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Programmes, resources, and needs of HIV-prevention nongovernmental organizations (NGOs) in Africa, Central/Eastern Europe and Central Asia, Latin America and the Caribbean

J. A. KELLY[1], **A. M. SOMLAI**[1], **E. G. BENOTSCH**[1], **Y. A. AMIRKHANIAN**[1,2], **M. I. FERNANDEZ**[3], **L. Y. STEVENSON**[1], **C. A. SITZLER**[1], **T. L. MCAULIFFE**[1], **K. D. BROWN**[1], and **K. M. OPGENORTH**[1]

1*Medical College of Wisconsin, Milwaukee, USA*

2*Botkin Municipal Hospital for Infectious Diseases, St. Petersburg*

3*Miami University, Florida, USA*

Abstract

This study assessed the programmes, resources, and needs of HIV-prevention nongovernmental organizations (NGOs) in 75 countries in Africa, Central/Eastern Europe and Central Asia, Latin America and the Caribbean. Multiple databases and expert recommendations were used to identify one major HIV-prevention NGO in the capital or a large city in each country, and in-depth interviews were conducted with each NGO Director. Most NGOs are carrying out their programmes with minimal funding and few regularly employed personnel. Most are highly dependent on international donors, but reliance on small grants with short funding periods limits programme development capacity. HIV-prevention activities varied by region, with African NGOs most likely to use peer education and community awareness events; Eastern European NGOs most likely to offer needle exchange; Latin American NGOs to have resource centres and offer risk reduction programmes; and Caribbean organizations to use mass education approaches. Across regions, NGOs most often targeted the general public and youth, although specialized at-risk groups were the additional focus of attention in some regions. Limited funding, governmental indifference or opposition, AIDS stigma, and social discomfort discussing sex were often cited as barriers to new HIV-prevention programmes. NGOs are critical service providers. However, their funding, programmes, and resource capacities must be strengthened if NGOs are to realize their full potential in HIV prevention.

Introduction

Throughout the world, nongovernmental organizations (NGOs) play a critical role in the delivery of HIV-prevention services. Governments usually carry out AIDS surveillance functions, may initiate broad AIDS education campaigns, and develop national strategic plans for HIV prevention. However, governmental agencies often lack the experience, knowledge, or will to successfully work with marginalized groups vulnerable to AIDS, and governments may not be trusted or be well-attuned to the needs of some populations. For these reasons, NGOs serve as bridges to at-risk communities and are frequently the major providers of direct HIV-prevention services to vulnerable groups such as injection drug users (IDUs), men who have sex with men (MSM), commercial sex workers, youth in high-risk situations, prisoners, migrants, and other disadvantaged segments of the community (Crane & Carswell, 1992).

Correspondence: J. A. Kelly, Ph.D., Center for AIDS Intervention Research (CAIR), Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 2071 North Summit Avenue, Milwaukee, WI 53202 USA. Tel: 414-456-7700. Fax: 414-287-4209. E-mail: kdemming@mcw.edu.

NGOs have long represented and provided services to impoverished and marginalized groups across diverse areas of health and social development (Akukwe, 1998; Benson et al., 2001; Craplet, 1997; Motin & Taher, 2001; Mburu, 1989; Smith, 1989). Because they typically originate from - or are specifically organized to serve - community constituencies, NGOs can respond with culturally sensitive programmes. NGOs are often characterized by relative absence of bureaucracy and flexibility to quickly develop innovative new programmes, low cost of operation, autonomy from restrictive and conservative governmental policies, the potential for high levels of community participation in programme development, and the ability to reach and advocate on behalf of population segments in greatest need of services (Akukwe, 1998; Craplet, 1997; Gellert, 1996). These characteristics are especially relevant to the field of HIV prevention, where one must quickly curtail a rapidly advancing infectious disease epidemic, where governments may be reluctant to undertake focused and explicit programmes on sensitive sexual behaviour and drug use safety topics, and where direct prevention services may be more successfully targeted by organizations that are already trusted and knowledgeable of the culture and values of communities they serve (Crane & Carswell, 1992; Kalibala et al., 1997; Wiesman, 1991).

However, many social development NGOs in developing countries face significant operational challenges. These include limited organizational infrastructure, few sources of stable and long-term funding, reliance primarily on volunteer efforts, high personnel turnover, and a paucity of networking and programme coordination opportunities (Akukwe, 1998; Smith, 1989; McKee et al., 2000). The extent to which these challenges also confront NGOs that work specifically in the area of HIV prevention is unknown. While there have been occasional reports about the programmes of AIDS NGOs in the west (Klein et al., 1998; Somlai et al., 1999; Valdiserri et al., 1997) and single or small NGO networks in other regions (Mercer et al., 2001; Andruschchak & Khodakevich, 2000; Haour-Knipe et al., 2000; Hernandez-Chavez, 1995), little systematic, largescale research has assessed the programmes, needs and organizational characteristics of HIV-prevention NGOs in the international arena. By gaining a comprehensive understanding of their current programmes and activities, and by determining their present resources, it will also be possible to plan strategies to better meet NGO needs and strengthen their capacities.

This study obtained detailed information about the prevention programmes being undertaken by a large international sample of NGOs, each identified as a major HIV-prevention service provider in the capital or a large city of its country. In addition to identifying the types of HIV-prevention programmes presently being carried out by NGOs in these regions, we elicited data to assess their capacity and resource issues, the populations served, and barriers faced by NGOs that work in the area of HIV prevention.

Methods

Identification and Selection of Study NGOs

NGOs in this research are organizations participating in a study evaluating the effectiveness of computer-based methods for improving information exchange and technology transfer between HIV-prevention researchers and international service providers (Kelly et al., 2004). Findings reported in this article are from in-depth interviews conducted with each NGO prior to its participation in the technology transfer project.

We sought to create a sample that consisted of one leading and well-established HIV-prevention NGO actively carrying out service programmes in each country in the project's four world regions. To do this, a two-stage selection process was used. First, we reviewed international directories HIV-prevention NGOs in each country, NGO presentations made at international and regional AIDS conferences; lists of NGOs participating in regional AIDS

consortia and networks; and other sources. This process resulted in the identification of HIV-prevention NGOs in most countries and multiple NGOs in many of them. In the second phase of the search process, and especially for countries where more than one HIV-prevention service provider had been found, we used both an NGO's citations across multiple databases and expert recommendations from national and international sources (including UNAIDS and UNDP) to identify which NGO appeared well-established and had a large scale of direct service HIV-prevention activity.

The Director of each selected NGO was invited to participate in the study. Some NGOs could not be contacted even after repeated attempts. In these cases, the next most-established and active NGO from a country was invited. Of all NGOs with whom contact was made, all but one (99% response rate) agreed to participate. It was not possible to locate a major HIV-prevention NGO in several countries especially in North Africa, small Caribbean islands, and countries undergoing extreme political turmoil. The sample consisted of a total of 75 NGOs (27 NGOs in Africa, 25 NGOs in Central/Eastern Europe and Central Asia, 15 in Latin America, and 8 in the Caribbean). Table I lists the cities and countries of NGOs participating by region.

In-depth interviews with NGO directors and measures administered

In-depth structured telephone interviews were scheduled with the Director or the Prevention Director of each NGO in late 2001. Interviews were conducted by professionals with backgrounds in the social or behavioural sciences and familiar with the region's culture. Interviews, lasting 2-3 hours, were carried out in English, Russian, Spanish, or French, depending on the language preference of the NGO Director. The interviews followed a standardized script that included both closed- and open-ended questions, although interviewers probed as needed to obtain full responses. Because the assessment interview elicited very specific information that might not be known without advance preparation, Directors were provided with a copy of the topics and information being requested in advance of the interview. NGOs were compensated to offset the staff time needed to compile and organize the data, and all were assured that the information they provided would be presented only in aggregate. The following areas were assessed:

NGO organizational characteristics—Directors indicated their organizations' number of full-time staff, part-time staff, and volunteers; when the NGO began to provide HIV-prevention services; the NGO's annual budget (later converted to US dollar equivalents); and how much of the total budget was devoted to HIV prevention. Because some NGOs engaged in activities other than HIV prevention, Directors described other agency activities.

NGO funding sources—Each Director identified the funding sources for the NGO's activities and indicated how much of the current year budget was derived from each source.

Current HIV-prevention direct service programmes being offered by the NGO—The interviewer asked the Director to identify the NGO's three largest HIV-prevention programmes offered during the past six months. If an NGO offered fewer than three programmes, only the number offered were described. For each programme, the Director responded to a series of open-ended questions and probes intended to provide a detailed picture of the programme's target population, methods, goals and operation.

Client populations served by NGO HIV-prevention programmes—The interviewer summarized the community populations served by the three largest programmes that had been described and then asked the Director to identify any other populations that were served during the past six months.

Barriers faced by the NGO—The interview asked Directors to identify sources from which they received technical assistance in programme development and to rate the usefulness of each source. The interview also elicited information on the three greatest barriers, obstacles, or challenges encountered by the NGO when it attempted to implement HIV-prevention programmes.

Interview coding and summarization

All interviews were audiotape recorded. The interviewer listened to the audiotape and wrote summaries of the Director's responses within each topic domain. These written summaries, translated into English, were reviewed by a team of experienced HIV-prevention researchers. Members of this team coded responses into categories that had been developed earlier for the following domains: types of funding sources, types of HIV-prevention programmes offered, community populations served, and types of barriers faced by the NGO. The categories are those shown in the Results section tables. Data on NGO organizational characteristics and other quantitative variables were entered directly into the database without summarization or category coding. Because of major HIV epidemiology and disease burden magnitude differences across world regions, countries were grouped by region for all result presentations.

Results

Budgets and organizational characteristics of HIV-prevention NGOs

Table II presents data on the budgets and organizational characteristics of NGOs in the sample. One of the most striking findings is the very small budgets of most NGOs, both with respect to their total operations and their budgets for HIV-prevention activities. NGOs in Africa operated with annual total budgets of under $104,000 per year, $64,000 devoted to HIV-prevention programmes. In Central/Eastern Europe and Central Asia, funding paucity was even more extreme. Although located in cities with average population sizes exceeding 1.1 million, these NGOs had median total annual budgets of less than $55,000, with only $35,549 for prevention programme funding. Latin American NGOs had budgets slightly higher than those in other regions (median total budget = $120,000, HIV-prevention budget $87,000 per year), but most were also in large cities with average population sizes of over 1.5 million residents. Caribbean NGOs are located in countries smaller than NGOs in other regions. They had budgets in the mid range among those of other regions (median total budget $90,000, median prevention budget $48,500).

As Table II shows, NGOs in Latin America and Africa had been carrying out HIV-prevention programmes for the longest periods, and Central/Eastern European NGOs for the briefest length of time. Except for the smaller personnel sizes of Caribbean region NGOs, HIV-prevention organizations elsewhere had a median of five full-time staff and several part-time personnel. Forty percent of NGOs in Central/Eastern Europe and Central Asia, 40% of NGOs in Latin America, 50% of Caribbean region NGOs, and one-third of the organizations in Africa had three or fewer full-time personnel. However, even these modest figures probably overstate the staff capacities of the NGOs. Many Directors indicated that their programmes were staffed by personnel who were paid when funding was available but who volunteered when funds were not available. NGOs had a median of between 12 and 45 volunteers. Some NGOs, especially those in Africa and Central/Eastern Europe, had very large numbers of volunteers involved in their programmes. The majority of NGOs in all regions provided services other than HIV prevention. These were most often primary medical care, social, and other services to persons living with HIV/AIDS. Latin American NGOs also often provided reproductive health and family planning services, those in Eastern Europe often provided substance abuse treatment, and Caribbean NGOs frequently also carried out vocational and life skills programmes.

Table III shows NGO budget sources. NGOs in all world regions are highly dependent on foreign and international aid donors. Between 36% (Caribbean region) and 71% (Central/Eastern Europe and Central Asia region) of NGOs' budgets are from international aid organizations, international private charitable foundations, and foreign governments. International aid and relief organizations, chiefly programmes of United Nations entities, fund NGO programmes at relatively consistent percent-of-budget levels across the four regions (26% to 35% of NGO budgets). International private foundations, especially the Soros Foundation, support a high percent (31%) of NGO HIV-prevention activities in the Central/Eastern Europe and Central Asia. Caribbean NGOs derive a higher percentage of their budgets from in-country sources (such as home country governments and fundraisers) than NGOs elsewhere, and NGOs in Africa and Latin America have the most diversified range of funding sources. Less than 25% of the HIV-prevention budgets of Central/Eastern European and Central Asian NGOs come from in-country national or private sources, whereas at least 38% of all other regions' NGO budgets come from in-country sources.

Community populations served by HIV-prevention NGOs

Table IV summarizes the community populations served by NGOs in the four world regions. HIV-prevention programmes directed toward the general public were the most common activities of NGOs in Africa, Latin America, and the Caribbean; 60% or more of NGOs in these regions targeted the general public or general community. Programmes for youth were also common across NGOs in all regions. NGOs in Africa, often confronting generalized heterosexual epidemics, were most likely to target the general population (66% of NGOs) and youth (59% of all NGOs). No African NGOs identified either MSM or IDUs as target populations. By contrast, and reflecting the HIV epidemiology currently predominant in their regions, NGOs in Central/Eastern Europe and former Soviet republics of Central Asia were most likely to target HIV-prevention activities toward drug users (56% of NGOs), while 33% of Latin America NGOs directed prevention programmes toward gay or bisexual men. Other than in Latin America, few NGOs targeted HIV-prevention efforts to MSM and - with the exception of Africa - few NGOs directed prevention activities toward high-risk heterosexuals. Programmes for incarcerated populations and commercial sex workers were uncommon across most of the regions.

HIV-prevention programmes being carried out by NGOs

Director descriptions of their organizations' three largest HIV-prevention direct service programmes were coded into one of 11 programme types. These programme categories and the percentages of NGOs offering each type of activity are shown in Table V. There were considerable differences in programme types most common across the four regions. Almost 60% of NGOs in Africa carried out peer education programmes, a percentage higher than found in other regions. In Central/Eastern Europe and Central Asia, nearly half of NGOs conducted needle exchange programmes; needle exchange was not reported as a major activity of NGOs anywhere else. Forty percent of Latin American NGOs carried out intensive HIV risk-reduction programmes for individuals or as group workshops. In the Caribbean, information dissemination approaches such as print material distribution and making presentations about AIDS in the community were reported by half of the NGOs.

Other types of HIV-prevention programmes offered by 20% or more of NGOs in a region included AIDS awareness community events and condom distribution by African NGOs; peer education programmes, AIDS educational presentations and materials distribution, one-on-one outreach, and supportive services to persons living with AIDS (PWA) and their families by Central/Eastern European and Central Asian NGOs; and peer education, intensive individual and group workshops, and PWA support services by Caribbean region NGOs. Latin American NGOs offered a greater variety of different HIV-prevention programme types than NGOs in

other regions including mass media campaigns and the operation of AIDS resource centres and telephone hotlines.

When asked about the value of sources of information used to gain new information about AIDS prevention, 80% of NGO Directors cited information sharing with other agencies as 'very useful'. UNAIDS was rated as very useful by 68% of Directors, conferences by 64%, Internet information by 68%, journal articles by 51%, and official government information by 28% of Directors.

Barriers to implementation of effective HIV-prevention programmes

Table VI summarizes the greatest barriers reported by NGOs to HIV-prevention programme implementation. Not surprisingly, limited funding was most frequently cited. Between 70% and 100% of NGOs in Africa, Central/Eastern Europe, and the Caribbean included low funding as one of their three greatest barriers. Forty percent of Latin American organizations also cited limited funding as a barrier, although a higher percentage (73%) reported secular cultural beliefs and stigma as a major obstacle. In other regions, AIDS-related stigma was usually also one of the two greatest barriers faced, and social discomfort or opposition to discussing sexuality was frequently seen as a barrier. Government indifference or opposition to HIV-prevention work was cited by more than half of NGOs in former Soviet and socialist countries as one of their greatest barriers. One-third of Latin American and 30% of African NGOs also reported lack of government support as problematic to their efforts.

Discussion

While NGOs are major providers of HIV-prevention services in most areas of the world, little research has systematically assessed the structure, resources, and programmes being offered by AIDS NGOs across multiple regions. Strong and effectively functioning NGOs have the potential to deliver HIV-prevention services to marginalized, hard-to-reach, and vulnerable communities, especially those with cultural, social and health needs different than more advantaged populations. By virtue of their organizational autonomy and community-based roots, NGOs are potentially able to carry out explicit and culturally tailored programmes that governments may be reluctant or unable to directly undertake. For these reasons, findings about HIV-prevention NGO programmes and characteristics can guide the development of efforts to strengthen their resource capacity, expand existing programmes, and undertake new initiatives.

NGOs in this sample were established and regarded as leading providers of HIV-prevention services in their respective countries. In this light, the small size of their overall budgets and also budgets for prevention programmes are of great concern. Even taking into account the modest cost of programme operation in most of these countries, NGOs were dramatically underfunded relative to urgent HIV-prevention needs. Not surprisingly, this was reported to be the primary barrier to new programme implementation. Many NGOs in the sample elaborated on this point by noting that most grants available to them have short funding periods and small funding levels. Such factors create programme instability, make it difficult to establish long-term programme development plans, and require that organizational effort be constantly focused on seeking funds to replace those lost when short support periods end.

Most NGOs in this international sample had many more volunteers than compensated staff. Volunteers play important roles in carrying out the programmes of NGOs and help the organizations maintain strong links to the communities they serve. However, volunteers do not necessarily have competencies in critical areas and are not always stable and reliable. Sufficient levels of paid, professional staff are essential to the effective long-term functioning and stability of nongovernmental organizations (Crane & Carswell, 1992). This study's findings underscore the need to make greater financial resources available to HIV-prevention NGOs, awarding

funds for periods long enough to permit meaningful programme development rather than constant short-period grant seeking, and strengthening staffing infrastructure. Much of this support will need to be from international and foreign donors.

Across regions, NGOs differed considerably in their length of organizational existence, types of programmes offered, and community populations served. African NGOs were the most established, had long histories of HIV-prevention work, and relied extensively on peer education, community AIDS awareness events, and condom distribution in their programmes. With generalized heterosexual epidemics in sub-Saharan countries, African NGOs usually targeted their programmes toward the community as a whole and toward young people. In contrast, and with an epidemic that has emerged virulently but only in the recent post-Soviet era, Central/Eastern European and Central Asian NGOs have existed for the shortest periods, and most focus attention toward needle exchange for drug users and prevention programmes for youth. Central/Eastern European NGOs had the smallest average budgets of any region and were most likely to cite lack of governmental support as a barrier. In the Soviet era, state systems were the sole providers of public services, and there is almost no history of community-based, nongovernmental organizations in post-Soviet countries. Thus, AIDS NGOs in post-Soviet countries confront not only the same challenges as HIV-prevention NGOs elsewhere but also the additional challenges of developing organizational structures and missions in the absence of local models for their operation (Kelly & Amirkhanian, 2003). Caribbean NGOs focused virtually all of their HIV-prevention activities on the general public, youth, and persons with HIV/AIDS; were least likely to target specialized at-risk community populations; and tended to rely on AIDS information dissemination. Latin American NGOs offered the most diversified range of HIV-prevention programme types, carried out frequent risk reduction counselling and skills-building workshops, but targeted MSM somewhat less often than might be expected in a region with a large proportion of infections among gay or bisexual men.

Across regions, a high proportion of all HIV-prevention activities involved providing basic AIDS education. Such programmes are relatively inexpensive, require few specialized resources, and are sustainable. At the same time, the behavioural science and public health literatures suggest that more intensive prevention approaches beyond AIDS education alone can have considerable impact on risk reduction (CDC, 1999; Coates, 1990; NIH, 1997; NIMH, 1998; Kelly & Kalichman, 2002). In the research arena, the HIV-prevention interventions most often studied intensive, theory-based, multiplesession, individual or group risk reduction interventions and widescale community mobilization approaches. It will be important to increase the resource capacity of HIV-prevention NGOs in resource-poor countries so that they can carry out programmes more complex than basic AIDS educational and awareness activities. It will also be critical for HIV-prevention researchers to develop and evaluate risk reduction intervention approaches that can be culturally tailored and that are feasible within the modest resource capacities of many NGOs. Programme cost and cost-effectiveness issues are extremely relevant considerations within the international HIV-prevention arena (Holtgrave & Pinkerton, 2000; Pinkerton et al., 1998).

NGOs do not carry out their programmes in isolation from governments, other service organizations and structures, funding sources and donors, and social values in their countries. This study's findings on barriers to programme implementation indicate that governmental indifference or opposition, stigma, religious beliefs, and public discomfort concerning sexuality are all impediments to HIV-prevention programme implementation by NGOs. Interventions capable of having profound positive HIV-prevention impact are often structural, policy and community-level approaches that require the participation of not only NGOs but also the active support of governments, policymakers and other stakeholders (Hanenberg et al., 1994; Sweat & Dennison, 1995). Models for strengthening the cooperation among these constituencies are needed. Although our study focused on HIV-prevention programmes, a large

proportion of NGOs also provided health care and AIDS-related support services. As access to antiretroviral therapy (ART) regimens is expanded globally, NGOs are logical partners in the provision of ART services to vulnerable and hard-to-reach groups. Strategies will also be needed to increase the capacity of NGOs to also play these new roles.

Several limitations of this research should be noted. Only one major HIV-prevention NGO in each country's capital or large city was selected for inclusion in the sample. Most countries have multiple nongovernmental organizations involved in HIV-prevention efforts, and the characteristics of NGOs in this sample may not be typical of other NGOs in the countries. There is also great heterogeneity across countries in our sample with respect to magnitude and epidemiology of HIV epidemics, the level of state versus NGO involvement in HIV-prevention efforts, the local or national character of NGO interventions, and the size of community populations served. There were not enough NGOs in the sample to permit stratification of agencies within regions to explore potential differences associated with these background factors. While types of HIV-prevention programmes were assessed, the interview did not assess the effectiveness of NGO programmes. It was also difficult to measure the scale and scope of prevention programmes being undertaken by NGOs; many organizations were unable to specify the number of community members exposed to their programmes using common and reliable metrics. Analyses of programme operation, scale, and success will require further research.

Many writers have called for the mobilization of resources, programmes, and international will to prevent HIV infections in world regions confronting major AIDS epidemics. Strengthening the capacity of NGOs to lead in these efforts is a major component of an effective global HIV-prevention strategy.

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Table I

Countries and cities represented in the study sample, by region

Africa	
Algeria (Oran)	Mali (Bamako)
Benin (Porto-Novo)	Mauritania (Nouakchott)
Burkina Faso (Bobo Dioulasso)	Morocco (Rabat)
Burundi (Bujumbura)	Niger (Niamey)
Cameroon (Yaounde)	Nigeria (Ibadan)
Central African republic (Bangui)	Sao Tome e Principe (Sao Tome)
Congo (Brazzaville)	South Africa (Pietermaritzburg)
Cote d'Ivoire (Bouake)	Sudan (Khartoum)
Eritrea (Asmara)	Swaziland (Manzini)
Ethiopia (Addis Ababa)	Tanzania (Dar es Salaam)
Gambia (Banjul)	Togo (Lome)
Ghana (Accra)	Tunisia (Sfax)
Kenya (Nairobi)	Uganda (Kampala)
	Zambia (Lusaka)
Caribbean	
Antigua and Barbuda (St. John's)	Dominican Republic (Santo Domingo)
Bahamas (Nassau)	Haiti (Port-au-Prince)
Cayman Islands (Grand Cayman)	St. Kitts and Nevis (Basseterre)
Cuba (Havanna)	St. Vincent and Grenadines (Kingstown)
Central and Eastern Europe, and Former Soviet Republics of Central Asia	
Albania (Tirana)	Macedonia (Skopje)
Armenia (Yerevan)	Moldova (Chisinau)
Azerbaijan (Baku)	Poland (Szczecin)
Belarus (Minsk)	Romania (Bucharest)
Bulgaria (Sofia)	Russia (Moscow)
Czech Repupblic (Prague)	Slovakia (Bratislava)
Estonia (Tallinn)	Slovenia (Ljubljana)
Georgia (Tbilisi)	Tajkistan (Khorugh)
Hungary (Budapest)	Turkmenistan (Ashgabat)
Kazakhstan (Almaty)	Ukraine (Kiev)
Kyrgyzstan (Bishket)	Uzbekistan (Tashkent)
Latvia (Riga)	Yugoslavia (Belgrade)
Lithuania (Vilnius)	
Latin America	
Argentina (Buenos Aires)	Guyana (Georgetown) Venezuela (Caracas)
Belize (Belize City)	Mexico (Mexico City)
Bolivia (La Paz)	Nicaragua (Managua)
Brazil (Rio de Janiero)	Paraguay (Asunicon)
Chile (Santiago)	Peru (Lima)
Columbia (Bogota)	Suriname (Paramaribo)
Ecuador (Quito)	Uruguay (Montevideo)

Table II

Budgets and organizational characteristics of HIV prevention NGOs in four world regions

Characteristic	Africa (*n* = 27)	Central/Eastern Europe & Central Asia (*n* = 25)	Latin America (*n* = 15)	Caribbean (*n* = 8)
Population size of NGO city				
Median	615, 987	1,141,465	1,577,649	103,598
Range	42,407-3,000,000	20,318-8,802,000	47,724-8,236,890	15,500-2,200,000
Annual total NGO budget in U.S.D.				
Median	$103,960	$54,427	$120,000	$90,000
Range	$3,434-$3,606,636	$900-$600,000	$16,000-$668,151	$10,000-$1,440,000
Annual NGO budget for HIV prevention activities in U.S.D.				
Median	$63,124	$35,549	$87,000	$48,500
Range	$3,434-$721,327	$630-$450,000	$20,833-$367,483	$3,991-$250,000
Years that NGO has carried out HIV prevention activities				
Median	7.0	4.0	9.0	5.0
Range	3-18	2-12	7-18	1-10
Number of full time NGO staff				
Median	5.0	5.0	5.0	2.5
Range	0-45	0-20	0-15	0-8
Number of part time NGO staff				
Median	1.5	6.0	3.0	0.0
Range	0-63	0-40	0-11	0-2
Number of NGO volunteers				
Median	45.0	30.0	11.5	12.0
Range	0-1,200	3-1,000	0-100	3-700
Percentage of NGOs that provide services other than HIV prevention	81.4%	92%	100%	75%

Table III

Funding sources of HIV prevention NGOs in four world regions

Percent of NGO Budget Derived from Each Funding Source	Africa (*n* = 27)	Central/Eastern Europe & Central Asia (*n* = 25)	LatinAmerica (*n* = 15)	Caribbean (*n* = 8)
NGO's home country national or state government	16.3%	14.7%	18.3%	27.5%
Foreign governments	12.8%	7.8%	7.5%	10.0%
International aid organizations (such as UN organizations)	28.5%	33.1%	35.0%	26.3%
International private charitable foundations	17.5%	30.5%	17.2%	0%
Self-funding (fundraisers)	21.6%	9.8%	22.0%	32.8%
Miscellaneous other sources	3.3%	4.1%	0%	3.4%

Table IV

Community populations served by NGOs in four world regions

Population	Percent (n) of NGOs Serving Population			
	Africa (*n* = 27)	Central/Eastern Europe & Central Asia (*n* = 25)	Latin America (*n* = 15)	Caribbean (*n* = 8)
Youth	59.3% (16)	44.0% (11)	26.7% (4)	50.0% (4)
General community or general population	66.6% (18)	32.0% (8)	60.0% (9)	62.5% (5)
Men who have sex with men (MSM)	0	8.0% (2)	33.3% (5)	0
Injection drug users (IDUs)	0	56.0% (14)	13.3% (2)	0
Commercial sex workers (CSWs)	14.8% (4)	20.0% (5)	6.7% (1)	0
Prisoners	3.7% (1)	12.0% (3)	0	0
High-risk heterosexuals	22.2% (7)	4.0% (1)	6.7% (1)	0
PWAs and their families	18.5% (5)	24.0% (6)	6.7% (1)	50.0% (4)

Table V

Types of direct service HIV prevention programmes offered by NGOs in four world regions

HIV Prevention Programme Type	Percent (n) of NGOs Offering Program Type			
	Africa (*n* = 27)	Central/Eastern Europe & Central Asia (*n* = 25)	Latin America (*n* = 15)	Caribbean (*n* = 8)
AIDS talks and print materials distribution	14.8% (4)	20.0% (5)	20.0% (3)	50.0% (4)
AIDS hotlines and resource centers	3.7% (1)	12.0% (3)	26.7% (4)	12.5% (1)
Peer education	59.3% (16)	28.0% (7)	20.0% (3)	25.0% (2)
Condom distribution	22.2% (6)	4.0% (1)	13.3% (2)	0
Mass media campaigns	14.8% (4)	4.0% (1)	26.7% (4)	0
Intensive individual sessions and group workshops on HIV risk reduction	18.5% (5)	16.0% (4)	40.0% (6)	25.0% (2)
HIV counselling and testing	3.7% (1)	8.0% (2)	6.7% (1)	12.5% (1)
Supportive and secondary prevention services for PWAs and their families	18.5% (5)	24.0% (6)	6.7% (1)	50.0% (4)
Needle exchange	0	48.0% (12)	0	0
Individual outreach	11.1% (3)	20.0% (5)	20.0% (3)	0
Community event programmes	25.9% (7)	16.0% (4)	6.7% (1)	12.5% (1)

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Table VI

Most important barriers to effective HIV prevention programme implementation reported by NGOs in four world regions

Barrier	Percent (n) of NGOs Citing Each Barrier			
	Africa (*n* = 27)	Central/Eastern Europe & Central Asia (*n* = 25)	Latin America (*n* = 15)	Caribbean (*n* = 8)
Funding	70.3% (19)	72.0% (18)	40.0% (6)	100.0% (8)
Personnel issues	7.4% (2)	16.0% (4)	6.7% (1)	37.5% (3)
Government indifference or opposition	29.6% (8)	52.0% (13)	33.3% (5)	12.5% (1)
Low community perceptions of risk	3.7% (1)	16.0% (4)	20% (3)	0
Other serious social problems (e.g., poverty, war)	14.8% (4)	25.0% (5)	6.7% (1)	0
Religious beliefs	22.2% (6)	8.0% (2)	26.7% (5)	12.5% (1)
Secular cultural beliefs/mores				
a) Stigma	33.3% (9)	36.0% (9)	73.3% (11)	50% (4)
b) Gender equity issues	11.1% (3)	4.0% (1)	6.7% (1)	12.5% 1)
c) Discomfort/opposition to discussing sexuality	22.2% (6)	4.0% (1)	20% (3)	25% (2)
d) Myths about HIV transmission	18.5% (5)	0	13.3% (2)	0
Insufficient infrastructure (e.g., poor roads)	14.8% (4)	4.0% (1)	6.7% (1)	12.5% (1)
Miscellaneous	11.1% (3)	8.0% (2)	0	0

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