

AIDSMARK

REGIONAL LESSONS LEARNED

Latin America and the Caribbean

With the exception of a few countries, such as Haiti and Bolivia, the Latin America and Caribbean region is characterized by strong economies. The region's gross national income per capita grew from \$3,700 in 2000 to more than \$4,000 in 2005, and the regional economy grew by 5 percent in 2006 (1). However, this growth has remained largely inequitable as the region continues to exhibit some of the greatest income inequality in the world (2). Taking these factors into consideration, AIDSMark programs marketed a range of high-quality products at varying prices, each attuned to the needs, preferences and purchasing power of a defined target population.

AIDSMark responded with funding and technical assistance to HIV epidemics in 13 Latin American and Caribbean countries: **Belize, Bolivia, Brazil, Costa Rica, Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua and Panama.** With adult HIV prevalence ranging from 0.1 percent in Bolivia to 3.8 percent in Haiti (3), epidemics in most of these countries remain concentrated, while in some Central American and many Caribbean nations they have become generalized (3). Unsafe sexual behavior drives the HIV epidemic in this region (4). In some Latin American countries, men who have sex with men (MSM) account for as much as 25 to 35 percent of new HIV infections (4). Though surveillance systems are relatively weak in parts of the Caribbean, heterosexual sex is believed to cause the majority of new HIV infections, while MSM also play a greater role than is commonly acknowledged (4). Commercial and cross-generational sex and concurrent sexual partners are also noteworthy risk factors for HIV in Latin America and the Caribbean (4).

Lessons Learned

A strong regional office can capitalize on shared language and culture to achieve economies of scale.

In 1997, with U.S. Agency for International Development (USAID) support, Population Services International (PSI) formed the Pan American Social Marketing Organization (PASMO), a coordinated network of national Central American social marketing entities. PASMO's head office in Guatemala develops an overall regional strategy covering Guatemala, El Salvador, Nicaragua, Honduras, Costa Rica, Belize and Panama. The head office provides technical assistance to country offices and processes data and reports on the region, while country offices devise sales strategies and manage day-to-day program administration (5, 6). As AIDSMark's implementing partner, PASMO took advantage of shared language and similar cultures across Central America to position regional brands of health products that could be instantly recognized by highly mobile populations. These similarities also



For more information contact us at:

PSI
1120 19th Street, NW
Suite 600
Washington, DC 20036
Phone (202) 785-0072
Fax (202) 785-0120

www.psi.org

allowed PASMO to procure products in larger quantities and develop standardized materials, peer education modules and promotional media for use across the seven countries, thereby reducing costs and benefiting from economies of scale. Although the health product brands were the same, each country still needed to develop and implement promotional campaigns locally and adapt materials to tailor programs to their individual contexts.

Higher-priced, value-added health products may have broader appeal than anticipated by traditional social marketing paradigms.



The VIVE line of condoms was first introduced in Central America through PASMO in the mid-1990s. In keeping with the “total market approach,” which renders subsidies of health products more efficient by shifting higher-income consumers away from subsidized products (7), PASMO diversified its line of condoms according to income-based market segmentation. In addition to a low-cost condom for lower-income consumers, higher-priced, value-added (i.e., colored, flavored, extra thin, and ribbed) condoms for higher-income consumers were introduced. Growing the high-end market was also designed to generate a revenue stream that could sustain PASMO’s country programs and continue to subsidize commodities for consumers with lower purchasing power (6). The strategy was successful. However, an unusual finding was that the higher-priced, value-added condoms proved popular when sold in brothels, which typically cater to lower-income consumers. This experience challenges the traditional social marketing paradigm by suggesting that value-added health products aimed at high-end markets have the potential to be marketed to low-income consumers as well. While the

finding is noteworthy, it is important to point out that traditional pricing strategies continue to prove highly effective. For instance, when PSI/Haiti bifurcated the female condom market and introduced a lower-priced brand for low-income women (particularly commercial sex workers [CSWs]), female condom sales in the country quadrupled (8).

Despite the challenges of working with local non-governmental organizations (NGOs), high-risk groups can be reached more effectively by leveraging the strengths of these collaborators.

Working with a variety of local collaborators in each country was an important aspect of AIDSMARK-funded programs in Latin America and the Caribbean. These collaborations were not without their challenges. Many small local NGOs have administrative and financial weaknesses that hinder timely and efficient program implementation. Despite these challenges, local NGOs seem to be stronger in Latin America and the Caribbean than in many other regions of the world, with years of experience reaching high-risk groups. As such, these NGOs became essential collaborators in many of the countries in the region where PSI works, enabling PSI to reach target populations indirectly while providing guidance and capacity-building support to the local NGOs.



In Brazil, AIDSMARK worked with DKT and other cooperating agencies to expand availability of male condoms to high-risk groups and strengthen private sector HIV prevention entities and efforts. With the participation of several other NGOs in four Brazilian states, PSI distributed nearly 281 million condoms, generating more than two million couple-years of protection and more than 782,000 disability-adjusted life years.^a

^a Couple-years of protection measures years of protection from unintended pregnancy. Disability-adjusted life year (DALY) essentially is a year of healthy life lost due to illness or injury. At PSI, we refer to DALYs and years of healthy life gained as a result of our interventions.



In the Dominican Republic, PSI developed a mass media campaign^b to increase risk perception among youth and used local NGOs already working with this group to reinforce campaign messages through interpersonal communication (IPC) activities. The program had extensive reach: in a Gallup Republica Dominica survey of 1,200 youth, 60 percent spontaneously reported having seen or heard of the “Trusted Partner” campaign, and more than 80 percent recalled having seen the campaign when prompted (9). In addition, 73.6 percent of respondents reported that the campaign made them think in a different way about their sexual behavior, and 20.4 percent reported that they are more careful with their sexual partner as a result of the campaign (9).



In Haiti, AIDSMark funded prevention of mother-to-child transmission (PMTCT) services working in close collaboration with public and private hospitals as well as NGOs. Maximizing the strengths of each entity, AIDSMark created mass media campaigns to increase awareness of and demand for PMTCT services, while collaborators ensured that these services were delivered to the most vulnerable populations (8). PSI/Haiti also worked with local NGOs to reach CSWs. The Foundation for Reproductive Health and



Family Education implemented PSI/Haiti’s “Condomania” program activities encouraging correct and consistent use of both male and female condoms with all partners. The program worked in brothels and client-soliciting areas and emphasized condom negotiation skills, sexually transmitted infection (STI) screenings and HIV counseling and testing through peer education and print materials. PSI/Haiti also coordinated with the other groups targeting CSWs, such as the Port-au-Prince local government, to ensure consistent messages from all programs and avoid duplication of outreach activities (10).

HIV prevention programs can enhance health impact by involving members of target populations in innovative participatory roles ranging from program development to improvement and expansion.

In Nicaragua, PASMO developed the “Vive la Vida” behavior change communication program targeting MSM who did not identify themselves as gay or bisexual. Vive la Vida was designed to increase self-risk perception for STI/HIV/AIDS and motivate MSM to adopt healthier behaviors through an interactive “edutainment” format. To identify and reach members of this “hidden” group, PASMO relied on current program participants to invite others within their social networks to prevention activities held at “safe” bars and cantinas. The final session featured a graduation ceremony where participants invited MSM friends and recruitment for the next program began. This “snowball” effect allowed the program to reach more MSM than would otherwise have been possible. An evaluation of the program showed that it was highly successful: more than 40 percent of participants were MSM who did not self-identify as gay or bisexual and normally would not have been reached through other channels (6). Moreover, consistent condom use among participants significantly increased from 22 percent to 47 percent (6). Capitalizing on regional similarities,

^bThe “Trusted Partner” Campaign was developed in response to research suggesting a primary barrier to condom use among youth is trust of their sexual partner. PSI/Dominican Republic created the campaign to dispel misconceptions and increase risk perception with complementary IPC activities implemented by local NGO collaborators.



PSI/Mexico also implemented Vive la Vida with MSM and, building on its success, adapted the program for use in prisons and with heterosexual people living with HIV/AIDS (11).

In the Dominican Republic, CSWs were integrated directly into the design and implementation of the *Pante* condom social marketing project, whose goal was to increase access to condoms among CSWs and their clients. From the start of the project, CSWs affiliated with a national NGO were hired on a revolving basis to pack the Pante condoms, enabling them to take a break from sex work for several weeks at a time and, in some cases, save enough money to start their own businesses. CSWs helped to validate the product packaging and developed the Pante condom slogan, “*Por Amor a la Vida, Usa Condón*” (For the love of life, use a condom), in addition to helping select the packaging and manufacturer for the Pante lubricant. Current and former CSWs have been trained



as sales agents and are responsible for distributing the product to commercial sex establishments. CSWs also routinely participate in promotional activities for occasions such as World AIDS Day, Carnival and other activities, where they proudly wear the Pante logo that they consider “theirs.” This integration of the target population at every step of the project design has helped solidify their identification with the product and its use. In a national survey conducted in the Dominican Republic in 2006, 87.7 percent of all CSWs reported using Pante during last sex act with a new client (12).

References

1. World Bank, “Latin America and Caribbean: Regional Brief” (October 2007), available at <<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/0,,contentMDK:20340156~pagePK:146736~piPK:146830~theSitePK:258554,00.html>>, accessed August 3, 2007.
2. United Nations Development Programme, *Human Development Report 2005* (New York, New York, 2005).
3. UNAIDS, *2006 Report on the Global AIDS Epidemic* (Geneva, Switzerland, 2006).
4. UNAIDS, *Fact Sheet: Latin America* (Geneva, Switzerland, 2006).
5. Imran Zafar, “PASMO AIDSMARK End of Project Report [El Salvador]” (PASMO: San Salvador, 2003).
6. PASMO, “AIDSMARK Final Report” (Guatemala City, Guatemala, 2005).
7. Department for International Development (DfID), “Review of DfID’s Approach to Social Marketing: Note of Meeting April 22–23, 2004” (2004), available at <www.dfidhealthrc.org/publications/srh/meeting-note.pdf>, accessed September 5, 2007.
8. PSI/Haiti, “AIDSMARK Project Final Report” (Port-au-Prince, Haiti 2003).
9. PSI/Dominican Republic, “AIDSMARK trusted partner campaign: Final report” (Santo Domingo, Dominican Republic, 2004).
10. PSI/Washington, “Haiti Workplan,” AIDSMARK internal document. 2005.
11. PSI/Mexico, “AIDSMARK End of Project Report” (Mexico City, Mexico, 2005).
12. PSI/Dominican Republic, “TRaC Survey with Commercial Sex Workers in the Dominican Republic” (Santo Domingo. Horwath Consulting, 2006).

This report was made possible through support provided by the Global Bureau of Health/HIV-AIDS, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-97-00021-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

© 2007 by AIDSMARK. All rights reserved.

Photo credits:
Hubschman, PSI/DR