutions that provide voluntary counseling and testing and care for other STIs with an aim of increasing the demand for both types of services.

5. COMPONENTS OF THE USAID PREVENTION PROGRAM IN MEXICO

The USAID prevention program focused on BCC and CSM activities to decrease vulnerability and sexual risk behavior and to promote health-seeking behaviors, such as STI treatment and HIV testing. The BCC component was rolled out quickly, while the CSM component was delayed. Separate implementation mechanisms for the two program components created challenges in management and resulted in various “disconnects” in program implementation. The initial BCC program objectives focused on sexual risk reduction, yet in the project’s fourth year, it was tasked with addressing intravenous drug use. In light of such significant challenges, many program successes can be highlighted. A brief description of the program components is provided in this section, followed by program results in the next section of this report.

5a. BCC Activities

In Mexico, HIV is transmitted primarily through sexual contact among high-risk populations and the sharing of injection instruments among PWID. The goal outlined in USAID’s BCC program framework is to promote healthy behaviors that have zero or low risk of

^h The focus emphasizes abstinence, being faithful, and using condoms.

transmitting HIV or other STIs. The USAID program identified and directed communication interventions towards target populations in specific geographic hotspots. Figure 2 provides a map of program sites.

Grounded in BCC best practices, the USAID program adapted a series of interventions and messages to the Mexican context. The implementation strategy included a focus on reaching the highest possible coverage of target populations in high-risk areas. Experience in the field, paralleled with local research results, brought about several programmatic changes over the

course of implementation, improving the interventions for the target populations. For example, field research on PWID and incarcerated populations in 2008 led to new interventions that not only focused on promoting healthy sexual behaviors, but also included communication campaigns to avoid sharing needles.

USAID implemented prevention strategies and messages that supported policies promoted by Mexican authorities. For example, campaigns with messages about abstinence and fidelity aimed toward the general populations were not conducted. However, program managers reported that abstinence and being faithful messages were incorporated into individual, small group, and general scope interventions with MSM and FSW, while also imparting information about condoms.

The prevention interventions can be grouped into six categories: individual outreach, group outreach, multi-session activities, support groups, event-based activities, and communication campaigns. The individual, small group, and multi-session behavior change interventions were designed using the Stages of Change theoryⁱ. (Prochaska et al., 1997)

The individual interventions consisted of one-on-one peer education and risk reduction counseling. The primary intervention, *Salvando Vihdas*, utilized *promotores*, or peer educators, to target MSM and FSW in venues where they were likely to meet new sex partners. *Promotores* were also used to reach incarcerated populations and PWID. The intervention promoted the prevention behaviors through in-person education and risk reduction sessions. *Ciberabordajes* was an online individual intervention introduced in

**Key Behaviors Promoted by the USAID
BCC Program**

- abstinence/delay in the initiation of sexual relations
- non-serial mutual fidelity between partners who know and periodically confirm their negative status
- reduction in number of sexual partners
- consistent condom use with stable and casual partners
- use of water-based lubricants
- referral for diagnosis and treatment of STIs
- referral for voluntary HIV counseling and testing

ⁱ The Stages of Change Theory is a psychological model of health behavior address the temporal dimension of behavior change. This theory articulates five stages of the adoption of a certain health behaviors: *Precontemplation* with no consideration of initiation of the behavior; *Contemplation* with intention or serious consideration, but without any behavior; *Preparation* or *Decision* with strong intention and irregular or tentative performance of the behavior; *Action* with recent initiation of the behavior; and *Maintenance*, i.e. the establishment of permanent behavior. (Prochaska et al., 1997)

2008. Through Internet chat rooms, it provided one-on-one prevention education and counseling for young MSM to address the key behavioral goals.

Group outreach consisted primarily of the interactive activity, *VIHDA*. The *lotería*-type game disseminated HIV and STI prevention messages. It was modified in Mexico to include abstinence and being faithful messages, as well as messages about correct and consistent condom use. *Vive la Vihda* is a multi-session group activity that aimed to promote safer sexual relationships and correct and consistent condom use among MSM, PLWHA, and incarcerated populations.

Confidencias was a prevention intervention implemented during regular PLWHA support group meetings. Beginning in 2008, the intervention promoted low-risk sexual practices and adherence to antiretroviral medications.

Three targeted communication campaigns were implemented. *Acaba Seguro* promoted consistent condom use among MSM through its message to always carry a condom. The campaign utilized a communication strategy in open spaces, discos, and bars. *Tu belleza no tiene precio* was based on face-to-face approaches and promoted condom use with different FSW partners: occasional clients, regular clients, and romantic partners. The FSW campaign was based on the Stages of Change theory. Communication materials including posters, cards, and other supplies supported key messages. *No la roles* targeted PWID to promote safe injection through the distribution of educational materials and the painting of graffiti with key program messages in shooting galleries.

The BCC program also set up booths or *kioskos* in public areas and at events. Through the booths, the program distributed educational materials, information about STI clinics, and condoms for FSW, MSM and the general population and demonstrated correct condom use.

5b. Availability of Condoms in Non-traditional Places

A USAID effort called the Condom Availability in Private Sector High-Risk Outlet Project in Mexico was a separate project focusing on targeted CSM. A 2008 MSM behaviors (PSI Mexico, 2008) demonstrated that limited access to condoms continued to be a consistent barrier to condom use among this population. Additionally, a significant number of non-condom users reported that condoms were not available in the moment they were needed. The CSM program pursued an innovative response to increase condom accessibility given that, in Mexico, virtually all condom distribution is through pharmacies, supermarkets, stores, and similar traditional venues.

In this context, the program was designed to increase the availability and promotion of condoms in non-traditional venues (bars, discos, brothels, grocery stores, etc.) with the objective of centering efforts exclusively on the prevention of HIV in vulnerable populations. The target groups for this program were MSM and FSWs, given that high-risk behaviors practiced in these groups showed inconsistent condom use, low condom use with regular partners, and some use of oil based lubricants or the absence of lubricants.

The CSM program was divided into three components: mapping of high-risk zones, product delivery, and a communication campaign. For condom delivery, the recruitment of experienced sales and communication personnel, who would be trained in social marketing, and gender and sexual diversity issues, was proposed. The plan for obtaining condoms included negotiating with condom manufacturers and local distributors to secure lower prices along with establishing initial contacts with the owners or managers of potential venues to encourage them to allow condom distribution.

Specific condom brands were to be distributed on the basis of the target populations' socioeconomic status. Sico, Trojan, and Durex, would be distributed to gay bars in Mexico City, while lesser-known brands like Do it Lovely, Vive, or Prudence would be distributed in areas with a lower socioeconomic level. Furthermore, the CSM team planned to have water-based lubricants in these non-traditional venues. In coordination with CENSIDA and state HIV programs, the project considered free distribution of condoms in specific locations.

A communication campaign called *Shingón* was designed and implemented to promote condom use among target populations and to increase the visibility of MSM and FSW meeting places where condoms were sold. The campaign distributed promotional products, such as condoms, baseball caps, and T-shirts.

6. PROGRAM RESULTS

USAID prevention interventions targeted MSM, MSW, FSW, and PWID, which Mexican national authorities had identified as priority populations. Additionally, USAID reached migrants and incarcerated populations. In 2008, based on the HIV prevalence of MSM and PWID, CENSIDA identified 44 sites requiring prevention interventions. During the 2005-2009 program period, the USAID prevention program worked in a total of 25 sites. All but four of these locations corresponded to CENSIDA's priority sites. USAID continued to fund only one such site after CENSIDA selected the national priority locations (figure 2).

Importantly, the government of Mexico indicated that while in some sites, including Mexico City, there was an overlap of USAID and CENSIDA supported prevention activities, in other locations, no HIV prevention programs existed. National health authorities also indicated that they were not aware of USAID's criteria for selecting prevention sites and populations. Both national and local governments suggested improved communication between health authorities and USAID programs regarding sites and population selection.

6a. CMS Activities

CSM activities were limited to Acapulco, Cancún, and Veracruz. However, due to high security risks as well as the lack of a local condom distributor, Acapulco was replaced with Playa del Carmen. The program focused on specific "hotspots" where sex work was wide spread. Initially, a database of 1,200 hotspots in 21 cities throughout Mexico was compiled. The CSM program narrowed its sites to 32 hotspots in Acapulco, Cancún, and Veracruz after accounting for the BCC program's geographic coverage.



Work on establishing condom availability in non-traditional venues began in 2006 through the CSM program, although actual sales distribution did not begin until 2008. At the time that fieldwork for this study (2008-2009) was conducted, records showed that the program's condom sales totaled approximately 1,700 boxes of condoms, with 3 condoms per box. Subsequent program reports showed that a total of approximately 38,000 branded condom units were sold by the final project year (2009). All lubricant sales (120 units) for the CSM program took place in Cancún. Concurrently, approximately 30,000 free condoms were distributed by USAID. Beneficiaries were primarily sex workers, clients of sex workers, and MSM.

During 2008, Veracruz and Cancún conducted the largest distribution of free condoms, with Cancún and Playa del Carmen reporting the highest condom sales. From October 2008 until June 2009, Veracruz significantly increased the free distribution and sale of condoms. The government noted significant CSM successes by USAID in the Mayan Riviera (Cancún and Playa del Carmen) due to high HIV prevalence and a lack of other organizations distributing free condoms.

Importantly, the prevention activities for the BCC and CSM programs were conducted separately in Veracruz. The BCC and condom distribution teams competed for access to program sites. The CSM team was of the opinion that the BCC program's free condom distribution hurt its condom sales. In turn, the BCC *promotores* were competing to achieve condom distribution targets set by PSI. In practice, the two programs divided the sites; and the BCC team did not continue to enter into the non-traditional venue sites.

6b. BCC Activities

In 2005, the BCC program began operating in 11 cities located in eight states and expanded to 24 cities in 15 states by 2006 (figure 2). In 2008, a strategic decision was made to decrease the program's geographic coverage to eight cities in seven states, with a slight decrease in the number of activities implemented and people reached. Mexico City, Chetumal, Cancún, and Veracruz were the only cities to be supported by the BCC program for all five years of the BCC program.

The USAID BCC program implemented approximately 57,000 activities between fiscal years 2005 and 2009 (the USAID fiscal year begins Oct. 1; e.g. the 2005 fiscal year began Oct. 1, 2004). During the first three fiscal years, the number of activities increased from 11,000 to 14,000, coinciding with the increase in number of sites. By fiscal year 2008, geographic coverage became markedly more concentrated and decreased to approximately 12,000 activities. About 10,000 activities were conducted in the first eight months of the 2009 fiscal year. As seen in figure 3, prevention activities focused primarily on MSM, FSW, and mobile populations during the first two fiscal years of the program (FY2005-FY2007). In the 2008 fiscal year, with the introduction of BCC interventions focusing on PWID and incarcerated populations, there was a clear shift in the program's target groups. The proportion of incarcerated populations reached with interventions increased from 2 percent in the 2005-2007 fiscal years to 15 percent in the

2008-2009 fiscal years. The focus on mobile populations, uniformed personnel, and clients of FSWs decreased between these periods. (MSW are included in the “other” category in figures 3.) Program data further supports the observation of a programmatic shift in the 2008 fiscal year, confirming a strategic focus on populations engaged in the riskiest behaviors in fewer sites.

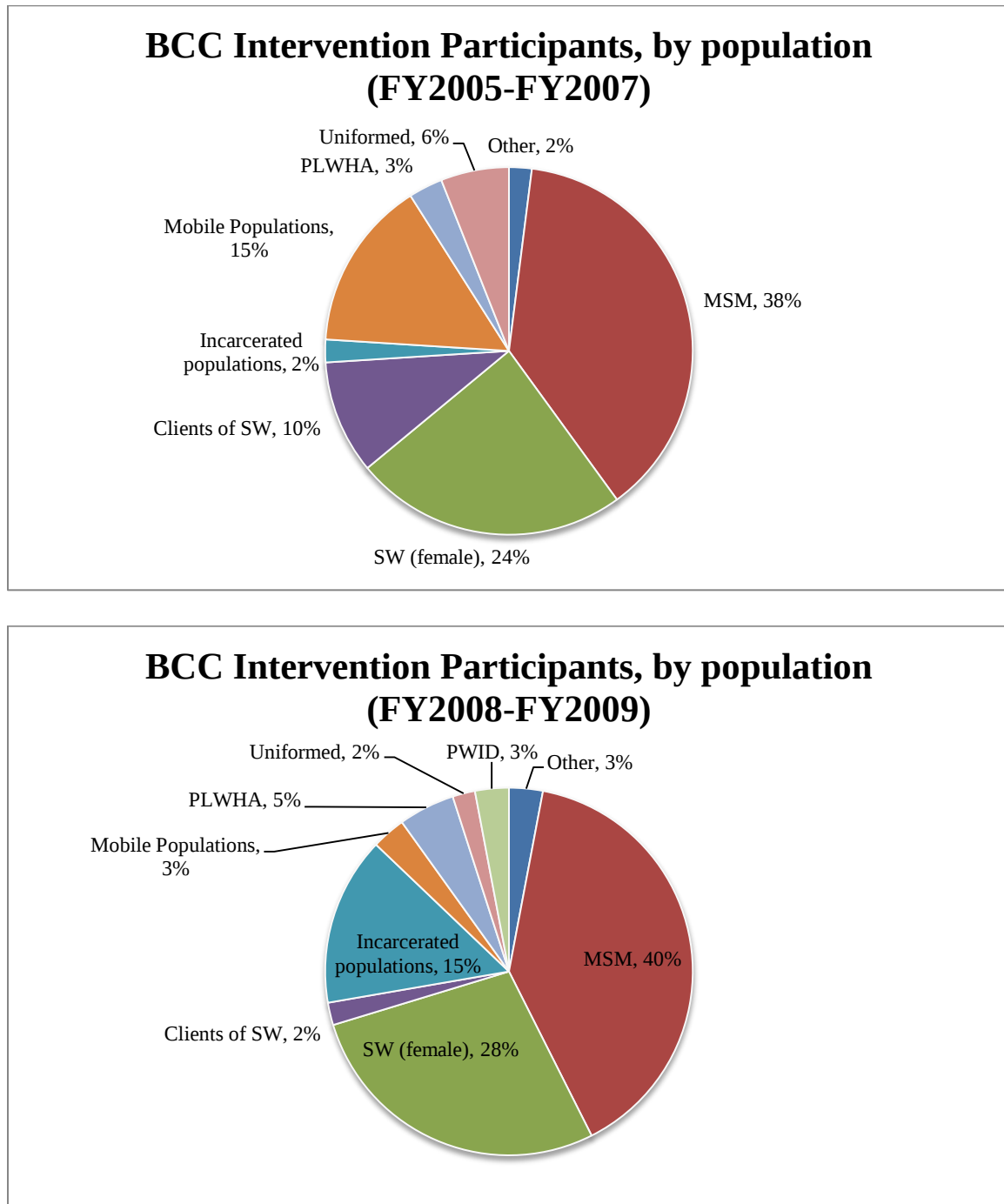


Figure 3: BCC participation by population and fiscal year

Throughout the project, the individual intervention called *Salvando VIHdas* was the predominant program activity, representing over 70 percent of all BCC activities (figure 4). From 2005 to 2008 fiscal years, there was a steady increase in the number of individual interventions and a decrease in the number of small group interventions. *Salvando VIHdas* was the only individual intervention made available to *promotores* until *Ciberabordaje* began in 2008. This online intervention represented 3 percent of the activities in 2008 and 5 percent in 2009 fiscal years.

Salvando VIHdas

This intervention reached MSM and FSW with individual face-to-face educational and risk reduction sessions, based on the Stages of Change theory. It promoted:

- reduction in number of sexual partners
- consistent condom use with stable and casual partners
- use of water-based lubricants
- referral for diagnosis and treatment of STIs
- referral for voluntary HIV counseling and testing

A Based on interviews with program managers and visits to program sites, the BCC *promotores* implementing the individual interventions were well trained. National authorities reported advantages to working with the program's *promotores*, including the fact that they were young, supported and accompanied the authorities in risky situations, and maintained contact with hard to reach populations such as PWID. The *promotores*

built a strong rapport with these groups. The national authorities indicated that the USAID BCC program was the only project that reached these difficult areas.

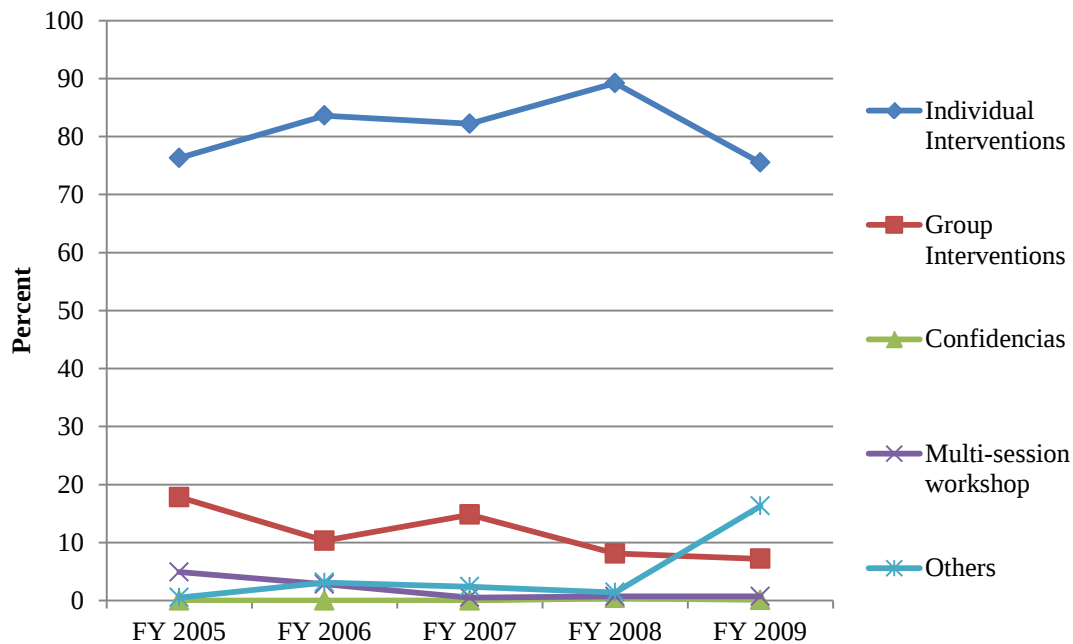
Promotores' Recommendations for Program Improvement

- Revitalize and vary program activities.
- Decrease the number of *Salvando VIHdas* activities that are implemented and introduce more communication campaigns.
- Adapt the activities and materials to local context and specific subgroups.
- Develop promotional and supportive materials made from more durable materials.
- Distribute condoms and lubricants preferred by the target populations.

The BCC program implementation strategy focused heavily on the total number of participants and emphasized the number of individual interventions completed each year. One negative result of this strategy was that the *promotores* visited the same few sites many times. Field observations indicated frequent repetition of *Salvando VIHdas* to

the same individuals who already knew the messages and, therefore, only requested free condoms. *Promotores* suggested varying the individual activities as to not "wear out" the populations. Field visits also indicated challenges that *promotores* faced in expanding to new sites with small populations.

Over the program period, the group intervention *VIHDA* and the group multi-session activity *Vive la Vida* decreased as a percentage of over all activities. *VIHDA* represented as much as 18 percent of the BCC activities in the first year of the project, but by 2009, it decreased to 7 percent. The small group multi-session activity, *Vive la Vida*, represented as much as 5 percent of the project in 2005 fiscal year and about 1 percent by 2008 and 2009. *Confidencias* represented less than 1 percent of the activity in 2008 and 2009.



* Others include *Acaba Seguro* Communication campaign, *No La Roles* Communication Campaign, and work sessions with incarcerated populations

Figure 4: Distribution of HIV BCC interventions by fiscal year (2005-2009)

Additional program activities (“other”) included workshops with incarcerated populations, the operation of information booths at large events, and targeted communication campaigns. These interventions represented very little program effort at the start of the project. However, with the introduction of the targeted communication campaigns (*Acaba Seguro*, *Tu Belleza no Tiene Precio*, and *No la Roles*) a sharp increase (16.4 percentage points) in the “other” category can be seen by 2009 (figure 4).

Limited program information was available on specific interventions implemented with migrant and incarcerated populations. Migrant populations represented a significant proportion of the program participants between 2005 and 2007 fiscal years. Incarcerated populations were reached during all five years of the program with a noteworthy increase in the second half of the program period. Field reports indicated that the interventions for incarcerated populations were well received and that the *promotores* in Mexicali expressed interest in expanding the prevention activities to the entire inmate population.

USAID tracks the number of persons reached with the appropriate ABC message for their individual risk factors. Table 6 provides the number of people reached with BCC activities that focused on AB messages and did not focus on AB messages. Program managers confirmed that these figures are the number of contacts with individuals per activity for each year.

Table 6: Population Reached with BCC Activities by AB or Non-AB Message, 2007 to 2009 Fiscal Years[^]

	Oct. 1, 2006 to Sept. 30, 2007	Oct. 1, 2007 to Sept. 30, 2008	Oct. 1, 2008 to June 30 2009 [^]
Number reached with one-to-one or small group HIV/AIDS prevention interventions that focused on AB	33,836	27,143	26,719
<i>Men</i>	25,203	21,715	19,968
<i>Women</i>	8,633	5,428	6,751
Number reached with one-to-one or small group HIV/AIDS prevention interventions that did not focus on AB	117,053	81,430	106,873
<i>Men</i>	86,194	65,144	79,868
<i>Women</i>	30,859	16,286	27,005
Total	150,889	108,573	133,592

[^] FY2009 is a partial year. Data from July 1, 2009 to September 30, 2009 was not available at the time of field work.

The only BCC intervention with explicit materials designed to promote AB messages implemented during the program period was the small group intervention *VIHDA*. This intervention represented 11 percent of the activities between 2007 and 2009 fiscal years. The BCC program also distributed materials that included AB messages from booths at large events (included in the “other” category in figure 5). Booths at large events represented 1 percent of the activity between 2007 and 2009. Out of all the activities supported by USAID between 2007 and 2009, 29 percent of the people reached with prevention activities were reached with AB messages through large events and small group interventions. The remaining 71 percent of the people reached with BCC activities between 2007 and 2009 received messages such as correct and consistent condom use, use of water-based lubricants, use clean needles, and the importance of getting an HIV test. The types of interventions that were used to reach people with these messages include: *Salvando Vihdas*, *Ciberabordajes*, *Vive la Vida*, *Confidencias*, and the three communications campaigns.

6c. Impact on Behavior in the MSM Population

The purpose of the program directed toward the MSM population was to promote safer sexual behaviors through partner education, BCC campaigns, and the utilization of CSM with wide coverage in order to increase access and availability of condoms and water-based lubricants. A second round of surveys (PSI Mexico, 2009) of the MSM population was conducted in 2009 in Cancún, Mexico City, Guadalajara, Mexicali, and Veracruz with the objective of monitoring changes in behavior.

In the framework of this study, an analysis of the 2009 survey was done to learn if exposure to PSI Mexico's activities has driven changes in behavior. Researchers applied standard statistical methods of propensity score matching to compare behaviors of MSM who had been exposed to *Acaba Seguro*, *Shingón*, *Salvando VIHdas*, and other BCC activities (exposed group) respective to the behaviors of MSM who had not been exposed (control group). The principal statistically significant results follow.

Reduction in number of sexual partners among MSM:

- Exposure to one of the program campaigns or activities had an average approximate reduction of two to three casual partners with whom they had anal sex or penetration.
- High exposure to the *Acaba Seguro* campaign resulted in an average decrease of eight casual partners.
- Exposure to the program reduced the number of casual partners with whom MSM had anal sex by between 22 percent and 53 percent (figures vary depending on the statistical model considered) when compared to the control group.

Condom use in the 12 months prior to the MSM survey:

- Individuals who were exposed to BCC program campaigns and activities reduced the number of times they did not use condoms by five, which is to say that they increased condom use.
- The exposed group used a condom between 30 percent and 59 percent (numbers vary depending on the statistical model considered) more than the control group.

For **condom use during last sexual encounter**, the individuals exposed to any of the BCC interventions (campaigns or other activities) showed an increased probability of having used a condom during their last sexual encounter by around 5 percent compared with people who were not exposed to any BCC interventions.

For **carrying condoms**, the individuals who had been exposed to a BCC program intervention or campaign increased their probability of carrying a condom by between 19 percent and 45 percent (numbers vary depending on the statistical model employed) with respect to individuals who have not been exposed to the intervention. However, it must be considered that the probability of carrying condoms in the exposed group is still low (5.5 percent to 9.4 percent).

For **HIV testing**, on average, the program increased the number of times that an individual had tested for HIV by between 14.9 percent and 76.5 percent (numbers vary depending on the statistical model considered).

7. RECOMMENDATIONS

This paper makes the following recommendations:

Innovative intervention strategies: Consider new strategies and best practices. For example, a mobile clinic for sex workers supported by the University of California showed promise in Mexicali. Explore key structural interventions such as removing the obligatory HIV testing for sex workers. Removing obligatory testing may promote voluntary counseling and testing among this population. Always look for proactive ways to adapt prevention strategies, such as the Tom Patterson’s motivational interviewing technique used in northern border cities in Mexico or the PEER Methodology used in Central America and the Caribbean.

Feasibility study for needle exchange programs: In July 2010, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) issued new guidance for HIV prevention among PWID. The new guidance encourages a “comprehensive HIV prevention package” for PWID including needle and syringe programs and harm reduction strategies previously prohibited by PEPFAR. According to the revised guidance “needle exchange and syringe programs (NSPs) do not increase the numbers of persons who begin to inject drugs or increase the frequency of drug use” and “studies have shown that NSPs result in decreases in drug-related risk behavior.” (PEPFAR, 2010) Future programming in Mexico should use the change in guidance as an opportunity to explore the feasibility USAID-funded NSPs.

Develop appropriate goal behaviors and BCC messages for targeted high risk groups: In 2005, PEPFAR introduced a new rule that at least two-thirds of all funds for preventing sexual transmission of HIV should be spent on promoting AB messages. The remaining one third of money for preventing sexual transmission was to be spent on condoms and related activities.

These spending requirements led to the inappropriate use of AB messages with high risk populations in Mexico as described above and in table 6. Seventy-one percent of the people reached with BCC activities between 2007 and 2009 were reached with messages such as correct and consistent condom use, use of water-based lubricants, using clean needles, and getting an HIV test, while the remaining program activities focused on AB messages for high-risk groups.

Messages tailored to high-risk sexual behaviors should be increased to 100% of all program activities and supported by adequate condom distribution. Harm reduction and clean needle messages now can be supported by the provision of needle exchange and syringe programs. Future HIV prevention programs for high-risk populations, such as sex workers, MSM, and IDU, should choose evidence-based strategies and locally appropriate messages that are unhindered by outdated or ineffective approaches.

Evaluate the condom availability in non-traditional venues program: The program to increase private non-traditional condom outlets and the BCC program to change risky

behaviors of people most at risk for HIV infection, including CSM, were implemented in parallel, but were not coordinated. This management practice has been noted in USAID programs in more than one country. Further evaluation of these two condom promotion strategies and how they might be implemented as one strategy in Mexico would be useful to future planning.

Program monitoring and evaluation: Better program record keeping should be mandated. Routine program data quality checks should be implemented by USAID for the next HIV prevention program. Baseline and end-line behavior surveys should be well planned and well funded at the start of the program, in order to allow for comparison. Clearly defined target populations, well designed sampling methodology, and HIV testing will allow the next prevention program to be evaluated using behavioral surveys.

Program coverage: According to anecdotal evidence, the BCC program was reaching the same individuals with the same materials over and over, which can lead to a saturation of the message. In order to increase the quality of the interventions, future programs should use the strong relationships with previously identified target populations to introduce new prevention strategies, new materials, and new messages that are tailored to each local population as stated in the first recommendation. Once quality programming and strong monitoring and evaluation have been established in key sites, geographic expansion is possible.

Local and national governments have suggested the following proposals: in the state of Veracruz, increase the reach of the program to Boca del Río, which is part of the metropolitan area of the city of Veracruz, and consider the incorporation of Coatzacoalcos, San Andrés, Cosamaloapan, and Tierra Blanca. Starting from the work based in Mexicali, consider the inclusion of Kilometer 53, which is on the border with Sonora. With the Mexico City base, consider changing the interventions toward missions further away from the center of the city and with a smaller presence of other organizations, and incorporating surrounding municipalities in the state of Mexico where are organizations are not working (or agree upon associations with the existing organizations in order to avoid overlap in the work being done).

Target populations: Prioritize PLWHA, SWs, MSM, and IDU. Consider expanding programs to transgender communities and incarcerated populations, but keep in mind new prevention strategies are required for new target populations.

PLWHA: Programs for PLWHA must include comprehensive support services. PEPFAR uses the term “prevention with positives” (PwP) to describe a minimum package of services. PwP includes providing HIV-positive individuals with information about ways they can protect their own health, encouraging and counseling HIV-positive persons to prevent transmission of HIV, promoting and providing condoms to sexually active HIV-positive individuals, developing strategies to increase adherence to prevention of mother-to-child transmission of HIV and therapeutic treatment regimens, discussing with all HIV-positive persons strategies for disclosing one’s HIV status to sex partners, and offering confidential HIV testing to the sex partners of and children born to all

individuals who are living with HIV/AIDS.

Field research on transgender populations: In order to explore the need and feasibility of work with transgender populations, small-scale, qualitative research should be considered.

Adolescents and young people: It is not recommended for USAID programs to direct efforts toward these vulnerable populations because other agencies are providing programming for them. When working with a broad general population, significant resources are required to obtain evident changes in behavior and HIV prevalence.

Relations with national, state, and local HIV/AIDS authorities: With a goal of better utilizing resources to provide maximum coverage and quality, it is highly recommend that the implementing partner charged with conducting activities is empowered and required to coordinate with the local and national governments. Host country government authorities have better knowledge of the characteristics of the epidemic, the needs of the population, and the corresponding prevention work being done by other organizations. Additionally, coordinated work will permit the agency that is conducting the activities to diminish problems with police and business owners. A strong relationship with the health services authorities will provide proper referrals.

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