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# AIDSCOM Lessons Learned

AIDS Prevention Counseling



Technology Transfer

Traditional Healers as Peer Educators

Condom Social Marketing

Mass Media Campaigns

## AIDS Prevention in Africa

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**OVERVIEW**

of

**AIDSCOM  
Lessons Learned**

***AIDS PREVENTION IN AFRICA***

***The AIDSCOM Project***

***The Support for Research and Analysis  
in Africa Project***

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# ***HIV/AIDS PREVENTION IN AFRICA***

## **OVERVIEW**

The AIDS Public Health Communication Project (AIDSCOM), funded in 1987 by the U.S. Agency for International Development (USAID) to assist developing countries in mounting effective HIV prevention activities, worked in more than 50 countries, including 22 in Africa. The project's contribution to HIV prevention integrates lessons learned from health education, behavior science, social marketing, and disease prevention. The objectives of AIDSCOM's technical assistance were to increase knowledge and understanding of AIDS and HIV infection, develop effective prevention methodologies, and encourage the behavior changes necessary to reduce the spread of HIV. During the six years ending November 30, 1993, AIDSCOM focused on several communication strategies to meet these goals.

This document explores lessons learned from AIDSCOM-initiated HIV prevention strategies and their applications for Africa. First, however, it is important to acknowledge seven common threads--vital premises that transcend strategy or target group--that ran through AIDSCOM's approaches. These premises are as follows:

1. **Individual Worth.** One of the first reactions to the AIDS epidemic worldwide was that the disease affected not "mainstream" people but those on the fringes of society (for example, gay and bisexual men, injection drug users, commercial sex workers). These people were considered of less value than those in the "mainstream" and as people who perhaps "deserved" AIDS. One of the premises of AIDSCOM was that everyone matters; for example, it is as important to educate and counsel a commercial sex worker as it is to educate and counsel her customer.
2. **High-risk Behavior vs. High-risk Group.** In the 1980s, many public health officials believed that there were "high-risk groups" that could easily be targeted for prevention activities or, in some cases, for quarantine. It became clear early in the epidemic that a person was at risk, not due to identification with any particular group, but due to participation in certain high-risk *behaviors*. A man who identified as heterosexual would not listen to messages targeting gay men, even if he had regular sexual intercourse with other men. Similarly, a woman who had sex for her room and board would not be captured by messages targeting commercial sex workers. A guiding premise of AIDSCOM was to target high-risk behaviors rather than high-risk groups.
3. **Explicit Discussion of Sex and Sexuality.** In most cultures, sex and sexuality are difficult--if not taboo altogether--topics for discussion. The impact of this taboo on HIV/AIDS prevention can be profound, since sex and sexuality must be discussed openly to prevent the bulk of HIV transmission. This means explicit age-appropriate discussion of the full range of sexual activities.

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***AIDSCOM Lessons Learned***

Omitting life-saving information due to embarrassment or squeamishness can be disastrous. For example, while conducting formative research for the development of a school-based AIDS education curriculum, AIDSCOM found through focus group interviews that many parents believed anal sex was safer than vaginal sex. Their beliefs were based on the fact that they had never heard anal sex discussed as risky in HIV prevention programs. Similarly, nonexplicitness can give people a false sense of security.

The range of sexual orientations also must be discussed. Increasing numbers of indigenous African lesbian and gay organizations have indicated that many of their members are involved in heterosexual marriages, since it is culturally expected that everyone will marry and have children.

4. **Status of Women in Society.** Sexism and misogyny flourish globally, resulting in a largely disenfranchised, overburdened, underpaid, and underconsulted segment of most societies. These women feel largely powerless to change their lives, in the boardroom or the bedroom. Many men and women see decisions about sexuality and reproduction as largely the purview of men. The implications for HIV prevention are profound. Commercial sex workers are no longer perceived as the only women at risk of contracting HIV. Increasingly, married and unmarried women of different socioeconomic backgrounds, from urban and rural areas, are being exposed to HIV through sexual contact, whether or not they are monogamous. Education helps women understand the disease and how they can prevent being exposed to the virus. But even in areas where women learn the facts about HIV/AIDS, many continue to engage in behaviors that put them at risk. This phenomenon is due largely to women's economic dependency on men and normative beliefs surrounding the role of women in society.

Considering that women frequently lack the autonomy to protect themselves from HIV infection, AIDSCOM concluded that when designing prevention strategies for women, it is important to look at women less in terms of their biological differences from men and more in terms of the social relationships between men and women. This focus makes it important to look at women not only as half of the equation, but also in relation to men and the way in which relationships between men and women are socially constructed.

5. **Vulnerability of Youth in Society.** Throughout the world and in virtually every culture, young people experiment with sex, alcohol, and, where available, drugs. This combination can be particularly deadly in an age of HIV. Many HIV-seropositive individuals in their 20s probably were infected as teenagers. Girls are particularly vulnerable because older men are seeking younger "AIDS-free" sexual partners and, in turn, are infecting younger and younger girls. Because children and youth also are relatively powerless (unable to vote, work, pay for school, and make decisions), they can become orphans, runaways, or homeless people who are at the mercy of and possibly exploited by older, more resourceful people. All sectors of society--families, schools, churches, government and nongovernmental organizations (NGOs)--are responsible for working with youth to ensure that they have access to information and commodities necessary to protect themselves. Society is responsible for enabling today's youth to

become tomorrow's leaders, *a generation free of AIDS.*

6. **Humanize the Face of AIDS.** One of the first responses of governments throughout the world to the AIDS epidemic has been denial: this disease happens only to *people elsewhere who do not look or behave like us, who do not speak our language.* A profound indicator of behavior change is personal knowledge of someone with HIV or AIDS. Worldwide, therefore, it has been important to have indigenous people come forward with their own stories or the stories of loved ones who live with or who have died of HIV disease. There may be resistance to and arguments against this practice, ranging from protection of client confidentiality to the fact that the practice would be inflammatory. Another argument might be that such a public acknowledgement would be a blow to tourism.

Workshops, media campaigns, public presentations, and videos that include personal testimony from a Person with AIDS and, possibly, a family member affected by HIV/AIDS, have inevitably put a human face to the epidemic. Such testimonies have inspired countless people to become involved with something that can clearly affect them and their families.

7. **Partnerships and Local Collaboration.** To ensure knowledge, skills, and technology transfer, as well as project sustainability, AIDSCOM established partnerships with local NGOs, community-based organizations (CBOs), and private voluntary organizations (PVOs). Local NGOs, CBOs, and PVOs were invaluable access points to target audiences and gave credibility to the activities undertaken. Interventions conducted in collaboration with local organizations proved less likely to be seen with suspicion or, worse, with hostility, as solutions attempting to be imposed from outside. Also, these partnerships facilitated the sustainability of initiatives. Partners ranged from groups such as international donors or PVOs (for example, UNICEF, WHO, Planned Parenthood, Red Cross) to totally indigenous organizations (for example, Federation of Ugandan Employers, the Organization of Tanzanian Trade Unions [OTTU], traditional healers in rural South Africa).

Keeping in mind these seven common threads, this paper briefly discusses lessons learned via key strategies and target audiences identified during the six years of AIDSCOM. More in-depth discussions of the lessons learned are available in the field notes included in this package.

## I. RESEARCH LESSONS LEARNED

- When developing interventions, it is better to begin with an understanding of the particular behavior rather than with assumptions about the type of information people need to change that behavior. Research on the external and internal factors that influence behavior can be used to identify promising intervention points. Communication and other social marketing techniques can be used creatively to result in effective interventions.
- While the findings differ from population to population and from country to country, in

the domain of HIV prevention, there are two particularly promising intervention points: skills and social norms.

### *Skills*

- \* Individual skills, both actual and perceived, are the first important intervention point. Interventions that increase skills also increase safer sexual behaviors. A person needs to know *how* to perform a behavior as well as to perceive that he or she *can* perform that behavior.
- \* In addition to physical skills (for example, using and buying condoms), social skills are important. Social skills include communicating and negotiating for safer sex. Negotiation involves verbal and nonverbal communication. Because sexual behavior involves two people, interventions are needed that help people learn how to influence each other effectively.

### *Social Norms*

- \* Social norms, both actual and perceived, are the second important intervention point. Perceived social norms refer to people's perceptions about whether others who are important to them think they should engage in a behavior. For example: Do most people who are important to us think we should use condoms, and who is important in this domain?
  - \* The evidence indicates that perceived social norms are related to risk behavior. Social norms can be changed with public communication, and influencing social norms can facilitate behavior change.
- AIDSCOM research activities indicate that risk behavior is changing, but it is changing gradually. We must be modest in our expectations of the time and effort necessary for sexual behavior to change.
  - There is some evidence behavior change can be facilitated with a variety of communication and other marketing interventions that involve integrated communication strategies and are based on formative research, tested with research, targeted to segments of audiences, and developed with sound program planning processes.

## **II. HIV/AIDS PREVENTION COUNSELING**

In the Western context, the value of counseling to prevent HIV transmission became clear during the first five years of the epidemic. Many African languages, however, did not even have a word for the concept of counseling. Counseling--where it did exist--often was seen as a group or community activity rather than a one-on-one phenomenon, as it is more commonly known in the West.

REDSO/WCA, the USAID regional office in Abidjan, requested that AIDSCOM assist in conducting two international training-of-trainer workshops on HIV prevention counseling. Representatives of 21 West and Central African countries took part in the 1990 francophone workshop in Abidjan and the 1991 anglophone workshop in Banjul. Although a few participants were familiar with HIV/AIDS prevention counseling concepts and such counseling was somewhat in place in a few locales, both groups spent considerable time defining how these concepts would be implemented in their own cultural contexts.

While assisting the Zambian Ministry of Health in the development of the counseling training video *Challenges to AIDS Counseling* and its accompanying guide, AIDSCOM helped the AIDS Control Program study the differences among various prevention counseling concepts.

**Lessons Learned:** Following are some of the lessons learned through these initiatives:

- International workshops, where participants from different countries within a region discuss, role play, and make recommendations regarding prevention counseling guidelines, can be useful in creating culturally relevant programs within the region. Ideally, regular follow-ups to these workshops should determine how well these programs are being implemented and sustained.
- It also can be effective to use videos and role plays to model new behaviors and encourage counselors to find creative ways to overcome diverse cultural barriers they encounter in their work.
- It is important for prevention counselors to understand the need for "nondirective" counseling--to be able to give clients information and then help them make their own decisions and solve their own problems, rather than offering them only advice.
- Models of innovative counseling techniques can help confront sensitive issues or cultural norms such as talking with strangers (especially elders) about sexual behavior and condom use. For example, the video models different behaviors such as asking permission to discuss sensitive topics or finding a comfortable, private place to talk with clients.

### III. LOCAL PARTNERSHIPS

AIDSCOM consistently fostered partnerships with institutions that were new to health promotion activities. These institutions fell primarily into two broad categories: *those with specific technical expertise* needed for the design or implementation of HIV prevention interventions and those that are referred to as *constituent groups*.

Included in the first category are commercial research and advertising firms, plus university-based research units. In every region, collaboration with these agencies increased skills in the design of AIDS-related knowledge, attitudes, beliefs, and practices surveys; behavioral analysis; message testing; and so on. AIDSCOM also facilitated ongoing partnerships among these

technical firms and nongovernmental organizations (NGOs), community-based AIDS action groups, and government ministries.

Constituent groups usually were existing organizations active in other areas or embryonic groups formed primarily to engage in HIV prevention work. These included women's groups, labor unions, professional or business associations, religious and youth groups, organizations of People with HIV/AIDS, and so on. Some institutions had hundreds and often thousands of members, while others developed from a few individuals with a passion to become involved. Almost all of AIDSCOM's local partnerships established in Africa belonged in this category of *constituent groups*.

AIDSCOM's goal was to establish partnerships with local NGOs, PVOs, CBOs, and the private sector to facilitate knowledge, skills, and technology transfer and strengthen local capacity for organizations to develop, implement, evaluate, and sustain HIV/AIDS prevention programs.

**Lessons Learned:** Following are some of the lessons learned through these initiatives:

- Local partnerships enabled AIDSCOM and its programs to remain centered on and to engage people as actors who make behavioral decisions and who influence others to do the same. AIDSCOM's partners were a constant reminder that this work was really about their lives, families, and communities and tapping the strength of those bonds.
- Local partnerships increased the likelihood of successful innovation. AIDSCOM's partners offered access to and an understanding of those many "cultures within the culture." In addition, they were driven to push the boundaries of what was socially accepted and to challenge prevailing norms, fears, and prejudices. This was a sometimes thankless but unavoidable aspect of effective HIV prevention work.
- Local ownership of community-based HIV/AIDS prevention and support projects facilitates development of culturally relevant, effective, and sustainable projects.

#### **IV. PERSONAL TESTIMONY TO MOTIVATE CHANGE**

AIDSCOM's goal was to encourage and teach local organizations to use personal testimony as an informational and motivational technique to promote sexual behavior change. More specifically, the goal was to introduce personal testimony as one way to help health and social service professionals improve their counseling skills by gaining immediate knowledge of the physical and emotional trauma associated with being HIV-seropositive or having AIDS. It was hoped that after participants witnessed the power of this technique, they would incorporate it into their own prevention activities as soon as it was culturally feasible.

**Lessons Learned:** Following are some of the lessons learned through these initiatives:

- A technique such as using public testimonials to portray important individual and societal

issues may not be commonly employed within a culture. But it often can be adapted to become a useful tool.

- In a workshop context, part of a panel's success results from a solid planning and support from conference organizers and facilitators. Working with local trainees and facilitators to help them feel comfortable using testimonials is as important as encouraging the organizers to allow the panel discussion.
- Planning mechanisms for informal discussions after the panelists speak can help participants deal with their anxieties and move toward a more in-depth consideration of workshop topics. In an ideal situation, participants would have adequate time to eat, drink, and have informal discussions with the panelists both before and after the presentations.

## V. MASS MEDIA CAMPAIGNS

Mass media campaigns in three countries provided some insight into the role these activities can play in increasing awareness of HIV/AIDS prevention among a country's population.

### **Philippines: *Barkada***

In 1990, AIDSCOM ran an initial general population campaign in metropolitan Manila. The objective of that campaign was to correct myths and increase knowledge about HIV prevention. A second campaign was run in Manila that was targeted to young adults. This campaign was called *Barkada*.

The level of sexual activity among young adults ages 18 to 24 in the Philippines was low, particularly among women. Specifically, 55 percent of young men and only 9 percent of young women had sex. The objectives of the campaign were to reinforce delaying the onset of sexual intercourse and to promote condom use once an adolescent decided to become sexually active.

The amount of agreement with two beliefs about waiting for marriage at the time of the pretest and again at the post-test was measured. The beliefs included the following: "It's important for guys to get experience with sex early" and "It's okay for guys to wait to have sex until they're married." Surveys showed increased disagreement with the first belief and increased agreement with the second belief during the time period between the two tests.

### **Eastern Caribbean: *Parents and Youth***

In the Eastern Caribbean, AIDSCOM's *Parents and Youth* campaign was designed to help parents recognize that many teens were sexually active, to facilitate discussion, and to suggest to parents that condoms could protect their children.

The campaign ran for several months in St. Vincent. At the end of the campaign, 100 parents, 100 teens, and 100 other adults were interviewed. Comparing the group that was exposed to the

campaign with the group that was not (nonexposed), the campaign clearly had an impact on perceived social norms. Project staff asked the exposed and nonexposed groups whether they believed that others (partners, friends, and parents) think they should use condoms. The percentages who believed that others think they should use condoms were higher among those exposed to the campaign than among those not exposed. The differences were statistically significant for perceptions of pressure from friends and partners.

These and other studies of integrated communication campaigns indicate that media campaigns can influence attitudes, outcome and self-efficacy beliefs, and normative beliefs, all of which evidence indicates are likely to be internal factors that can function as determinants of sexual behavior.

### **Ghana: *Get Protection***

In Ghana, the integrated communication campaign emphasized the need to *Get Protection* and encouraged or gave people permission to wait to have sex. The campaign made use of radio, television, print, and school outreach programs.

AIDSCOM collected data on the percentage of sexually active people using a condom in 1991 (before the campaign) and again in 1992. Among those who were unmarried or who reported they had more than one partner, the percentage of condom use increased significantly.

The Ghana campaign had a unique impact on "noncondom" risk behavior--that is, on initiation of sexual activity. There is some evidence that the campaign increased the age of sexual initiation. In addition, data show that sexual activity among 15-year-old females decreased significantly.

**Lessons Learned:** Following are some of the lessons learned through these initiatives:

- Consistent messages in various media and nonmedia sources can result in increased awareness about HIV/AIDS and some behavior change. However, more personal strategies may need to be invoked to significantly increase and sustain behavior change.

## **VI. AIDS EDUCATION TO IN-SCHOOL AND OUT-OF-SCHOOL YOUTH**

It must be acknowledged that there is no single correct way to reach all of the at-risk youth in any given country, community, or even family. In some developing countries, less than 50 percent of young people see the inside of a classroom, with far fewer girls benefiting from formal education than boys. Targeting AIDS education in the public and private schools nationwide will reach only a modest proportion of the youth; however, the schools do provide an access point for those who attend, plus their families and friends in the wider community. Other useful access points for both in-school and out-of-school youth include youth groups, churches, sporting clubs, marketplaces, discos, and special events.

In Malawi, USAID asked AIDSCOM to assist in developing an AIDS education program for public and private schools nationwide. The program was made as inclusive as possible from the outset. Project staff engaged three government ministries, various religious groups, youths, and political and tribal leaders in the process of conducting formative research, developing a curriculum, testing and revising materials, introducing the curriculum to parents and communities, and implementing and evaluating the program.

**Lessons Learned:** Following are some of the lessons learned through these initiatives:

- AIDS education is multidimensional and includes cultural, historical, political, social, economic, and religious aspects that must not be ignored, along with the expected medical and pedagogical concerns.
- Difficult questions must be confronted and answers provided at an early stage, such as what grade level sexual transmission and condom use should be brought into the curriculum.
- Teams writing AIDS education materials must represent the spectrum of society, including those opposed to teaching the subject, so that compromises can be worked out in the drafting committee, not in public confrontations once teaching has begun.
- The project must have the guarantee of educational authorities that AIDS education will be incorporated into the regular school curriculum and will be included in examinations.
- The cooperation and support of parents should be solicited to help create an atmosphere in which teachers and school administrators feel free to discuss in the classroom culturally relevant issues such as sexual behavior.
- It is important to stress at every opportunity to the public, particularly parents, that the purpose of AIDS education is not to encourage promiscuity, but to provide young people with information they need to save their lives and the lives of others.

## **VII. TRAINING OF TRAINERS**

When consulting with government ministries and NGOs concerning the most appropriate people to be trained as trainers in HIV prevention, it has been important to consider who is most accessible to grassroots populations that engage in high-risk behavior, who has the most leadership potential for influencing high-risk behavior, and who is most likely to have the necessary short- and long-term commitment to sustain the intervention.

In Ghana, performing artists were targeted for AIDS education training of trainers because the nature of their work allowed them to reach large audiences. Also, primary health care providers were trained to train others within the Ministry of Health in Ghana.

In Malawi, district health officers and education inspectors were trained to train their instructors within their district on how to use the comprehensive AIDS prevention curriculum.

In South Africa, traditional healers (sangomas) were identified as the group with the greatest potential for reaching the most people. Sangomas are regularly consulted by 80 percent to 85 percent of the Black population. Sangomas are not only the first to be consulted on health matters, but also the first point of contact on issues concerning marital problems, community conflicts, or sociopolitical unrest.

In Swaziland, Tanzania, and Uganda, workers were identified as appropriate recipients of AIDS education training to train peer educators who would then disseminate HIV prevention information to fellow employees at the various worksites and to family, friends, and neighbors.

**Lessons Learned:** Following are some of the lessons learned through these initiatives:

- Training of trainers requires intensive and sustained effort. It takes a great deal of time--involving screening of trainers of trainers, repeated training sessions, and significant supervision and follow-up--to train a trainer of trainers and/or peer educator.
- Maintaining quality assurance is labor-intensive, but essential. After trainers are trained, it is important to implement regular face-to-face follow-up and update meetings to assess knowledge, attitudes, and ability to demonstrate proper condom usage and to determine whether trainers are delivering consistent messages.
- We must look beyond the traditional sources of HIV/AIDS prevention trainers (for example, teachers, health care providers) to the nontraditional sources. Examples of nontraditional sources include sangomas, who are ideally placed to confront the cultural taboos regarding discussion of sex and sexuality; performing artists; and co-workers (peer educators).

## **VIII. FAMILY PLANNING PROGRAMS**

One of the greatest challenges of working in HIV prevention was finding ways to access hard-to-reach populations and provide them with appropriate prevention information and services. AIDSCOM found that one successful approach was to identify existing intermediaries that already had established access to these individuals and work with these groups to add an HIV component to their existing activities. Some of these groups already were working in some sort of health activity; others were constituent organizations or private-sector firms with no experience in health issues.

Working with nongovernmental groups--including family planning organizations--proved to be an effective strategy for AIDSCOM to continue promoting HIV prevention information and services, even in countries where the U.S. Congress had restricted using development funds for work with public-sector organizations.

**Lessons Learned:** Following are some of the lessons learned from AIDSCOM's collaboration with family planning programs:

- Family planning organizations are well-positioned to incorporate HIV/AIDS prevention into their activities, since they already deal with many individuals who engage in high-risk behaviors; they already are trained to discuss sensitive issues such as sex, sexuality, and condom use; and they already have well-established service and distribution networks.
- Since family planning counselors and their clients frequently did not see condoms as the method of choice for contraception, counseling techniques had to be re-evaluated to address HIV/AIDS prevention.
- The process for incorporating HIV/AIDS prevention into family planning must involve ongoing in-service training, since understanding and commitment evolves in stages according to staff readiness at the outset.

## **IX. WOMEN AND AIDS**

In 1990, AIDSCOM received funding from the Agency for International Development's (A.I.D.) Women in Development Office to conduct a multisite research and intervention project to help understand the factors that influence behavior change in women and effective ways to support new behaviors. This project, conducted in Brazil, Tanzania, and Indonesia, used theory-driven behavioral research on the underlying determinants of behavior to design country-specific HIV/AIDS prevention curricula for women and their sexual partners. The curricula were designed to 1) empower women with the knowledge, skills, and confidence to negotiate for safer sex and 2) provide a social support system for women to influence their partners' sexual behavior.

**Lessons Learned:** Following are some of the lessons learned through AIDSCOM's Women and AIDS projects in Brazil, Tanzania, and Indonesia:

- Globally, women are at different stages on the learning curve and behavior change continuum. In Indonesia, women did not yet feel comfortable discussing sexual behavior and HIV prevention with other women, let alone their sexual partners. In Brazil, women felt fairly comfortable discussing sexual issues with women, but not with men. Tanzanian women were the furthest along the learning curve in terms of knowledge, attitudes, and behavior: 72 percent reported they could refuse to have sex with their main sexual partner for whatever reason, 53 percent reported insisting their partner use a condom, and 39 percent reported refusing to have sex if their partner would not use a condom.
- Women should not be viewed in isolation from men. In Tanzania, 57 percent of the women reported that *they and their partner* made sexual decisions together, 17 percent reported that *their partner* made these decisions, and 26 percent reported that *they* made these decisions. Since women are rarely autonomous in making decisions that affect their bodies, it is important to design gender-specific interventions to reduce HIV transmission

to women. This means including men in the interventions.

- Men are open to and interested in participating in AIDS education and HIV prevention trainings that their sexual partners are attending. The Tanzania intervention involved four sessions for women, one session for their sexual partners, and a combined session for the women and their partners. Although a low turnout by men was anticipated, 88 percent of the women's partners attended the training session for men.
- Participatory research can be a powerful methodology to develop culturally relevant and effective prevention strategies. In Tanzania, participatory research allowed AIDSCOM and its local partner, OTTU, to develop culturally relevant questionnaires. Also, since local women conducted group face-to-face interviews using questionnaires they had designed and pretested in their native language, respondents were more likely to speak candidly. Data collected through participatory "action" research were translated into program interventions found to be relevant to the target audience. Relevance results from the target audience being involved in all phases--conceptualization, research design, data collection, intervention design, implementation, and evaluation.

In addition to the Women and AIDS Projects funded through the Women in Development Office of A.I.D., AIDSCOM and the AIDS Control and Prevention Project (AIDSCAP) implemented the Community HIV/AIDS Model of Prevention and Support (Project CHAMPS). Project CHAMPS was a pilot community-based project targeting South African HIV-seropositive women and their sexual partners and families. Project staff conducted formative research to determine the issues that were most salient to the women and their families. Then, they developed materials; trained health care and social service providers; and recruited, trained, and supervised community field workers to provide vital prevention, education, and support services to these families.

**Lessons Learned:** Following are some of the lessons learned during the first year of the pilot project:

- Local ownership of community-based HIV/AIDS prevention and support projects facilitates development of culturally relevant, effective, and sustainable projects.
- South African mothers involved in design and pretesting of materials reaffirmed previous findings that indicate clients want materials they can leave around their homes that will not mention HIV or AIDS, but will still be useful to them and those around them.
- Formal education has been consistently disrupted for decades and school is considered less important for females, so literacy is particularly low among South African women. Therefore, written materials were geared for a low-literate audience, and field workers were trained to help clients identify people whom they could trust to assist them with the materials at home.
- Written materials must be geared for a low-literate audience in Africa, where school

generally is considered less important for females, and in South Africa, where formal education has been consistently disrupted for decades.

- It is difficult to engage women in HIV/AIDS problem-solving when their basic needs are not being met (for example, when they have no food for their families). Future strategic planning for the initiative should consider funds for assistance to develop some form of income generation for clients struggling with basic survival issues. Otherwise, these clients may never be able to prioritize their health concerns to prevent further sexual/perinatal HIV transmission and disease progression.

## X. SOCIAL MARKETING OF CONDOMS

Extensive field research conducted in Tanzania was used to develop a Tanzania-specific condom called *Salama* (safe or secure) that would appeal to men in the target audience. Subsequent research after social marketing of the condoms began demonstrated that the availability of the *Salama* condom and of condoms in general increased in three ways: by being available in more outlets, by being available in shops as well as pharmacies, and by being available in more zones of the city. Further, preliminary evidence supported AIDSCOM's hypothesis that intervening on a structural factor by increasing availability facilitates behavior change.

**Lessons Learned:** Following are some of the lessons learned through the AIDSCOM Condom Social Marketing Project:

- Tanzanian men were open about and interested in discussing sex, AIDS, and condoms. They expressed definite opinions about these subjects.
- *Salama* was significantly more attractive as a condom name than *Simba* (lion) or other more aggressive images.
- Appeals to personal and family responsibility were more appropriate than appeals to fear or pleasure.

## XI. CONDOM BROCHURES

Much of AIDSCOM's early work built condom skills by teaching participants to put a condom on a surrogate model. Since face-to-face activities have limited reach and often need to be reinforced over time, AIDSCOM used focus group research to design a condom brochure that would reinforce the face-to-face condom skills-building activities. Additionally, the condom brochure was to provide men and women with practical tips that would make condom usage more effective. AIDSCOM worked closely with the target audience (sexually active adults) to design the format, art style, and text for its condom brochure--all of which were pretested and revised.

**Lessons Learned:** Following are some of the lessons learned through these initiatives:

- The AIDSCOM brochure can reinforce skills and knowledge acquired through face-to-face condom skills-building sessions. The brochure and demonstration used in combination is the most ideal training method.
- Materials developed for one region can be culturally appropriate and effective in other regions.

## **XII. IT'S NOT EASY**

*It's Not Easy*, the first AIDS film produced in Africa, was created with technical assistance from AIDSCOM. After a U.S. premiere of the film, hosted by members of Congress, it was recommended that the appropriateness of the film for U.S. audiences, particularly African-Americans, be explored. As a result--with the assistance of the National Urban League and the American Red Cross--the hypothesis that materials targeted for audiences of a developing country can be effective in a developed country was tested.

**Lessons Learned:** Following are some of the lessons learned through exploring the appropriateness of *It's Not Easy*.

- The film *It's Not Easy* is appropriate for U.S. audiences.
- The film increased both knowledge about sexual transmission and behavioral intentions.
- The film seemed especially appropriate for African-Americans, who liked the film and thought they learned more from the film than non-African-Americans.
- The film had a more positive impact on African-Americans than non-African-Americans regarding beliefs about people with AIDS, sexual transmission of AIDS, and attitudes about staying with one sexual partner.

# **HIV/AIDS PREVENTION IN AFRICA**

## **EXECUTIVE SUMMARY**

The AIDS Public Health Communication Project (AIDSCOM), funded in 1987 by the U.S. Agency for International Development (USAID), represents a six-year effort to assist developing countries in establishing and implementing effective HIV prevention activities. AIDSCOM provided technical assistance in this area to more than 50 countries, including 22 in Africa. This package explores lessons learned from AIDSCOM-initiated HIV prevention strategies and their applications for Africa. The package consists of the following:

1. **Overview.** This document describes some of the basic premises that drove the project work, including the need for *all* individuals to be armed with HIV/AIDS prevention information, the importance of targeting high-risk behaviors rather than "high-risk groups," the need to explicitly discuss the full range of sexual activities and sexuality, the importance of targeting the most vulnerable segments of society (for example, women, youth), the effectiveness of humanizing the epidemic through personal testimony of those affected by HIV/AIDS, and the advisability of working through already-established community-based organizations (CBOs). The overview also provides a synopsis of lessons learned via attached field notes.
2. **AIDSCOM Research Lessons Learned.** AIDSCOM research activities were guided and organized by the Applied Behavior Change (ABC) Framework. This framework helped AIDSCOM work collaboratively and coordinate the following lessons learned:
  - Risk behavior is decreasing, albeit slowly, in some key populations. Evidence indicates that this decrease is at least partially due to interventions and programs funded by the Agency for International Development.
  - Social norms are a key determinant of sexual risk behaviors and can be influenced with communication interventions.
  - Interventions that influence skills are effective at facilitating safer sex practices.
3. **Challenges to Conducting Research in Africa.** Conducting field research in Africa can be complex under even the most ordinary circumstances. Some of AIDSCOM's operational research-related lessons learned include the following:
  - Researchers designing questionnaires to be translated into other languages should use simple concepts, especially when the questionnaires will be used in interviews with non-native speakers.
  - When possible, members of the target audience should be involved in every stage of research design, implementation, and evaluation. Such "participatory" research

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**AIDSCOM Lessons Learned**

- optimizes skills transfer and is likely to be more relevant to all concerned.
  - The final version of a questionnaire should be carefully pretested among a group that is similar to the target population, then revised where necessary.
4. ***HIV/AIDS Prevention Counseling.*** Whenever individuals and families are dealing with the stigma, fear, and anxiety associated with HIV/AIDS, it is important to have proactive community-based prevention counseling systems in place. AIDSCOM promoted this throughout Africa. Lessons learned include the following:
- International and cross-cultural prevention counseling workshops can be useful in creating culturally relevant programs within a region.
  - It can be effective to use videos and role plays to model new behaviors and encourage counselors to find creative ways to overcome diverse cultural barriers.
  - It is important for prevention counselors to understand the need for "nondirective" and "nonjudgmental" counseling.
5. ***Local Partnerships.*** AIDSCOM established partnerships with local nongovernmental organizations, private voluntary organizations, CBOs, and the private sector to facilitate knowledge, skills, and technology transfer and strengthen local capacity for organizations to develop, implement, evaluate, and sustain HIV/AIDS prevention programs. Lessons learned include the following:
- Local partnerships enabled AIDSCOM to remain centered on and engage people as actors who make behavioral decisions and who influence others to do the same.
  - Local partnerships increased the likelihood of successful innovation.
  - Local ownership of HIV prevention activities will help sustain these activities.
6. ***Personal Testimony to Motivate Change.*** AIDSCOM encouraged and taught local organizations to use personal testimony about HIV/AIDS as an informational and motivational technique to promote sexual behavior change. Lessons learned include the following:
- A technique such as using public testimonials to portray important individual and societal issues may not be commonly employed within a culture. But it often can be adapted to become a useful tool.
  - Planning mechanisms for informal discussions after a public testimonial can help participants deal with their anxieties and move toward a more in-depth consideration of workshop topics.
7. ***Mass Media Campaigns.*** AIDSCOM used mass media campaigns to raise the awareness of HIV/AIDS prevention issues among general populations. Lessons learned include the following:
- Media can become part of a process of behavior change if they are integrated into other more personal approaches to HIV/AIDS education, without which behavior

change may not be sustained.

8. ***AIDS Education to In-school and Out-of-school Youth.*** Because many vulnerable youth--particularly females--may never attend school regularly, it is important for AIDS education curricula in schools programs to be coordinated with outreach programs targeting out-of-school youth in other settings. In developing school-based curricula, the following lessons were among those learned:
- Teams writing AIDS education materials must represent the spectrum of society, including those opposed to teaching the subject, so that compromises can be worked out in the drafting committee, not in public confrontations once teaching has begun.
  - The project must have the guarantee of educational authorities that AIDS education will be incorporated into the regular school curriculum.
  - The cooperation and support of parents should be solicited to help create an atmosphere in which teachers and school administrators feel free to discuss in the classroom culturally relevant issues such as sexual behavior.
  - It is important to stress to the public, particularly parents, that the purpose of AIDS education is not to encourage promiscuity, but to provide young people with information they need to save their lives and the lives of others.
9. ***Training of Trainers.*** AIDSCOM worked to identify, recruit, train, and supervise a cadre of trainers in various fields who would in turn train others in HIV/AIDS prevention. These included populations ranging from traditional healers and performing artists to mental health professionals and peer educators in the workplace. Lessons learned include the following:
- It is important to look beyond the traditional sources of HIV/AIDS prevention trainers (for example, teachers, nurses) to such innovative populations as traditional healers, who are ideally placed to confront the cultural taboos regarding discussion of sex and sexuality; performing artists; and co-workers (peer educators).
  - Workplace programs can influence behavior change.
  - Training trainers requires intensive and sustained effort.
  - Maintaining quality assurance is labor-intensive but essential.
10. ***Family Planning Programs.*** Working with nongovernmental groups, including family planning programs, proved to be one successful approach to accessing hard-to-reach populations to provide them with HIV prevention information and services. Often, this approach required providing these groups with an appropriate conceptual approach to HIV/AIDS prevention work. Lessons learned include the following:
- Family planning organizations are well-positioned to incorporate HIV/AIDS prevention into their activities.
  - The process for incorporating HIV/AIDS prevention into family planning must

involve ongoing in-service training, since understanding and commitment evolves in stages according to staff readiness at the outset.

11. **Women and AIDS.** AIDSCOM used theory-driven behavioral research to study the underlying determinants of behavior to design an HIV/AIDS prevention curriculum for women and their sexual partners. AIDSCOM also undertook a project to help promote a community-based response to the prevention, education, and support service needs of HIV-seropositive mothers and their sexual partners and families. Lessons learned include the following:

- Women should not be viewed in isolation from men.
- Men are open to and interested in participating in AIDS education and HIV prevention trainings that their sexual partners are attending.
- Participatory research can be a powerful methodology to develop culturally relevant and effective prevention strategies.
- Written materials must be geared for a low-literate audience in Africa, where school generally is considered less important for females, and in South Africa, where formal education has been consistently disrupted for decades.
- It is difficult to engage women in HIV/AIDS problem-solving when their basic needs are not being met (for example, when they have no food for their families). Therefore, income generation becomes a vital component of projects targeting women.

12. **Social Marketing of Condoms.** When people elect not to abstain from sex, not to be mutually faithful, and not to practice nonpenetrative sex acts, then it is important that they know about and are motivated to use condoms and that there is an adequate and accessible supply of condoms. Lessons learned include the following:

- Men will be open about and interested in discussing sex, AIDS, and condoms.
- Target audiences may surprise researchers concerning their choice of condom names, designs, and packaging.
- Appeals to personal and family responsibility are more appropriate than appeals to fear or pleasure.

13. **Condom Brochures.** Early AIDSCOM research in Trinidad and Tobago, Jamaica, and the Dominican Republic revealed that many men and women did not know how to put on a condom correctly. AIDSCOM designed an instructional brochure to fill this knowledge gap. Lessons learned include the following:

- The AIDSCOM brochure can reinforce skills and knowledge acquired through face-to-face condom skills-building sessions. The brochure and demonstration used in combination is the most ideal training method.
- Materials developed for one region can be culturally appropriate and effective in other regions.

14. ***It's Not Easy***. AIDSCOM tested the cross-cultural appropriateness of the Ugandan AIDS film *It's Not Easy*. Lessons learned include the following:
- *It's Not Easy* is appropriate for U.S. audiences.
  - The film increased both knowledge about sexual transmission and behavioral intentions.
  - The film seemed especially appropriate for African-Americans, who liked the film and thought they learned more from the film than non-African-Americans.
  - The film had a more positive impact on African-Americans than non-African-Americans regarding beliefs about people with AIDS, sexual transmission of AIDS, and attitudes about staying with one sexual partner.

## ***Field Note #1: AIDSCOM Research Lessons Learned***

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During its six years, AIDSCOM worked with colleagues in the field of international HIV prevention to conduct more than 100 research studies. Some were qualitative and others quantitative. They included formative research to design interventions, experimental studies to pretest them, and impact evaluations to assess changes in behavior. Small studies involved 20 to 50 participants; large studies, thousands of participants. Project staff used interviews, self-administered questionnaires, observations, and focus group discussions; staff stopped people on the street, at work, in schools, in stores, and at home.

AIDSCOM's research activity was guided and organized by the Applied Behavior Change (ABC) Framework. The ABC Framework has the following three components:

- 1.. The *program planning cycle* takes the program manager through the steps of assessing, planning, pretesting, implementing, and monitoring.
2. The *social marketing core* assists the program manager in making strategic management decisions, such as whether and how to intervene on product, price, promotion, or place.
3. The *behavior constellation* describes the priority internal and external behavioral factors the program manager needs to understand, target, and monitor.

This framework helped AIDSCOM work collaboratively and coordinate its lessons learned. AIDSCOM staff found that the key to research and theory-based intervention design is continual collaboration and contact between researchers and program managers and between the United States and the field. The ABC Framework helped AIDSCOM coordinate its work by giving the project a common vocabulary.

A common theory-based conceptual framework such as the ABC Framework not only contributes to effective program design, it is critical to efficient evaluation and program replication. It enables the evaluator to discover not only that a program changed behavior, but potentially how or why the behavior changed.

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***AIDSCOM Lessons Learned***

## EVALUATIVE LESSONS

It is impossible to present or even summarize all of AIDSCOM's research findings in this brief document. Consequently, this document will focus on three evaluation lessons from AIDSCOM's more rigorous quantitative studies. AIDSCOM believed the lessons are consistent with what other international and domestic researchers finding. They are as follows:

1. Risk behavior is decreasing, albeit slowly, in some key populations. Evidence indicates that the decrease is at least partially due to interventions and programs funded by the Agency for International Development.
2. Social norms are a key determinant of sexual risk behaviors and can be influenced with communication interventions.
3. Interventions that influence skills are effective at facilitating safer sex practices.

This document presents some studies and some data to support these points. It presents illustrative findings only. It examines impact sometimes by discussing changes over time and sometimes by comparing exposed to nonexposed. In all cases, AIDSCOM conducted its analyses both ways, and the results have been similar.

This document is not able to provide the details of the reports with the full findings, the inferential statistics, and the analyses that demonstrate that the findings are attributable to the interventions. Some of these reports are included as separate field notes in this package and have also been published in *A World Against AIDS: Communication for Behavior Change*.

## BEHAVIOR CHANGE: AFRICA

Evidence exists that risk behavior is changing and can be influenced. The following are examples from Africa: the worksite intervention in Uganda, the *Salama* condom social marketing program in Tanzania, and the *Get Protection* campaign in Ghana.

### Uganda: Worksite Intervention

The results of the evaluation of the Uganda workplace program are presented in field note #8. To summarize, the intervention was an integration of several components, including formal talks, talks with peer educators, and the dramatic film *It's Not Easy*.

Susan McCombie of the Annenberg School demonstrated that exposure to the worksite intervention was associated with change in internal factors, particularly knowledge about latency and perceived social norms. The percentage having correct knowledge about the latency period and the percentage believing that others use condoms was higher the heavier the degree of exposure to the worksite program.

In addition, there is clear evidence that safer sexual behavior increased. The percentage of sexually active adults using condoms was higher the heavier the degree of exposure to the intervention.

Therefore, AIDSCOM learned not only that workplace programs could be implemented in Africa and that they could facilitate change in risk behavior, but that the active ingredients in facilitating this behavior change were a better understanding of HIV infection and social norms.

### **Tanzania: *Salama* Condom**

One factor that inhibits condom use, particularly in Africa, is the availability of condoms. In Tanzania, AIDSCOM implemented a condom social marketing program to develop, distribute, and promote a new brand of condoms, the *Salama* condom.

AIDSCOM used a local research team to gather information on the availability of the *Salama* condom in three outlets at three different time periods, separately by zone of Dar Es Salaam. The outlets included pharmacies, shops, and what project staff called leisure outlets (bars, clubs, and hotels).

The research team gathered data on the percentage of outlets carrying condoms in the eight outer locations of the city for the three time periods. Researchers distinguished between those outlets carrying any type of condom and those carrying the new *Salama* condom.

Data showed that the percentage of pharmacies carrying the *Salama* condom increased as expected in the first year of the program. More important, evidence indicated that more shops were carrying not only the *Salama* condom, but also any brand of condom.

This research demonstrated that the availability of the *Salama* condom and of condoms in general increased in three ways: by being available in more outlets, by being available in shops as well as pharmacies, and by being available in more zones of the city.

### **Ghana: *Get Protection***

The results of the evaluation of the *Get Protection* campaign are presented in field note #6 of this series.

In Ghana, the integrated communication campaign emphasized the need to *Get Protection* and encouraged or gave people permission to wait to have sex. The campaign made use of radio, television, print, and school outreach programs.

This campaign was assessed with a large-scale impact evaluation in two areas of Ghana. Baseline data from a representative sample of about 1,500 15- to 30-year-olds were collected in July 1991 before the campaign and again in July 1992, about a year after the program.

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AIDSCOM collected data on the percentage of sexually active people using a condom in 1991 and again in 1992. Among those who were unmarried or who reported they had more than one partner, the percentage of condom use increased significantly.

The Ghana campaign had a unique impact on "noncondom" risk behavior--that is, on initiation of sexual activity. There is evidence that the campaign increased the age of sexual initiation. That is, data show that the percentage of 15-year-olds who reported sexual activity decreased significantly among both males and females.

### **BEHAVIOR CHANGE: OTHER REGIONS**

#### **Mass Media Programs: Philippines and Eastern Caribbean**

A number of AIDSCOM programs were integrated communication programs with significant mass media components. This document describes the results of two of these programs, which were directed at youth. One was developed in the Philippines and the other in the Eastern Caribbean.

#### **Philippines: *Barkada***

In 1990, AIDSCOM ran an initial general population campaign (including young adults) in metropolitan Manila. The objective of that campaign was to correct myths and increase knowledge about HIV prevention. AIDSCOM ran a second campaign in Manila that was targeted to young adults. This campaign was called *Barkada*.

The level of sexual activity among young adults ages 18 to 24 in the Philippines was low, particularly among women. Specifically, 55 percent of the young men and only 9 percent of the young women had had sex.

Thus, the intent was to give the audience permission to not have sex--to tell them that they could wait until marriage and that they should think and talk about it first. Another message for the young men was that they should use a condom if they were going to have sex.

#### **Evaluation Plan**

To evaluate this campaign, AIDSCOM conducted and compared knowledge, attitudes, beliefs, and practices (KABP) surveys of two samples of 300 young adults ages 18 to 24. The surveys assessed knowledge, attitudes, and beliefs with 5-point agree/disagree items and behavior with a closed-envelope procedure. AIDSCOM conducted the baseline survey in January 1992 and the follow-up in July 1992. The campaign ran from February to April 1992.

### **Recall Scores**

The recall scores for the campaign were as follows: over 60 percent of both men and women recalled the tag line *Think about it, talk about it*. Over 20 percent recalled the copy, and approximately 60 percent recalled the situation for the *Virgins* spot. For the *Locker Room* spot, only a small percentage recalled the copy, and about 20 percent recalled the situation.

### **Impact on Wait until Marriage**

AIDSCOM did not expect to demonstrate an impact on risk behavior. Basically, detecting an impact on delay of intercourse is difficult and involves a longer time frame for the intervention and the evaluation.

There is, however, strong evidence that the campaign had the expected impact on some of the key internal determinants of risk behavior, particularly for the young men.

AIDSCOM measured the amount of agreement with two beliefs about waiting for marriage at the time of the pretest and again at the post-test. The two beliefs were: it's important for guys to get experience with sex early, and it's okay for guys to wait to have sex until they're married. Surveys showed increased disagreement with the first belief and increased agreement with the second belief during the time period between the two tests.

Similar results were found with other beliefs. In sum, there was evidence that the campaign affected beliefs about the acceptability of the behavior of delaying initiation.

### **Eastern Caribbean: *Parents and Youth***

In the Eastern Caribbean, AIDSCOM's *Parents and Youth* campaign was designed to help parents recognize that many teens were sexually active, to facilitate discussion, and to suggest to parents that condoms could protect their children.

AIDSCOM conducted extensive formative research using national KABP surveys of representative samples of the national populations of several Eastern Caribbean countries. Analyses of these surveys revealed that the major cognitive predictor of condom use was perceived social norms. This suggested that influencing perceived social norms was likely to increase condom use.

Qualitative data from focus groups with parents and youth revealed that these norms included not only norms from friends and partners but also norms from parents. Therefore, as a first phase, AIDSCOM designed a *Parents and Youth* campaign to help parents recognize that many teens were sexually active, to facilitate discussion, and to suggest to parents that condoms could protect their children.

The campaign ran for several months in St. Vincent. At the end of the campaign, 100 parents, 100 teens, and 100 other adults were interviewed. Those who indicated they had heard a campaign on HIV prevention, on the radio, and on the topic of condoms were considered exposed. Using this definition of exposed, 72 percent of the sample was exposed to the campaign.

Comparing the group that was exposed to the campaign with the group that was not (nonexposed), the campaign clearly had an impact on perceived social norms. Project staff asked the exposed and nonexposed groups whether they believed that others (partners, friends, and parents) think they should use condoms. The percentages who believed that others think they should use condoms were higher among those exposed to the campaign than among those not exposed. The differences were statistically significant for perceptions of pressure from friends and partners.

These and other studies of integrated communication campaigns indicate that media campaigns can influence attitudes, outcome and self-efficacy beliefs, and normative beliefs, all of which evidence indicates are likely to be internal factors that can function as determinants of sexual behavior.

## SUMMARY

The following reviews the fundamental research lessons learned through AIDSCOM's HIV prevention work.

First, when developing interventions, it is better to begin with an understanding of the behavior rather than with assumptions about the type of information people need to change their behavior. Research on the external and internal factors that potentially facilitate and inhibit behavior with a particular population of interest can be used to identify promising intervention points. Then, communication and other social marketing techniques can be used creatively to result in effective interventions.

Second, while the findings differ from population to population and from country to country, in the domain of HIV prevention, there are two particularly promising intervention points: skills and social norms.

Skills are the first important intervention point. Interventions that increase skills also increase safer sexual behaviors. It's important to consider both actual and perceived skills. A person needs to know how to perform a behavior as well as to perceive that he or she can.

In addition to physical skills (for example, using and buying condoms), social skills are important. Social skills include communicating and negotiating for safer sex. Negotiation involves verbal and nonverbal communication. Because sexual behavior involves two people, we need interventions that help people learn how to influence each other effectively.

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There is clear evidence that skills--both actual and perceived, both physical and social--are related to behavior. Increasing skills facilitates behavior change. Further, skills can quite easily be developed.

Social norms, both perceived and actual, are a second important intervention point. Perceived social norms refer to our perceptions about whether others who are important to us think we should engage in a behavior. For example: Do most people who are important to us think we should use condoms? and Who are the important people in this domain?

The perceptions of men and women about their sexual partner's expectations for condom use and response to suggesting or asking for safer sex behaviors are major barriers to encouraging them to use condoms. These barriers often need to be removed.

Other factors that influence condom use include a person's perceptions about the beliefs of friends and relatives, a partner's friends and relatives, and health and religious professionals.

Sometimes people's perceptions of social norms accurately reflect actual norms; sometimes not. Sometimes the public's perception of what others are doing and want lags behind AIDSCOM's understanding of the norm, which is based on research.

As shown, the evidence indicates that perceived social norms are related to risk behavior. Social norms can be changed with public communication, and influencing social norms can facilitate behavior change.

Risk behavior is improving, but it is changing gradually. We must be modest in our expectations of the time and effort necessary for sexual behavior to change. There is some evidence that we can facilitate these changes with a variety of communication and other marketing interventions that involve integrated strategies and are based on formative research, tested with research, targeted to segments of audiences, and developed with sound program planning processes.

## ***Field Note #2: Challenges to Conducting Field Research in Africa***

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Conducting field research in Africa can be complex under even the most ordinary circumstances, considering the cultural, political, linguistic, communication, transportation, and other logistical issues that can arise in the process. The sensitivities of discussing personal and intimate details such as courtship, sexuality, and condom use can add a daunting dimension to this challenge for the researcher. During its six years of involvement in Africa, the AIDS Public Health Communication Project (AIDSCOM) learned several valuable lessons about such research, some of them more obvious than others. Some of AIDSCOM's research challenges are described below by country. Following these descriptions are the operational lessons learned.

### **GHANA**

AIDSCOM's objective in Ghana was to design a mass media campaign that would increase AIDS awareness and knowledge among adolescents and encourage behavior change that would reduce their risk of exposure to HIV. AIDSCOM found that consistent messages in various media and nonmedia sources could increase awareness about HIV/AIDS and some behavior changes. AIDSCOM also found, however, that other more personalized strategies may need to be invoked to significantly increase and sustain behavior change.

Messages needed to be kept simple, but explicit. In a television spot titled *The Storm*, an analogy was made between rubber boots and condoms--*when the rains come you need protection--rain boots can be helpful...Just as you protect yourself from the rain, protect your life against AIDS--don't be careless, get protection*. The wording was chosen to avoid using the word *condom*, which the Ministry of Health thought was too controversial. This nonexplicitness, however, caused some confusion among the public, some of whom asked whether the Ministry of Health was promoting rubber boots.

It was important to educate local counterparts concerning the best ways to incorporate focus group results into mass media campaigns. Although data from focus groups suggested that members of the public felt the word *condom* should be used in the campaign, the Ministry of Health felt using the word on national television would be ill-advised--hence, *The Storm*.

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***AIDSCOM Lessons Learned***

## **SOUTH AFRICA**

While studying traditional healers (sangomas) in South Africa, AIDSCOM/AIDS Control and Prevention Project (AIDSCAP) struggled with how explicit to be when asking questions at the outset of the project and in questionnaires administered in subsequent follow-up studies of the "first and second generations" of HIV/AIDS prevention training.

Since the original participants in the initiative represented essentially seven different home languages (Zulu, Xhosa, South Sotho, Tswana, Tsonga, Pedi, and Shangaane), both the questionnaire content and translation were of utmost importance. To eliminate the risk of offending participants during the initial interviews, project staff depersonalized the questions as much as possible. For example, interviewers asked, "At what age would you say boys in your area begin to experiment with sex?" rather than, "At what age did you begin experimenting with sex?" Also, some of the healers brought up the controversial question about whether sangomas have sex with their patients or students. Interviewers had to couch this question in the least threatening terms: "Do you know of cases where a traditional healer has had sex with his or her patient?" To this question, 86 percent answered yes.

Administering follow-up questionnaires to 70 participants in the first eight months of the "second generation" of training presented more logistical than substantive problems. Many of these trainings had been conducted in rural areas, "Black" townships, or squatter camps, so there was no convenient "preassigned" place for everyone to gather as there had been at the two "first-generation" training-of-trainer workshops. Therefore, the interviewers had to rely on less-than-efficient communication systems for assembling trainees for a day or two of interviewing in sometimes remote and isolated locations.

The two week-long workshops held during the "first generation" of training were well-documented and considered to be extended focus groups. Because these discussions were exclusively participatory rather than didactic, this variation on more traditional focus group discussions was extremely valuable.

## **TANZANIA**

Participatory research was considered to be a powerful approach to developing culturally relevant and effective prevention strategies for the Women in Development project in Tanzania. Such research allowed AIDSCOM and its local partner, the Organization of Tanzanian Trade Unions (OTTU), to question the norms that shape the unequal balance of power between women and men in a culturally acceptable way.

Project staff translated the data collected through participatory "action" research into program interventions that have been found to be relevant to the target audience. The interventions were relevant largely because the target audience was involved in every stage of the project--from concept formation to research design, data collection, and intervention design, implementation, and evaluation. AIDSCOM encountered considerable logistical problems, however, when attempting to have a literate target audience complete a self-administered delayed post-test a few

weeks after a project intervention. The confusion resulted largely from not having access to the same individuals after the fact.

In the process of conducting research, AIDSCOM staff trained others to be highly skilled trainers and provided a local nongovernmental organization with the skills, capacity, and credibility to implement similar studies that can be translated into practical interventions. OTTU continues to use the curriculum that AIDSCOM helped to develop at worksites throughout Tanzania.

During the condom social marketing project in Tanzania, a crucial operational lesson was learned while designing and conducting the audits for documenting condom accessibility at various access points in the country. While many interventions to change behavior are communications targeting internal factors such as beliefs and perceived norms, sometimes it is necessary to intervene on external factors--in this case, condom availability--before trying to increase condom use. After a census of potential outlets in Dar es Salaam--pharmacies, shops, and leisure outlets such as hotels and bars--a sample was selected to monitor the impact of the proposed condom distribution system. Audit results concluded that the overall percentage of outlets selling the Salama condom had increased, distribution had spread outside of the city center, and shops started carrying condoms and the Salama condom, in particular.

## UGANDA

In Uganda, questionnaires designed to glean information about sexual partners and sexual intercourse were difficult to translate from English into Luganda and Swahili. Because literal translations often can be confusing, in-depth studies of the translations had to be conducted before completing the instrument and training interviewers and focus group moderators. As a result, AIDSCOM found that the definitions of *wife*, *married*, and *casual partner* are subject to misinterpretation. Similarly, finding acceptable terms to describe sexual intercourse in different cultures was extremely difficult.

A second aspect of the Ugandan research involved evaluation of multiple-site interventions. Many of the sites where the AIDS in the Workplace intervention was conducted were at different stages of program development at the time of the evaluation. Consequently, the sample cannot be regarded as a simple before-midpoint-after design. Therefore, evaluation instruments had to be developed accordingly and conclusions drawn only after taking this into consideration.

## OPERATIONAL LESSONS LEARNED

- Language is the essence of worthwhile research. If people are forced to think and respond in a language other than their home language, the results are likely to be less reliable.
- Researchers designing questionnaires to be translated into other languages should use simple concepts, especially when the questionnaires will be used in interviews with non-native speakers.
- The target audience's reading and comprehension levels should be assessed.

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- **In-country capabilities to assist in questionnaire design and data collection and analysis should be assessed to optimize knowledge and skills transfer and program sustainability.**
  - **When possible, members of the target audience should be involved in every stage of research design, implementation, and evaluation. Such "participatory" research optimizes skills transfer and is likely to be more relevant to all concerned.**
  - **The final version of a questionnaire should be carefully pretested among a group that is similar to the target population, then revised where necessary.**
  - **Generally, people will be more comfortable and forthcoming being interviewed by or in focus groups with people of the same sex, of roughly the same age, and, more obviously, of the same culture.**
  - **No assumptions should be made regarding in-country capabilities. For example, it was impossible to photocopy and collate 200 copies of the 34-page knowledge, attitudes, beliefs, and practices surveys for the Women in Development AIDS in the Workplace Project in Tanzania. Instead, they had to be mimeographed, a time-consuming and labor-intensive process.**
  - **When possible, participatory workshops can be conducted as extended focus group discussions, with proper moderation, involvement of all participants, and proper documentation by trained recorders.**
  - **A self-administered delayed post-test may not be the most effective approach to collecting data, since it places a great deal of the burden on the respondent and employer and relies on literate respondents to comprehend the instructions and questions.**

## ***Field Note #3: HIV/AIDS Prevention Counseling in Africa***

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***Background:*** In nearly every African country where AIDSCOM worked, HIV/AIDS prevention counseling became a component of the technical assistance provided. In the Western context, the value of counseling in the prevention of HIV transmission became clear during the first five years of the epidemic. Many African languages, however, did not even have a word for the concept of counseling. Counseling--where it did exist--often was seen as a group or community activity rather than a one-on-one phenomenon, as it is more commonly known in the West.

***Objectives:*** The objective was to promote development of HIV/AIDS prevention counseling programs in African countries.

***Method:*** In the first two years of the project, AIDSCOM assisted local organizations and governments in designing, implementing, and sustaining prevention counseling programs in Sierra Leone, Uganda, Zimbabwe, Tanzania, Malawi, Rwanda, Burundi, and Zaire. Counterpart organizations ranged from national organizations such as the National AIDS Committees in Sierra Leone and Zimbabwe to local and regional groups such as the Bugando Hospital in the Mwanza region of Tanzania and The AIDS Support Organization in Uganda.

REDSO/WCA, the U.S. Agency for International Development regional office in Abidjan, requested that AIDSCOM assist in conducting two international training-of-trainer workshops on HIV prevention counseling. Representatives of 21 West and Central African countries took part in the 1990 francophone workshop in Abidjan and the 1991 anglophone workshop in Banjul.

AIDSCOM assisted the Zambian Ministry of Health in developing the counseling training video *Challenges to AIDS Counseling* and an accompanying discussion guide.

***Results:*** Although a few participants in the two international training-of-trainer workshops were familiar with HIV/AIDS prevention counseling concepts and such counseling was somewhat in place in a few locales, both groups spent considerable time defining how these concepts would be implemented in their own cultural contexts.

It was important in all of these workshops to have a comprehensive agenda that included not only basic information on HIV/AIDS transmission, presenting diseases, treatments, and prevention,

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***AIDSCOM Lessons Learned***

but also extensive discussion of local norms and values regarding family life, death and dying, religious and cultural constraints, women and AIDS, constraints to discussing sex and sexuality, plus presentations by people with HIV/AIDS and their families and friends. Equally important, however, was provision of adequate time for role playing and feedback so people could exchange innovative ideas on how to incorporate these sensitive issues into their ongoing counseling or other service provision activities.

The training video *Challenges to AIDS Counseling* was developed to address the following issues: defining AIDS counseling, describing challenges in AIDS counseling, finding a suitable environment for counseling, recognizing limitations as counselors, talking about sensitive subjects such as sex and condom use, and breaking the news of HIV infection to a client. The video presents composite sketches of the challenges faced by four prevention counselors who come to a provincial health center for additional training. AIDSCOM developed the content and format for the video through extensive interviews with experienced Zambian counselors and trainers regarding difficult counseling scenarios.

While assisting the Zambian Ministry of Health in developing the video and guide, AIDSCOM helped the AIDS Control Program study the differences among various prevention counseling concepts. One objective of the video and guide was to present a culturally acceptable definition of counseling that challenged traditional cultural norms. That meant clarifying individual and cultural values regarding the relative merits of giving clients advice as opposed to providing them with information, then helping them make their own decisions and solve their own problems. This "nondirective" approach requires considerable training and rehearsal via role plays in a safe, "nonjudgmental" setting with lots of opportunity for feedback from others in the room, particularly those from the same culture.

**Lessons Learned:** The following are the lessons learned:

- International workshops, where participants from different countries within a region discuss, role play, and make recommendations regarding prevention counseling guidelines can be useful in planting the seeds for culturally relevant programs within the region. Ideally, regular follow-up to these workshops should determine how well these programs are being implemented and sustained.
- It also can be effective to use video and role playing to model new behaviors and encourage counselors to find creative ways to overcome diverse cultural barriers they encounter in their work.
- It is important for prevention counselors to understand the need for "nondirective" counseling--to be able to give clients information and help them make their own decisions and solve their own problems, rather than offering them only advice.

- It is important for HIV/AIDS prevention counselors to understand the need for "nonjudgmental" counseling. Because of the stigma associated with this disease worldwide, counselors harboring any judgements or tendencies to "blame" someone for contracting HIV can do more harm than good. Helping clients through their own myriad responses (for example, depression, anger, guilt, fear, pain, suicidal thoughts, loss of control, loss of identity), as well as the possible negative responses of those around them (for example, rejection by family, employer, landlord, friends, or neighbors) requires that the counselor help with problem-solving without verbal and nonverbal judgements.
- Models of innovative counseling techniques can help confront sensitive issues or traditional cultural norms such as talking with strangers (especially elders) about sexual behavior and condom use. For example, the video models different behaviors such as asking permission to talk about sensitive topics or finding a comfortable, private place to talk with clients.

**Conclusions:** AIDSCOM's international workshops for HIV/AIDS prevention counseling planted the seeds for culturally relevant programs in African countries. An emphasis on the use of videos and role plays, as well as "nondirective," "nonjudgmental" counseling, was an integral part of the AIDSCOM effort.

In the process of developing appropriate prevention counselor training materials, it is important to involve members of the target audience at all stages. While developing a training video in Zambia, experienced counselors and trainers played an integral role from the beginning by discussing some of their worst fears, which then were used to promote discussions of various techniques for dealing with these situations.

## ***Field Note #4: Forming Local Partnerships***

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***Background:*** AIDSCOM consistently fostered partnerships with institutions that were new to health promotion activities. These institutions fell primarily into two broad categories: *those with specific technical expertise* needed for the design or implementation of HIV prevention interventions and those that are referred to as *constituent groups*.

Included in the first category are commercial research and advertising firms, plus university-based research units. In every region, collaboration with these agencies increased skills in the design of AIDS-related knowledge, attitudes, beliefs, and practices surveys; behavioral analysis; message testing; and so on. AIDSCOM also facilitated ongoing partnerships among these technical firms and nongovernmental organizations (NGOs), community-based AIDS action groups, and government ministries.

Constituent groups usually were existing organizations active in other areas or embryonic groups formed primarily to engage in HIV prevention work. These included women's groups, labor unions, professional or business associations, religious and youth groups, organizations of People with HIV/AIDS, and so on. Some institutions had hundreds and often thousands of members, while others developed from a few individuals with a passion to become involved.

Almost all of AIDSCOM's local partnerships established in Africa belong in the second category, *constituent groups*. This document focuses on AIDSCOM's partnerships with local constituents and lessons learned.

***Objectives:*** The goal was to establish partnerships with local NGOs, private voluntary organizations (PVOs), community-based organizations (CBOs), and the private sector to facilitate knowledge, skills, and technology transfer and strengthen local capacity for organizations to develop, implement, evaluate, and sustain HIV/AIDS prevention programs.

***Method:*** The process for identifying and working with local constituent groups, NGOs, PVOs, CBOs, and the private sector varied according to the objectives in each of the countries where AIDSCOM worked. In the case of Uganda and Tanzania, one of the objectives of the AIDS in the Workplace Projects was to reach and educate as many people as possible through multiple channels. Consequently, AIDSCOM collaborated with trade unions--the Federation of Ugandan Employers and the Organization of Tanzanian Trade Unions--to reach workers through the

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private sector; and the Tanzanian Council of Social Development and the Experiment in International Living (now known as World Learning) to reach workers at the community-based level. Similarly, the AIDS in the Workplace activities in Swaziland included collaboration with the Federation of Swazi Employers, the Federation of Swazi Trade Unions, and the Family Life Association of Swaziland.

Although selection criteria for partnerships varied from country to country and project to project, a few requirements remained constant throughout the countries where AIDSCOM worked. Most important for selection was an organization's access to the groups and communities that were being targeted and its credibility with these groups and communities. Another factor was the existence of, or potential for, a solid structure in which the operational functions of the organization could be managed.

**Results:** AIDSCOM forged meaningful and productive partnerships with more than 47 local NGOs, PVOs, and CBOs in Africa by involving them in every stage of strategy development. AIDSCOM found these constituent groups to be important to HIV prevention work for a number of reasons.

First, these constituent groups had *established networks that served communities* that often were difficult to reach and most in need of services. Local health authorities often had poor knowledge of and access to these communities and were ill-prepared to communicate effectively with them. The networks were used to create understanding, respect, and trust. The constituent groups already had a *people orientation*; they knew how to *talk the talk*. They often kept interventions focused on constituents' needs and adapted interventions and messages to make them more appropriate and credible.

In addition, these groups had *more than a professional interest* in HIV prevention. They had been driven to the work in response to the needs of their communities. Their passion and commitment often kept them involved at times when there were few support systems and even fewer signs of success.

Finally, for the above reasons, these constituent groups tended to *assume ownership* of their HIV prevention activities quickly and were able to develop culturally relevant interventions. Their ownership greatly boosted the likelihood of these activities continuing beyond AIDSCOM's involvement.

Although many constituent groups had the community networks, passion, and commitment important to HIV prevention work, many lacked basic organizational, management, and technical skills. Therefore, AIDSCOM provided these groups with all sorts of *institutional development assistance*--from core support to management skills to strategic planning.

One example of this institution-building is AIDSCOM's technical and financial support to establish the National Association of People Living with HIV/AIDS. This organization was

important for a number of reasons. When HIV/AIDS prevention programs became more aware of the need to use personal testimony from South Africans infected with HIV, program managers became eager to find people willing to speak publicly. Having an organization that can be contacted not only facilitated this vital component of the prevention task, but also offered a network to People with HIV/AIDS, whereby they could support one another in promoting better health and preventing progression of disease.

Many constituent groups sought other things from their partnership with AIDSCOM--links to broader networks and information about what others were doing (for example, what worked, what didn't). In these cases, AIDSCOM served as a *resource and referral service*, providing contacts, ideas, behavioral intervention models, and examples of new materials being developed. AIDSCOM also used third-country nationals as regional consultants, such as sending Ugandan trainers to conduct training-of-trainers workshops for the Swaziland AIDS in the Workplace program.

These contacts, materials, and ideas often have triggered what may have been AIDSCOM's most unique and important partnerships: those in which AIDSCOM played more of a *catalytic role*. With some of the more entrepreneurial organizations, AIDSCOM's assistance--whether in seed funding, training, materials, or linkages--turned out to be just what the respective groups needed to launch their own HIV prevention programs.

In Malawi, seed funding and technical direction jump-started two innovative HIV prevention projects. With support from AIDSCOM, the Private Hospital Association of Malawi and Medical Association of Malawi developed audio AIDS dramas, which are played in clinic and hospital waiting rooms. With AIDSCOM's support, a young adult theater and musical group in Lilongwe received much-needed equipment and musical instruments to create productions that deliver HIV prevention messages to general audiences. The group became part of the health education unit of the Ministry of Health and performs throughout Malawi.

For some constituent groups representing more marginalized communities, AIDSCOM offered needed *linkages and credibility* with other collaborators or donors. This was true in part with the traditional healers initiative in South Africa and with initiatives targeting youth in Malawi, where participants from across the religious, social, and political spectrum were engaged in the program development process. The U.S. Agency for International Development Mission staff in these situations have remarked on the diversity of people and organizations brought together and working together with AIDSCOM assistance.

**Lessons Learned:** The following are the lessons learned:

- Local partnerships enabled AIDSCOM and its programs to remain centered on and to engage people as actors who make behavioral decisions and who influence others to do the same. AIDSCOM's partners were a constant reminder that this work was really about their lives, families, and communities and tapping the strength of those bonds.

- Local partnerships increased the likelihood of successful innovation. AIDSCOM's partners offered access to and an understanding of those many "cultures within the culture." In addition, they were driven to push the boundaries of what was socially accepted and to challenge prevailing norms, fears, and prejudices. This was a sometimes thankless but unavoidable aspect of effective HIV prevention work.
- Local ownership of community-based HIV/AIDS prevention and support projects facilitates development of culturally relevant, effective, and sustainable projects.

**Conclusions:** As more and more international donor agencies begin to work with local organizations, donor coordination will become increasingly important. Donor agencies must coordinate among themselves to avoid duplication of work and increase sharing of information, thereby improving the cost-effective allocation of limited resources available to combat the global AIDS epidemic. Recipients of international donor assistance are charged with ensuring that proposed funding activities correspond to the overall institutional goals and objectives of their organization and do not duplicate existing funding efforts for similar project activities.

The more than 47 African institutions, agencies, and community groups that now are active and equipped with skills and experience in HIV prevention work may be one of AIDSCOM's most lasting and important contributions.

***Field Note #5: How Personal Testimony Can Motivate Change: Experiences from Cote d'Ivoire, The Gambia, Malawi, and South Africa***

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**COTE D'IVOIRE AND THE GAMBIA**

***Background:*** The AIDS Public Health Communication Project (AIDSCOM) was asked by REDSO/WCA, the U.S. Agency for International Development regional office in Abidjan, to facilitate two five-day regional conferences on the role of prevention counseling in HIV antibody testing and AIDS education. The first conference was held in Cote d'Ivoire for representatives of 11 African francophone countries, and the second was held in The Gambia for ten anglophone African countries. The attendees learned about HIV/AIDS prevalence in their region, received new information about the infection, discussed potential links between HIV/AIDS programs, learned about the role of counseling and counseling techniques in HIV prevention and treatment, identified opportunities for program and fiscal support, and established next steps for promoting HIV prevention. African facilitators for the francophone conference represented Zaire, Congo, Senegal, and Cote d'Ivoire--all countries with well-established HIV prevention programs. African facilitators for the anglophone conference were from The Gambia, Ghana, Sierra Leone, and South Africa.

Early in the planning stages with conference organizers, AIDSCOM staff recommended that the conference program include a panel discussion of Persons with AIDS (PWAs) and caregivers. Based upon their experiences in other countries, the staff thought that a panel discussion would emphasize the immediacy of the challenges associated with living with HIV/AIDS and illustrate the need for counseling and support for sustained behavior change. In many communities, personal testimony has had a powerful influence in changing opinions and subsequent actions.

Initially, organizers of both conferences were reluctant to accept the recommendation; they said it was culturally inappropriate within the African context. However, just before the francophone conference agenda was finalized, the following events convinced them to change their minds: 1) a prominent Ivoirien died of AIDS and the cause of this death was reported in the national media,

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including radio, which is heard by most of the local population; 2) a person with the disease described the impact of AIDS on his life on the radio in Abidjan; and 3) information about HIV/AIDS was broadcast on national radio. In the anglophone conference, the host country facilitators arranged with several Gambians to constitute a panel of HIV-seropositive individuals and their families and friends.

**Objectives:** The goal was to use personal testimony as an informational and motivational technique in a culture that avoids public discussions of personal problems. More specifically, the goal was to introduce personal testimony as one way to help health and social service professionals improve their counseling skills by gaining immediate knowledge of the physical and emotional trauma associated with being HIV seropositive or having AIDS. It was hoped that after participants personally witnessed the power of this technique, they would incorporate it into their own prevention activities as soon as it was culturally feasible.

**Method:** AIDSCOM staff worked with local trainees and facilitators to help them feel comfortable with the idea of using testimonials. In the francophone conference, a doctor who treated AIDS patients helped recruit the speakers for the panel. The doctor, who knew each speaker, chaired the discussion. An AIDSCOM staff member explained to participants how the panel discussion would proceed. Then, the doctor introduced the discussion and each speaker. One by one, each speaker told his or her story.

In the anglophone conference, all three of the Gambian panelists who had agreed to participate were unable to--two because they had changes of heart and one because she was too ill. Therefore, the facilitator from Sierra Leone, a seropositive father himself, was the only one who delivered a personal testimony. Two others, however, told stories on behalf of Persons with HIV/AIDS or their families.

Including such emotionally charged content in a workshop program, particularly one in which participants had never experienced such content, required making special provisions to help channel the ensuing emotions and respond to participant needs. After the panel discussion, a refreshment break was held to allow panelists and participants to meet and talk casually, as individuals, about the presentation. This helped participants think of PWAs as "normal" people. In the anglophone conference, the fact that participants had known the facilitator in another role for three days prior to his "coming out" with HIV had a dramatic effect on participants.

After the break, participants formed small groups, led by African facilitators, and shared their feelings about what they had heard and their thoughts about being diagnosed HIV-seropositive. Participants were openly emotional and moved by the experience. The break and small group discussions helped diffuse anxiety that grew during the panelists' testimony, brought closure to the activity, and prepared participants for the next steps.

**Results:** In both cases, participants concluded that, due to hearing the panel and talking about what they had heard and felt, they understood better how contracting HIV often severs support from family and village members. Most participants said that the presentation was powerful and

moving and that it helped make AIDS real to them as a disease that infects real people. Although some participants still felt uncomfortable about the testimonials, none regretted hearing or participating in the panel discussion.

Before the panel, many participants doubted the viability of prevention counseling in HIV antibody testing and AIDS education materials. After the panel and following discussions, participants said they were reconsidering some of their opinions. Facilitators described the panel as the turning point in the conference. Thereafter, participants were more forthright, sharing their experiences and concerns more freely. Participants also indicated that the knowledge they had gained from the panel resulted in increased readiness and skill to provide appropriate counseling for pre- and post-HIV testing, prevention, and treatment counseling.

### **MALAWI**

At the constitutional meeting of the National AIDS Committee in April 1989, AIDSCOM showed committee members a Ghanaian film featuring a woman in the terminal stages of AIDS. When various subcommittees subsequently discussed pertinent HIV/AIDS policy issues and made recommendations to the committee, it was recommended that a similar video should be made in Chichewa. The video would interview teachers, social workers, and health and social service professionals having contact with AIDS patients. When it came to depicting someone with AIDS, however, the subcommittee recommended that the Ghanaian woman should be spliced into the video, since Malawi, a country of 8 million people, was "too small" a country to allow someone to go public with such a diagnosis.

Conclusions reached after the ensuing discussion were that showing footage of a woman with AIDS from Ghana would not break down the denial of Malawians that HIV was a threat there, too. Therefore, it was unanimously agreed that Malawians with HIV/AIDS should be encouraged to go public with their diagnoses on video and in person, to confront denial in the country. Although a script was produced in 1991, research showed that people would prefer a dramatic video like the Ugandan AIDS film *It's Not Easy*. So, subsequently, two 40-minute dramatic videos were produced. The National AIDS Committee reconfirmed its commitment to the idea of People with HIV/AIDS speaking publicly about their situation, which several men and women now have done.

### **SOUTH AFRICA**

While training health and social service professionals in HIV/AIDS prevention in South Africa in 1990-91, pre- and post-test results indicated to AIDSCOM that most people felt that they had never seen somebody with AIDS and that they were not personally at risk for HIV. Denial of the epidemic was a major issue in the country, particularly given all the sociopolitical turmoil and violence associated with ending apartheid. Once again, it was proposed that personal testimony could help break down that denial.

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Since that time, People Living with HIV/AIDS have been incorporated into activities in South Africa in many ways. At the first National AIDS Conference of South Africa, a Zulu-speaking man with AIDS and an English-speaking man with AIDS were keynote speakers. They also were featured speakers at the launch of the National Charter of Rights and Responsibilities of People with HIV and AIDS. A National Association of People Living with HIV/AIDS has been developed and linkages have been made with the Global Network of People Living with HIV/AIDS (GNP+). The 1995 international GNP+ conference is scheduled for Capetown.

AIDSCOM-sponsored activities included personal testimony of People with HIV/AIDS from the outset. In training traditional healers as HIV/AIDS prevention trainers, one of the most highly effective was the presence and participation of people giving personal testimony. In all of the "first-generation" traditional healer trainings to date, a family of four (mother, father, and two children) with AIDS, plus a single young man and a married woman with AIDS, have been an integral part of the training. These people with AIDS became part of the personal network of many of the healers. Research continues to show the power this personal contact has in humanizing the disease, breaking down denial, and motivating people to become actively involved in HIV/AIDS prevention.

**Lessons Learned:** The following are the lessons learned:

- A technique such as using public testimonials to portray important individual and societal issues may not be commonly employed within a culture. But it often can be adapted to become a useful tool.
- In a workshop context, part of the panel's success results from solid planning and support from conference organizers and facilitators. Working with local trainees and facilitators to help them feel comfortable using testimonials is as important as encouraging the organizers to allow the panel discussion.
- Planning mechanisms for informal discussions after the panelists speak can help participants deal with their anxieties and move toward a more in-depth consideration of workshop topics. In an ideal situation, participants would have adequate time to eat, drink, and have informal discussions with the panelists both before and after the presentations.

**Conclusions:** With persistence, cultural relevancy, and the assistance of Persons with HIV/AIDS and their caregivers, families, and friends, personal testimony about HIV/AIDS can be used effectively as an informational and motivational technique in a culture that avoids public discussion of personal problems. Such personal testimony has had similar successful results in countries throughout Africa, as well as in the rest of the world. Once the "ice is broken," many other People Living with HIV/AIDS feel empowered to come forward and participate actively not only in HIV/AIDS prevention activities, but in educating themselves to help prevent progression of their own disease.

## ***Field Note #6: Designing Media Campaigns to Prevent HIV in Young People\****

**Background:** In August 1991, the Ministry of Health launched a multimedia campaign designed to increase awareness of AIDS and promote AIDS prevention in Ghana. The AIDS Public Health Communication Project (AIDSCOM) and Porter Novelli collaborated with Apple Pie, a local advertising agency, and the Ministry of Health to design and implement the campaign.

**Objectives:** The goal was to design a mass media campaign that would increase AIDS awareness and knowledge among adolescents and encourage behavior change that would reduce their risk of exposure to HIV.

**Method:** Exploratory focus group work was conducted to identify key issues to address in the campaign. Based on this work, television, radio, and other small media advertisements were designed to disseminate the following messages: 1) AIDS is not a foreign disease; 2) a person can have HIV for five or more years and still look healthy; and 3) personal behavior changes are necessary to prevent the spread of HIV. All messages concluded with the campaign tag phrase *Don't be careless, get protection*. After the initial July 1991 survey of knowledge, attitudes, and behaviors, the campaign ran for ten months. Afterward, another survey was conducted in the region to evaluate the impact of the campaign. Surveys were carried out among persons ages 15 to 30 in two regions of Ghana: Central (Cape Coast) and Brong-Ahafo (Techiman).

**Results:** The post-campaign results showed increased awareness of AIDS as a serious disease for young people in Ghana, better understanding of the length of the incubation period, and reduced belief in a cure. A number of prevention methods were mentioned more frequently, including remaining faithful, staying with one partner, abstaining from sex, and using condoms. Fewer people believed that their friends had more than one partner, indicating a potential shift in perceived norms. Knowledge that condoms could be used to prevent disease also increased.

Several significant changes in sexual behavior between the pre- and post-campaign periods were reported. After the campaign, fewer 15-year-olds were sexually active. Of those who were sexually active, more used a condom the last time they had sex. Among those who were unmarried or had a partner in addition to their spouse, 23 percent said they used a condom the last time they had sex, up from the 14 percent level reported during the premedia campaign period. Consistent use (always use condoms) rose from 7 percent to 12 percent. Condoms use among married people who report sex only with their spouses did not increase.

Condom use showed a significant relationship to exposure to the AIDS campaign. Among persons who were unmarried or had another partner, consistent condom use was correlated with a scale measuring exposure to the campaign. The association is significant after controlling for age, sex, educational level, and wealth.

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Although there was a significant increase, only a quarter of the respondents said they had talked to anyone about AIDS. The increase seen was predominantly in the category of friends. There was no evidence that people responded to the message that one should talk to his or her family about AIDS. Responses indicating rejection of a hypothetical brother with AIDS remained high. Reluctance to discuss AIDS within the family may reflect the fact that although awareness and knowledge were increasing, the stigma surrounding the disease remained extremely high.

**Lessons Learned:** The following are the lessons learned:

- Consistent messages in various media and nonmedia sources can result in increased awareness about HIV/AIDS and some behavior change. However, more personal strategies may need to be invoked to significantly increase and sustain behavior change.
- Messages need to be kept simple, but explicit. In the instance of a television spot titled *The Storm*, an analogy was made between rubber boots and condoms--*When the rains come you need protection--rain boots can be helpful...Just as you protect yourself from the rain, protect your life against AIDS--don't be careless, get protection.* The wording was chosen to avoid using the word *condom*, which the Ministry of Health thought to be too controversial. This nonexplicitness, however, created some confusion among the public, some of whom asked whether the Ministry of Health was promoting rubber boots.
- It is important to educate local counterparts about the best ways to incorporate focus group results into mass media campaigns. Although data from focus groups suggested that members of the public felt the word *condom* should be used in the campaign, the Ministry of Health felt using the word on national television would be ill-advised--hence, *The Storm*.

**Conclusions:** There is evidence that the campaign was successful in reaching a large percentage of the population. Spontaneous reports of hearing about AIDS on television or radio increased significantly, and almost half of the sample population could complete the campaign tag phrase correctly. As expected, exposure was higher in urban areas and lowest among rural women. Still, more than a quarter of rural women recognized the campaign phrase, indicating that the campaign had a substantial reach even among populations with less access to information.

The campaign succeeded in meeting its objective to increase awareness and knowledge; also, there is evidence of increased safer sexual behavior. Still, a high percentage of young people remain at risk due to early sexual initiation and multiple partners. Strategies that encourage delayed initiation of sexual activity and mutual monogamy should be developed. Additionally, a high level of stigma and discrimination continued to characterize the response of AIDS and is likely to complicate efforts to care for persons with AIDS.

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Partially excerpted from "Evaluation of Mass Media Campaign to Prevent AIDS Among Young People in Ghana-1991-1992," Susan McCombie and Robert Hornick, AIDSCOM/Center for International Health and Development Communication, University of Pennsylvania, and John K. Anarfi, Institute of Statistical, Social and Economic Research, University of Ghana. Lessons learned were not extracted from this evaluation.

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## ***Field Note #7: Developing AIDS Education for In-school Youth in Malawi***

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**Background:** In April 1989, as part of the Malawi National AIDS Control Programme's First Symposium on AIDS, the recommendation was made that a project be undertaken to develop AIDS education materials for schools, in recognition of the fact that HIV infection was increasing among school-age youth. Plans were made to hold a materials development workshop for educators, writers, artists, and other interested parties to begin drafting appropriate materials for use in Malawi's schools. The U. S. Agency for International Development provided technical assistance through the AIDS Public Health Communication Project (AIDSCOM).

There were constraints on AIDS education in Malawi. The major constraint was the difficulty in changing high-risk behaviors that contribute to the spread of HIV. Another constraint was the reluctance of Malawian parents to allow discussion of sexual matters with their children. This same reluctance applied to school administrators and teachers in the classroom. These constraints, along with a chronic shortage of educational resources, posed serious challenges to the success of AIDS education in this country.

**Objectives:** The goal was to implement a comprehensive AIDS education project in all of Malawi's public and private classrooms, primary through post-secondary, by the end of 1992. The aim of the project was to help reduce the spread of HIV infection among young people.

**Method:** Two workshops to prepare drafts of pupils' books and teachers' guides were conducted—the first in November 1989 and the second in February 1990. A workshop to make final revisions before pretesting was held in December 1990. At this point, 12 books had been drafted: separate pupils' books for Standards I-IV, with an accompanying teachers' guide; one pupils' book and a teachers' guide for Standards V-VIII; two books and a teachers' guide for Forms I-IV; and a students' handbook and a teachers' guide for post-secondary institutions. The books for Standards I-IV were in Chichewa, Malawi's national language. Other pupils' books and all teachers' guides were in English. All books contained many drawings, particularly the books for younger students.

Between 24 and 30 people participated in each workshop. They represented a broad cross-section of Malawian society, including the government ministries, nongovernmental institutions, the religious community, and donor agencies. Major contributions were made by representatives of three Ministries: Health, Education and Culture, and Community Services. Teachers from

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educational institutions, women's and youth groups, and religious leaders (Christian and Muslim) also participated. Other donors that provided substantial ongoing support were UNICEF and the World Health Organization.

In April and May 1991, a team from the Malawi Institute of Education led the field testing of the draft materials. The first step was to train ten resource people, who then trained teachers chosen to do trial teaching. Nineteen schools, approximately 90 teachers, and 6,000 students participated in the field testing, which involved schools in each of Malawi's three regions. The material in each book required three weeks to teach, after which the resource people collected detailed questionnaires from teachers and conducted follow-up interviews. In addition, pre- and post-tests were administered to selected classes to obtain additional data on the utility and impact of the curriculum materials.

**Results:** The response from teachers was strongly positive and included many constructive criticisms and recommendations to improve the materials. The most common recommendation was that the language in the books written in English be simplified, both for pupils and teachers. This applied most to the book that would be used for Standard V (a book intended for use in Standards V-VIII), since English is first used for instruction in Standard V. Therefore, a separate book containing less complex English was written for use in Standards V and VI.

Incorporating the textual revisions and making required changes in artwork was time-consuming. The first group of manuscripts for lower primary school was delivered to the printer in September 1991, and printed copies arrived in Malawi in February 1992. More than 200,000 books were required to launch the project in 1992.

The final activity prior to full implementation of the project was teacher training. Workshops were held in January 1992 to train more than 200 district inspectors of schools, the officers responsible for training teachers in their respective zones. Primary school teachers were trained first, since only the books for Standards I-IV had been printed and delivered in sufficient numbers. This training involved the head master and the lead teacher from each primary school (about 5,000 people total). Regular teaching of the AIDS materials began in April and May 1992.

A review panel approved the final versions of the books for upper primary, secondary, and post-secondary students. Then, teacher training and regular teaching at these levels began.

**Lessons Learned:** The following are the lessons learned:

- AIDS education is multidimensional and includes cultural, historical, political, social, economic, and religious aspects that must not be ignored, along with the expected medical and pedagogical concerns.
  - Difficult questions must be confronted and answers provided at an early stage, such as what grade level sexual transmission and condom use should be brought into the curriculum.
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- **Teams writing AIDS education materials must represent the spectrum of society, including those opposed to teaching the subject, so that compromises can be worked out in the drafting committee, not in public confrontations once teaching has begun.**
- **The project must have the full support and guarantee of educational authorities that AIDS education will be incorporated into the regular school curriculum and will be included in examinations.**
- **Curriculum materials should be extended to out-of-school young people.**
- **The cooperation and support of parents should be solicited to help create an atmosphere in which teachers and school administrators feel free to discuss in the classroom culturally relevant issues such as sexual behavior.**
- **It is important to stress at every opportunity to the public, particularly parents, that the purpose of AIDS education is not to encourage promiscuity, but to provide young people with information they need to save their lives and the lives of others.**

**Conclusions:** Malawi's AIDS Education for Schools Project represents a positive and promising approach that merits close observation by the world community. The Malawi experience can serve as a model of constructive cooperation among host government agencies and a combination of donors to fight the AIDS pandemic.

## ***Field Note #8: A Workplace-based Peer Education Program for HIV/AIDS Prevention in Uganda***

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**Background:** In 1989, the Federation of Ugandan Employers (FUE) and Experiment in International Living (now known as World Learning) implemented a workplace-based program to train peer educators to communicate HIV prevention messages to co-workers. The U.S. Agency for International Development provided technical assistance through AIDSCOM. Based on formative research, multiple channels were identified and materials developed to reach employees at 47 member companies of the FUE and 53 nongovernmental organizations in Uganda. Peer educators were trained to communicate HIV prevention messages to co-workers through formal and informal talks, by acting as role models for change, and by distributing and demonstrating the correct use of condoms. Produced to be used with the program were the Ugandan AIDS film *It's Not Easy*, the Ekanya comic book *Shocked into Sense*, and the brochures *Change Your Behavior and Prevent AIDS*, *Knowledge is Power*, and *Taking the HIV Test*. The comic book and *Change Your Behavior* brochure list seven steps to behavior change. All of these materials reinforced one another and reached the same audiences with consistent messages over a period of time.

**Objectives:** All of the components of the workplace-based peer education program in Uganda sought to 1) clarify basic facts about HIV/AIDS; 2) promote acceptance of people with AIDS; and 3) encourage safer sexual behavior. AIDSCOM conducted an evaluation of the program to determine whether it was implemented successfully and led to changes in knowledge, attitudes, and behavior.

**Method:** The evaluation of the Uganda workplace-based peer education program involved interviews with 1,599 employees and 61 peer educators working at sites where the intervention was implemented. Three surveys of knowledge, attitudes, and practices were conducted in eight organizations between March 1990 and October 1991. Interviews were conducted anonymously by interviewers who were not associated with the program or the sponsoring organization. The

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questionnaire was translated in Luganda and Swahili and was administered in these languages as well as in English, depending on the respondent's choice.

Because all sites were not measured at all points in time and the organizations were at different stages of program development at the time of the surveys, the sample cannot be regarded as a simple before-midpoint-after design.

Different analyses were conducted depending on the questions to be answered. The analyses that relied on the level of program activity (light, medium, or heavy) can be used as a starting point to evaluate the success of the project. Basically, each of the sites was classified according to the level of reported exposure to the project interventions. Sites where less than 20 percent of employees reported exposure to the interventions were classified as light; sites where 20 percent to 49 percent reported exposure were classified as medium; and sites where over 50 percent reported exposure were classified as heavy. Exposure to the project refers to exposure to one or a combination of the following interventions: attending formal talks, talking to peer educators, or viewing *It's Not Easy*.

AIDSCOM looked at the impact of the interventions on knowledge, attitudes, and reported behavior. For example, in the area of knowledge, AIDSCOM measured people's knowledge about the incubation period for HIV. Regarding attitudes and behavior, AIDSCOM studied people's beliefs about whether or not others use condoms and the impact of the interventions on condom use.

**Results:** By October 1991, 39 percent of those interviewed had attended a talk in the workplace, 34 percent had seen *It's Not Easy*, and 31 percent had talked to a peer educator; 62 percent of those interviewed had been exposed to at least one of these intervention components. There were significant improvements in knowledge and attitudes, including an increased proportion of those who knew the incubation period can exceed five years and those who believed others use condoms. The percentage of people who had correct knowledge and held that belief was higher the heavier the degree of exposure to the intervention.

Generally, the more one was exposed to the interventions, the higher the percentage of reported condom use over the two months prior to the interviews. People in sites where over 50 percent reported program exposure were four times more likely to have used a condom in the previous two months than those in sites where under 50 percent reported such exposure. Also, they were eight times more likely to have used condoms with at least one partner. Also, as a person was exposed to more components of the intervention--the HIV/AIDS talks in the workplace, the peer educators, and the film--the higher the percentage of reported condom use in the two months prior to the interviews.

**Lessons Learned:** The following are the lessons learned:

- Strategies with multiple components are powerful.

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- Workplace programs can influence behavior change.
- Workplace programs require intensive and sustained effort. For example, training a peer educator who can demonstrate effective communication skills and serve as a role model involves screening, repeated training sessions, and significant supervision and follow-up.

**Conclusions:** The results of the program evaluation suggest that the Uganda workplace-based peer education program was successful. The combination of contact with peer educators, attendance at talks in the workplace about AIDS, and viewing the film *It's Not Easy* was associated with improvements in knowledge and changes in perceived norms.

## ***Field Note #9: Organizing South African Traditional Healers to Mount Sexually Explicit HIV/AIDS Prevention Campaigns\****

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***Background:*** While community-based organizations (CBOs) played critical roles in HIV prevention, individuals who served at the grassroots level, although not as part of a formal Western-model CBO, also were identified as having the capacity to reach certain target groups. In South Africa, tradition healers (sangomas) are the *de facto* providers of health care for 80 percent to 85 percent of Black South Africans, both urban and rural, as well as some "colored," Indian/Asian, and white populations. While sangomas generally do not work through formal CBOs, they do function as community providers, offering traditional health care to individuals in both the healers' and patients' homes.

Qualitative research in the form of focus groups and in-depth interviews conducted in November 1992 confirmed that sangomas tend to be the first professionals consulted by many individuals with sexually transmitted diseases (STDs), including HIV. These individuals do not seek government and other Western medical services because these services usually are inadequately staffed, hard to reach due to their distant locations, and lacking in rural outreach programs. Also, many members of the majority population consider government services to be culturally unacceptable. In contrast, traditional healers are more numerous and geographically accessible to the Black majority population. They have credibility, acceptance, and respect among those they serve. Sangomas form a critical part of a health care delivery system that makes information and services available to individuals who would otherwise not have access due to physical and cultural barriers. These factors make traditional healers a key part of an appropriate system, or *place*, for delivering HIV prevention services in South Africa.

While traditional healers might be appropriate to play this vital role, the AIDS Public Health Communication Project (AIDSCOM), later joined by the AIDS Control and Prevention Project (AIDSCAP), did not know about the sangomas' level of interest, knowledge, and skills in this area, nor whether they could serve as effective agents of behavior change. Since discussion of sex and sexuality is considered to be taboo throughout the region, it was important to know

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***AIDSCOM Lessons Learned***

whether the prestige enjoyed by the sangomas in their communities would assist them in broaching these forbidden subjects.

**Objectives:** The initial goal was to determine the level of interest, knowledge, and skills of traditional healers in the area of HIV prevention and whether they could serve as effective agents of behavior change. The ultimate goal was to engage the help of traditional healers in combatting HIV/AIDS in South Africa through training other healers and incorporating HIV/AIDS prevention into their own healing practices.

**Method:** AIDSCOM spent a year consulting with traditional healer organizations to assess the feasibility of engaging them in the war against HIV/AIDS. AIDSCOM convened a preliminary week-long workshop in November 1992 involving 28 traditional healers to learn from them and provide them with additional information and skills. The workshop's goals were to 1) gather quantitative and qualitative information from healers about current knowledge, attitudes, beliefs, and practices related to STDs and HIV/AIDS; 2) upgrade the healers' knowledge levels and skills regarding STD- and HIV-related prevention and care; 3) encourage healers to apply their existing role as opinion leaders to the area of HIV/AIDS prevention and care; and 4) obtain their commitment to incorporate HIV/AIDS prevention into their practices, as well as train at least 30 other healers.

Participants represented five national traditional healer associations. AIDSCOM/AIDSCAP asked each organization to nominate men and women from rural and urban areas. The final roster was thought to represent virtually every region of South Africa, though later there was found to be some misrepresentation by associations trying to appear more "national" than they were. The workshop was significant because it was the first time representatives of these five traditional healer associations had come together to collaborate and share knowledge and skills.

During the workshop, staff and facilitators interviewed all 28 healers to understand better their roles in providing health care, as well as their knowledge, attitudes, beliefs, and practices related to HIV/AIDS.

A second follow-up workshop held in July 1993 determined that many healers had retained and increased their knowledge, some key participants had trained more than 600 other healers, and there was a strong commitment to continue the program.

**Results:** During the preliminary workshop, knowledge among the group of healers about HIV/AIDS transmission, prevention, and symptoms was sketchy; only one person mentioned HIV as the cause of AIDS, and only one mentioned continuous fever as a symptom. Twenty-five of the 28 believed that a person could carry and/or transmit HIV even if he or she looked healthy. Twenty mentioned sexual intercourse as a mode of HIV transmission, yet only eight mentioned condoms as a way to prevent transmission.

The workshop was the first in a series of train-the-trainer activities planned for traditional healers. At the end of the workshop, each participant committed to train 30 other traditional healers during the next six months and drew up an action plan accordingly. AIDSCOM helped organize follow-up workshops to be conducted by these original healers, resulting in more than 1,100 "second-generation" healers being trained by September 30, 1993. Each of these more than 1,100 committed to train 30 other sangomas within the next six months. Extrapolating from figures on patient load, if 30,000 healers were trained and seeing 1,000 patients per year, that would result in 30 million South Africans being reached with vital HIV/AIDS prevention information by the end of 1994.

AIDSCOM staff developed the workshop and ongoing train-the-trainer program based on their recognition of 1) the importance of making HIV/AIDS prevention and management services accessible to the Black majority population and 2) the existence of a network of service providers already providing accessible services. AIDSCOM made no attempt to change the service delivery system, since this system already was in place and thus could serve as a foundation on which to build a stronger HIV prevention program.

In helping the healers develop this capacity, AIDSCOM staff attempted to use its established method of working through Western-style CBOs, with offices, phones, and facsimile machines. However, this system did not fit the sangomas over time. Many people had become involved with their associations only so they could participate in this initiative designed to develop "national" organizations. During the subsequent eight months, however, it became clear that a much stronger community base existed through the *impande*, or network of sangomas descended from widely respected *gobelas*, or teachers.

Impandes are particularly useful as vehicles for dissemination of HIV/AIDS prevention information because they 1) have membership ranging from the tens into the thousands; 2) can have membership throughout the country and other African countries; 3) are multilingual; 4) have a stalwart allegiance to each other and to the group; 5) share information about healing practices widely with each other; and 6) convene regularly in social, community, and professional contexts.

For all of these reasons, both the "first- and second-generation" sangomas recommended that the project supported initially by AIDSCOM be sustained via the *impande* network. A year-end follow-up workshop was scheduled for November 1993, an 18-month follow-up workshop for July 1994, and a second year-end follow-up for November 1994.

**Lessons Learned:** The following are the lessons learned:

- Knowledge among the sangomas about HIV/AIDS transmission, prevention, and symptoms was sketchy during the preliminary workshop.

- The sangomas showed a high level of interest and skill in training additional healers and in delivering HIV prevention services in South Africa.
- Sangomas wanted very explicit dildos for condom demonstration, those *with veins*, to make it clear to other healers, students, and patients where the condom goes and how to put it on.
- Many sangomas had detected a relationship between lack of male circumcision and STDs, advising circumcision as a prevention measure.
- Because sangomas already had discussed intimate details of their patients' physical, emotional, and spiritual lives, they experienced few problems influencing behavior in the realm of sex and sexuality.
- Working through Western-style CBOs with offices, phones, and facsimile machines did not fit the sangomas; a much stronger community base existed through the impande network.
- The "second generation" of more than 1,100 sangomas retained HIV/AIDS prevention information better than the first had, perhaps because the first group was more effective at choosing appropriate trainees than AIDSCOM had been.

**Conclusions:** Sangomas have served as effective HIV prevention educators and agents for behavior change in South Africa. They have demonstrated by example and through training how to incorporate HIV/AIDS prevention information into their own healing practices. This included discussion of safer sexual practices, condom demonstration, and condom distribution. They have been instrumental in putting safer sexual practices into the vocabulary of at least 1,100 other South African traditional healers and countless patients throughout urban and rural areas of the country.

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<sup>1</sup>From 1990-92, AIDSCOM worked on this initiative; in September 1992, AIDSCAP joined in the initiative.

## ***Field Note #10: Working with Family Planning Programs on HIV Prevention***

**Julia Rosenbaum**  
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**John David Dupree**  
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***Background:*** One of the greatest challenges of working in HIV prevention has been finding ways to access hard-to-reach populations and provide them with appropriate prevention information and services. The AIDS Public Health Communication Project (AIDSCOM) found that one successful approach was to identify existing intermediaries that already had established access to these individuals and work with these groups to add an HIV component to their existing activities. Some of these groups already were working in some sort of health activity; others were constituent organizations or private-sector firms with no previous experience in health issues.

Working with nongovernmental groups--including family planning organizations--proved to be an effective strategy for AIDSCOM to continue promoting HIV prevention, even in countries where the U.S. Congress had restricted using development funds for work with public-sector organizations.

***Objectives:*** The goal was to work with family planning organizations to reach target populations with HIV prevention information and services.

***Method:*** Family planning organizations served as critical partners in reaching target audiences because of their demonstrated commitment to providing comprehensive reproductive health services and their extensive and varied service and distribution networks. In particular, family planning organizations, well-positioned to reach women and sexually active teens, already had active service and outreach programs. Their almost universal acceptance of the community-based distribution model dramatically increased accessibility to services and counseling by reaching beyond the clinic. Peer education programs were used widely to reach youth with comprehensive skills-building exercises to strengthen self-esteem and decision-making skills.

Often, the primary component lacking was an appropriate conceptual approach to HIV/AIDS prevention work. For many of our counterparts, that meant infusing new HIV/AIDS prevention skills and concepts into existing programs and activities. Depending on the circumstances, AIDSCOM provided ideas, skills, training, core support, credibility, networks, room to experiment and learn, and sometimes just a push to get started and keep going. Perhaps one of

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the most essential components of AIDSCOM technology transfer was to work with family planning health partners to face the human dimension of the disease--to break away from talking about risk groups (gays, commercial sex workers, and drug users) and focus instead on high-risk *behaviors* that do not allow an "us/them" approach to service provision.

Early in the epidemic, there was a running debate in the family planning community about the possibility of detracting from the results of hard-won battles to finally legitimize family planning messages. In some developing countries, for example, many still view contraception as bordering on "genocide" to limit indigenous populations. When the U.S. Agency for International Development--a long-time contributor to global family planning efforts--recognized the need to contribute to HIV/AIDS prevention as well, the debate re-emerged with vigor, because it linked family planning, sexuality, and death.

This debate manifested itself in the process of training family planning providers in HIV/AIDS prevention. In South Africa, for example, research conducted by the Medical Research Council has indicated that many family planning nurses already trained in government HIV/AIDS counseling courses were highly judgmental when approached by young men and young women for condoms and information about their use. Ongoing in-service training and direct contact with People Living with HIV/AIDS has proved to be the key to motivating even the most resistant to overcome these reservations.

**Results:** The following experiences from the field describe the results of the AIDSCOM effort to work with family planning organizations.

BEMFAM, the largest family planning nongovernmental organization (NGO) in Brazil, was identified as an institution uniquely suited to work in HIV/AIDS prevention. Because of its history of involvement in sexually transmitted disease prevention activities, BEMFAM was well-positioned to benefit from a program designed to sharpen skills and focus on HIV prevention. AIDSCOM's primary activity was providing training in communications research and materials development methodology. A collaborative effort was designed that allowed BEMFAM to work with smaller, local NGOs, providing them with training in this area as well. Three target audiences were selected--gay men, female sex workers, and street children--based on what was known about HIV transmission patterns in Brazil at that time. These audiences represented a radical departure from the traditional family planning audience.

AIDSCOM built on this initial experience to develop a series of additional training activities with BEMFAM. BEMFAM conducted a study of the behaviors of bisexual men; this study provided BEMFAM with a broader understanding of the importance of formative research and evaluation in developing effective interventions. A subsequent project targeting women attending BEMFAM's clinics provided BEMFAM with additional experience in the full research, intervention, and evaluation process.

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In the Dominican Republic, AIDSCOM worked with PROFAMILIA, the local private-sector affiliate of the International Planned Parenthood Federation (IPPF), to reach Dominican youth. For the past eight years, PROFAMILIA has conducted a "youth multiplier" program in the country's public schools, providing sexuality education with a family planning focus. Each year, PROFAMILIA trains 660 students in 40 high schools to act as peer educators on sexuality-related issues. These students in turn provide educational activities for their classmates, reaching a total of 20,000 students each year. The trained students conduct these activities during classroom hours.

At that point, PROFAMILIA's training program had not included HIV/AIDS information and activities, although the group recognized the need to expand its focus. To meet this need, a five-part training module was designed to motivate behavior change through changing social norms via the peer educators. PROFAMILIA incorporated the module into its training immediately after pretesting. By supplementing the existing curriculum and working through an existing infrastructure, this collaborative project reached PROFAMILIA's audience of 20,000 youth without a substantial investment by either organization.

In the Eastern Caribbean, AIDSCOM worked with the Caribbean Family Planning Affiliation (CFPA), the regional IPPF Affiliate, and the Caribbean Epidemiology Centre on the second phase of a youth-focused campaign. AIDSCOM asked CFPA to join the Phase I team because of its regional expertise in formative research and its extensive local network. In the formative research and concept testing phases, CFPA arranged with its local affiliates to organize groups for interviews and to support the visiting teams when they arrived on each island. After materials were produced, local chapters also were asked to help disseminate materials and provide overall support to the Phase II campaign.

AIDSCOM also worked with family planning associations in various African contexts. In collaborating with the Family Life Association of Swaziland on a coordinated industry-based family planning and HIV/AIDS prevention program, AIDSCOM helped train staff, conduct workshops, bring in experts from other African countries, and develop materials appropriate to this workplace program.

In South Africa, where Congressional anti-apartheid legislation prohibits collaboration with government structures, the Planned Parenthood Association of South Africa (PPA/SA) was a valuable collaborator, eager to increase its HIV/AIDS prevention activities. As a result, AIDSCOM arranged to send the PPA/SA youth coordinator from a Black township in the Northern Transvaal to a five-week course on AIDS and human sexuality in the United States; sent another youth outreach person on a three-week African study tour of Zimbabwe, Uganda, and Malawi; and sponsored staff and volunteers to attend various conferences, including the IX<sup>th</sup> International Conference on AIDS in Berlin in June 1993. Each of these participants has continued to train other PPA/SA affiliates in the techniques they have learned for incorporating HIV/AIDS prevention into family planning programs.

**Lessons Learned:** The following are the lessons learned from AIDSCOM's collaboration with family planning programs:

- Family planning organizations are well-positioned to incorporate HIV/AIDS prevention into their activities, since they already deal with many individuals who engage in high-risk behaviors; they already are trained to discuss sensitive issues such as sex, sexuality, and condom use; and they already have well-established service and distribution networks.
- Some long-established family planning organizations resisted incorporating HIV/AIDS prevention due to concerns about "contaminating" the family planning message with peripheral issues such as death, disease, homosexuality, monogamy, and prostitution. In this case, exposing staff to training in which they interact with People Living with HIV/AIDS has been found to be effective in motivating them to see the advantages of incorporating these issues.
- Since family planning counselors and their clients frequently did not see condoms as the method of choice for contraception, counseling techniques had to be re-evaluated to address HIV/AIDS prevention.
- The process for incorporating HIV/AIDS prevention into family planning must involve ongoing in-service training, since understanding and commitment evolves in stages according to staff readiness at the outset.

**Conclusions:** Working with family planning groups proved to be an effective strategy for AIDSCOM to provide HIV prevention information and services. These organizations demonstrated a commitment to providing comprehensive reproductive health services, an extensive and varied service and distribution network, an acceptance of the community-based distribution model, and the use of peer education programs to reach youth. Many of these groups lacked an appropriate conceptual approach to HIV/AIDS prevention work, which AIDSCOM provided them with.

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## ***Field Note #11: A Community-based Response to the Needs of HIV-seropositive Women in South Africa***

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***Background:*** The Natal/KwaZulu region of southeastern South Africa has been hardest-hit to date by the HIV/AIDS epidemic. Antenatal clinic seroprevalence studies have shown the numbers of HIV-infected women to be three or four times higher in Natal than in the Western Cape, with pockets of infection as high as 8 percent to 10 percent. Hospitals already overburdened with abandoned children have noticed an alarming increase of abandoned HIV-seropositive children, whose parents were unable or unwilling to care for them.

Needs assessment and feasibility studies requested by the U.S. Agency for International Development/South Africa (USAID/SA) from 1990-92 recommended proactive development of a community-based response to the problems of HIV-seropositive women and their families before the situation reached the magnitude already experienced by other African countries to the north, such as Uganda or Malawi.

AIDSCOM proposed to USAID/SA and local nongovernmental organizations (NGOs) that an Africa-specific variation of Project CHAMP--a U.S. program based at Children's National Medical Center and the Academy for Educational Development in Washington, D.C.--be piloted in Natal. This project would help promote a community-based response to the prevention, education, and support service needs of HIV-seropositive mothers and their sexual partners and families. After consultations with NGOs throughout the South Africa region, AIDSCOM/AIDSCAP (AIDS Control and Prevention Project) subcontracted the pilot project to the National Association of Child Care Workers (NACCW), a Durban-based NGO. NACCW was free of any ties to the apartheid regime, had an established track record of program management and training, and demonstrated sufficient infrastructure to sustain the project over the long term.

***Objectives:*** There were two goals. The first was to help organize a community-based response to the HIV prevention, education, and support service needs of HIV-seropositive mothers and

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their sexual partners and families in the pilot areas of Durban and Pietermaritzburg. The second was to help develop a grassroots network of trained health care workers, NGO staff, and community field workers to sustain the project over the long term. This would include recruiting, training, and supervising HIV-seropositive mothers who would become employed as community peer educators.

**Method:** Project CHAMPS (Community HIV/AIDS Model for Prevention & Support) hired its project coordinator, Ms. Dudu Mofokeng, on October 1, 1992. The project staff finalized relationships with two pilot referral hospitals and spent the next five months on the following: formative research, advisory group formation, materials development, training, implementation, and evaluation.

Formative research guided the program development, training, evaluation, and materials development components of the project. Project staff conducted nine focus groups throughout the region and in-depth interviews with nearly 30 HIV-seropositive mothers and one HIV-seropositive father. Accomplishing this involved transfer of skills such as questionnaire design, interviewing, and focus group moderation. Community advisory groups were developed in both pilot sites to oversee the project; these groups involved community leaders from organizations throughout the two catchment areas.

The materials development cycle involved drafting materials, pretesting them with target populations, revising and retesting them, and producing final products in both English and Zulu. The products included a field workers manual, a mother's handbook, two posters, and t-shirts.

South African mothers involved in designing and pretesting materials reaffirmed that clients want materials in their homes that do not mention HIV or AIDS, but still are useful to them and those around them. Therefore, a small "throwaway" flyer--with specific information on HIV/AIDS transmission, prevention, symptoms, and treatment--was produced. The understanding was that mothers could dispose of the flyer after reading it or hide it for future reference. The mother's handbooks have no HIV/AIDS references.

Zulu is the primary home language in the Natal/KwaZulu region, so all materials were developed in Zulu, as well as in English. Since formal education has been disrupted consistently for decades and school is considered less important for females, literacy is particularly low among South African women. Therefore, written materials were geared for a low-literate audience, and field workers were trained to help clients identify people whom they could trust to help them understand the materials at home. The project selected a program coordinator and field workers whose home language was Zulu to maximize cultural relevancy for clients.

Measuring the effectiveness of the pilot intervention was enhanced by involving an evaluator from the outset. The evaluation design spelled out everything to be measured, including agreed-upon indicators early in the project.

Project staff conducted several trainings for health care professionals, representatives of eight community-based organizations, and field workers hired from within the communities to be

served. Each field worker committed to provide prevention, education, and support services for up to ten client families.

**Results:** Ten community field workers were hired: five in Durban and five in Pietermaritzburg. Each was intended to have ten client families during the project's pilot year. The first 100 mothers enrolled in the project ranged in age from 14 to 36. Field workers met with their clients at least twice per month at locations of the client's choice to ease client fears of disclosure.

One of the legacies of apartheid has been, perhaps, a heightened suspicion of others' motivations. Due to this suspicion and the competition among NGOs for scarce resources, it was important for Project CHAMPS to be as "inclusive" as possible of interested members of the HIV/AIDS community. The feasibility study team consulted with members of more than 35 NGOs in the region to assess the viability of the pilot project. Staff or volunteer members of eight NGOs actually participated in the trainings and were members of the advisory committees. Accusations of "exclusivity" and "vertical new program" persisted, however.

The Natal/KwaZulu region is hard-hit by not only HIV/AIDS, but also civil unrest, violence, unemployment, migrant labor, transient and disrupted families, inadequate housing, high infant/maternal mortality, poor water and sanitation facilities, high incidence of disease (one of the few regions in South Africa that contends with malaria), and inadequate medical/dental care, among many others. The field workers found it difficult to engage mothers in HIV/AIDS problem-solving when they had no food for their families. The project tried liaising with programs such as Operation Hunger, but still struggled with helping place HIV/AIDS on the regional agenda.

Some field workers spent their own money or used their own food to help their clients at the expense of their own families. Since many women did not enroll in the program until they felt sick, field workers may have been dealing with situations closer to the end of the illness than they or the project had bargained for.

At the request of mothers who felt alone in their struggle, community field workers helped form peer support groups. These groups consisted of five to ten clients of a single field worker--or clients of two or more field workers--who met to share their experiences and provide mutual support. One long-term purpose of these groups was to help mothers gain the strength to come forward and begin peer education. The project and field workers also tried to interest other community groups in this peer education.

A year-end evaluation of Phase One--through February 1994--will provide guidance for the specifics of future directions in Phase Two. Preliminary results of the formative research, materials development, and beginning program implementation were presented at the IXth International Conference on AIDS in Berlin in June 1993; the 2nd International Conference on HIV in Mothers and Children in Edinburgh in September 1993; and the VIIIth International Conference on AIDS in Africa, Marrakech, in December 1993.

**Lessons Learned:** The following are the lessons learned:

- It is important for everyone to see this as a community-based project of an indigenous South African NGO. The role of outside technical advisors should be delineated clearly at the outset to prevent any blurring of the lines of authority.
- Mothers' requests for materials free of references to HIV/AIDS must be honored to accommodate their reluctance to disclose their HIV status.
- Literacy levels and language needs of the mothers need to be taken into account in materials development and hiring of appropriate culturally sensitive staff.
- To maintain the "inclusive" nature of the initiative, it was important to continue open collaboration and consultation, emphasizing on every occasion and through all written and oral communications that Project CHAMPS is community-based, with input from and services for all concerned people.
- Future strategic planning for the initiative should consider funds for assistance to develop some form of income generation for clients struggling with basic survival issues. Otherwise, these clients may never be able to prioritize their health concerns to prevent further sexual/perinatal HIV transmission and disease progression.
- Community field workers need additional training in setting personal and professional boundaries. Many are frustrated at not being able to solve their clients' problems, resulting sometimes in overextension of personal time and resources.

**Conclusions:** A proactive project organizing a community-based response to the prevention, education, and support service needs of HIV-seropositive women, their sexual partners, and families can be viable if it is as inclusive and vigilant as possible at the grassroots level. Involved members of the NGO community in Natal have expressed considerable interest in Project CHAMPS as it has unfolded in their region. The project's reputation has generated considerable interest from other regions of South Africa, as well as other African countries. Because Project CHAMPS was a pilot project, it has had to deny prevention, education, and support services to families who need them. Most families Project CHAMPS has served were enthusiastic about the help they received. They were grateful for counseling and help coping with HIV/AIDS, but also for assistance in accessing other services needed to reduce the negative impact of HIV/AIDS on them and their families.

After incorporating suggestions from the year-end evaluation in February 1994, it is recommended that the project expand to include pilots in at least two other areas of South Africa. If subsequent evaluations of the project and its networking format indicate that it is effective, Project CHAMPS could provide one example of a model that could work in other similar contexts throughout Africa.

## ***Field Note #12: Designing Gender-sensitive Prevention Strategies for Women in the Workplace***

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**Background:** In 1990, the AIDS Public Health Communication Project (AIDSCOM) received funding from the Women in Development Office of the U.S. Agency for International Development (USAID) to conduct a multisite research and intervention project to improve the understanding of factors influencing behavior change among women and effective ways to support new behaviors. This project was conducted in Tanzania, Brazil, and Indonesia. This document covers the objectives, methodology, results, and lessons learned specifically in the Women in Development/AIDS in the Workplace (WID/AIWP) Project undertaken in Tanzania. During 1990-93, AIDSCOM collaborated with the women's department of a local labor union, the Organization of Tanzanian Trade Unions (OTTU), and the National Insurance Corporation (NIC) to design, implement, and evaluate the WID/AIWP Project.

**Objectives:** The objectives of the project were to use theory-driven behavioral research to study the underlying determinants of the behaviors in order to design an HIV/AIDS prevention curriculum for women and their sexual partners. The curriculum was designed to 1) empower women with the knowledge, skills, and confidence to negotiate for safer sex and 2) provide a social support system in the workplace for women to influence their partners' sexual behavior.

**Method:** During the first two years of this project, data were collected and a curriculum was designed and implemented. Qualitative and quantitative questionnaires were administered to 100 women union members working at NIC in Dar es Salaam, Tanzania. Women were asked in face-to-face individual and group interviews about the advantages and disadvantages of engaging in these four behaviors: 1) discussing with my partner ways to protect both of us from AIDS; 2) convincing my partner to use a condom; 3) using a condom with my partner; and 4) refusing to have sex if my partner won't use a condom. The women also were asked to identify strategies for engaging in these four behaviors and their perceptions of the value of those strategies for persuading a partner to use condoms. Based on the qualitative and quantitative data collected, AIDSCOM assisted OTTU in designing a participatory curriculum for women and their sexual partners. The original curriculum consisted of four training sessions for women, one training session for their sexual partners, and a combined session for the women and men.

The training curriculum was taught to 200 women working at NIC and their sexual partners. A self-administered delayed post-test was developed to assess the impact of the training on the participants. Thirty days after the training, the female participants in the training--all of whom were literate--were expected to complete a post-test at their worksites, which would then be

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collected by women from OTTU. Unfortunately, it became logistically impossible for OTTU to locate and have access to the women who had participated in the original training because of work loads, vacations, transfers to other branches of the insurance company, and so on.

Consequently, a second model was designed to evaluate the impact of the intervention. In this model, the curriculum was taught to 85 women from 12 different worksites in Dar es Salaam. A knowledge, attitudes, beliefs, and practices (KABP) survey was administered to this group. The same survey was administered to 102 women who did not receive the training; this group served as the control group. Unlike the trainings that occurred during the first two years of the project, a KABP survey also was developed for the sexual partners of the women participating in the training. This survey assessing knowledge, attitudes, and behavioral intentions and practices, similar to the women's survey, was administered to the 75 men who received the training. The survey also was administered to 57 men who did not receive the training and who served as the control group. In addition, focus groups were conducted with the control and test groups following the trainings to assess the opinions of women and men regarding multiple partners.

It is worth noting that the control groups received AIDS prevention training immediately following the administration of the KABP survey. A condensed version of the *Women in Development AIDS in the Workplace Skills Training Curriculum* covering basic information about AIDS and risk reduction measures was covered over a four-hour period. Fifty-seven men and 102 women received this training.

**Results:** The following results represent analyses of data collected during the first two years of the project. When asked the best way to avoid AIDS, 62 percent of the women mentioned staying with one partner, and 24 percent reported condom use. The most frequently identified strategy for convincing a partner to use a condom was pointing out that their children might be orphaned if they don't use a condom. Most (72 percent) of the women indicated that they can refuse to have sex with their partner for whatever reason, 53 percent reported insisting their partner use a condom, and 39 percent reported refusing to have sex if their partner would not use a condom. When asked who makes the final decision about sexual matters, 57 percent of the women indicated that both they and their partner do, 26 percent reported that they do, and 17 percent stated that their partner does.

Preliminary results from the focus groups conducted following the October 1993 trainings to assess the opinions and attitudes of men and women regarding multiple partners suggest that women seek partners outside the marriage or main relationship for economic gains (for example, gifts, fabrics, meals, money). Women also have multiple partners to satisfy sexual needs that they believe their main partner is unable or unwilling to satisfy. Men reported that they have multiple partners because women "flaunt" themselves in front of them, and men have no choice but to concede to the sexual desires of women. Men also indicated that they engage in relationships outside their main relationship for added sexual pleasures derived from various sexual acts that they believe their partners would not engage in.

Quantitative data collected in October 1993 on women and their sexual partners are currently being analyzed. The results are likely to have implications for future gender and AIDS prevention strategies, since the individual KABP surveys completed by the women can be matched with similar surveys completed by their sexual partners and, consequently, can provide effective intervention points for educating couples.

**Lessons Learned:** Some of the lessons learned from AIDSCOM's WID/AIWP Project in Tanzania include the following:

- Women should not be viewed in isolation from men. Since women are rarely autonomous in making decisions that affect their bodies, it is important to design gender-specific interventions to reduce the transmission of HIV in women. This means that men must be included in the intervention to optimize the effectiveness of the strategy.
- Homework assignments given to the women proved to be an effective way to educate the women's sexual partners and to generate enough interest in the men to prompt them to attend the training session for men. Additionally, the women were able to educate the men, so that by the time the men arrived at the training, less time was spent on the basic facts about HIV/AIDS and more time on knowledge and skills-building activities that will facilitate effective communication and behavior change.
- Men will be receptive and interested in participating in AIDS education and prevention trainings that their sexual partners also are attending. In Tanzania, the intervention consisted of four sessions for women, one session for their sexual partners, and a combined session for the women and their sexual partners. Although a low turnout by the sexual partners of the women was anticipated, 100 percent of the invited partners attended during the first round of trainings (50 percent were invited), and 88 percent of the partners participated in the second round of trainings (all partners were invited during the second round of training).
- It is important to provide women and men with the skills needed to effectively communicate their sexual desires to each another. Perhaps if women and men were honest with one another about their sexual needs, they would remain monogamous.
- Participatory research can be a powerful methodology used to develop culturally sensitive and effective prevention strategies. In Tanzania, participatory research allowed AIDSCOM and its local partner, OTTU, to develop culturally relevant questionnaires. Also, since local women conducted group face-to-face interviews using the questionnaires that they had designed and pretested in their native language, respondents were more likely to respond candidly. Data collected through participatory "action" research was translated into program interventions that have been found to be relevant to the target audience. Relevance is due largely to the fact that the target audience was involved in every phase of the project--from conceptualization, research design, data collection, intervention design, implementation, and evaluation.

- A self-administered delayed post-test may not be the most effective approach to collecting data, since it places a great deal of the burden on the respondent and employer and relies on literate respondents to comprehend the instructions and questions.
- Workplace interventions can provide an opportunity for the distribution of condoms. During a two-week period alone, 18,000 USAID-donated condoms were distributed to the women and men participating in the skills training workshops.

**Conclusions:** Since women frequently lack autonomy in sexual relationships, it is important that men also adopt HIV/AIDS prevention behaviors. Therefore, it is important that prevention strategies that target women include as part of the overall training curriculum training sessions for sexual partners of the women.

## ***Field Note #13: Consumer Research and Condom Promotion in Tanzania***

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***Background:*** When designing a social marketing strategy, conventional wisdom may not always prove correct. It is essential to conduct fresh, carefully targeted market research that considers both the audience and the context for a new product or message. In Tanzania, this approach helped avert what might have become a marketing disaster.

The AIDS Public Health Communication Project (AIDSCOM) and its local counterparts planned to conduct social marketing research to name and position a commercial condom product in Tanzania. The research was part of the Condom Social Marketing (CSM) Project, which complemented the National AIDS Control Programme's public-sector condom distribution effort. The CSM Project represented a collaboration between Pharma Plast Ltd., a local medical supplies manufacturer and distributor; Cette International, Ltd., and Scanad, local promotional firms; and AIDSCOM.

Based upon experiences in other countries in the region and anecdotal information from Tanzania, the AIDSCOM social marketing team had developed its own assumptions with which to conduct its research. These were that 1) the research team would encounter resistance from local officials, institutions, and community leaders in obtaining authorization and support for conducting the research; 2) Tanzanian men would be uncomfortable discussing condoms, sex, and AIDS and would be neutral, at best, about using condoms; 3) Tanzanian men would prefer *Simba* (lion) as a brand name for a new condom because it connotes bold, aggressive, masculine qualities; and 4) Tanzanian men would not respond to appeals to personal or family responsibility.

***Objectives:*** The goal was to develop a brand name, package design, and product positioning for a new commercial condom product and the national mass media campaign to promote it in Tanzania.

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***AIDSCOM Lessons Learned***

**Method:** As part of its formative research, AIDSCOM and its counterparts introduced the concept of consumer-oriented focus group research to learn what young Tanzanian men knew and felt about condom use and AIDS prevention. Researchers conducted 16 focus groups in and around Dar es Salaam and the more conservative town of Bagamoyo, in the Coast Region. Eight groups consisted of men ages 18 to 35, six included working men of various professions, and two included post-secondary students. To gather background material, researchers interviewed six other groups: two with people who would sell condoms, two with female sex workers, and two with young unmarried working women.

The principal research questions were: What are the main barriers to and motivating factors for regular condom use? What condom attributes do young men prefer and why? and What would be a good brand name, package design, and product positioning concept for a new commercial condom product? Researchers tested participants' attitudes toward and preferences for six brand names for a new condom for Tanzania: *Protector*, *Guardian*, *Sungura* (a Kiswahili word for jackrabbit), *Simba* (lion), *Mlezi* (family guardian), and *Salama* (safe or secure). They also tested a variety of three-pack condom package designs. Then, they asked about promotional appeals and how potential consumers might respond to them.

**Results:** Researchers noted that participants' AIDS awareness and knowledge resulted largely from the National AIDS Control Programme's public information campaigns. Participants cited radio, newspapers, posters, cinema, cultural groups, and health personnel as key sources of information. Most participants knew what condoms are and that they are used to prevent pregnancy and sexually transmitted diseases (STDs), including HIV. Almost all had seen condoms; more than half had used condoms. The most common motivating factor for condom use was fear of STDs, especially AIDS. While several participants believed they were at some risk of HIV infection, few identified their own sexual behavior as directly contributing to this risk. Few male participants reported regular condom use. They were reluctant to use condoms with steady partners. Other barriers to condom use were lack of availability, unfamiliarity, economics, breakage, and general apathy.

Researchers also found that, in 12 of the 16 focus groups, participants' first or second choice for the condom name was *Salama*. Participants chose *Salama* because it is easy to pronounce, it signifies security and safety, and it implies that the product has been checked and is safe for use. Only one group preferred *Simba*, the name that AIDSCOM had thought the groups would choose; groups said sexual relations require tenderness, not the fierceness of a lion. Most groups preferred a light-blue packaging design with *Salama* repeated three times. They said blue is calm and would make purchasers feel at ease. Participants chose the promotional appeal *Be safe, be smart...use a condom and enjoy the rest of your life* because it is simple and neutral. The second choice was *Protect your future and your family, prevent AIDS infection, use a condom*. Participants appeared to respond favorably to the appeal to family and personal responsibility.

**Lessons Learned:** The focus groups provided insights that were contrary to the AIDSCOM team's expectations. The following are the lessons learned:

- The researchers received willing assistance from regional development officers, ward secretaries, and local branch secretaries of the state political party in conducting the research.
- Tanzanian men were open about and interested in discussing sex, AIDS, and condoms. They expressed definite opinions about these subjects.
- *Salama* was significantly more attractive as a condom name than *Simba* or other more aggressive images.
- Appeals to personal and family responsibility were more appropriate than appeals to fear or pleasure.

**Conclusions:** Key insights provided by social marketing research enabled AIDSCOM and its local counterparts to appropriately name and position a commercial condom product in Tanzania. Based upon this research, AIDSCOM and the Tanzanian social marketing team decided there was adequate interest among young Tanzanian men to justify placing a commercial condom in the marketplace. The research also provided valuable insight into what motivations and approaches might be used to encourage more Tanzanians to use condoms. The condom use instructions that were developed later, also through extensive field testing, reflected the positive responses received from being frank and appealing to personal and family responsibility.

## ***Field Note #14: Designing an Instructional Condom Brochure***

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***Background:*** Early AIDSCOM research in Trinidad and Tobago, Jamaica, and the Dominican Republic revealed that many men and women did not know how to put on a condom correctly. As part of its AIDS prevention activities in the Eastern Caribbean, AIDSCOM collaborated with local organizations to design an instructional condom brochure to fill this knowledge gap.

***Objectives:*** The objective was to design an instructional brochure that would reinforce condom skills taught in face-to-face condom skills training sessions. Additionally, the condom brochure was to provide men and women with practical tips that would make condom usage more effective.

***Method:*** Much of AIDSCOM's early work built condom skills by teaching participants to put a condom on a surrogate model. Since face-to-face activities have limited reach and often need to be reinforced over time, AIDSCOM used focus group research to design a condom brochure that would reinforce the face-to-face condom skills-building activities. AIDSCOM worked closely with the target audience (sexually active adults) to design the format, art style, and text for its condom brochure--all of which were pretested and revised.

***Results:*** After the condom brochure was finalized, AIDSCOM conducted a study with two groups of people in the Caribbean to compare the effectiveness of teaching proper condom skills through two techniques: a condom demonstration using a model, and an illustrative condom brochure without a condom demonstration. AIDSCOM staff presented a live condom demonstration to one group, showing group members how to put on and remove a condom properly. AIDSCOM gave the second group copies of the condom brochure only, containing graphics that illustrate how to put on and remove a condom properly. After the intervention, AIDSCOM asked both groups to demonstrate how to put on and remove a condom, using a surrogate model.

Both interventions significantly increased condom usage skills. Using a skill index with a possible "perfect" score of 25, the group that viewed the live demonstration increased its score from a "before" score of 13.0 to an "after" score of 24.7. The group that received the brochure increased its score from 13.6 to 21.1.

In addition, preliminary data comparing respondents who received a condom demonstration and the AIDSCOM condom brochure to respondents who received only the condom demonstration

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suggest that the interventions are most effective when used together; the condom brochure is particularly useful in reinforcing skills and knowledge acquired through live demonstrations.

The condom brochure was developed in the Caribbean, but has been popular in AIDSCOM programs in all regions. A Peruvian nongovernmental organization reprinted it with its own funds when its stock supplied by the Agency for International Development was depleted. City health programs in Birmingham, Alabama; Boston, Massachusetts; and Washington, D.C., have printed and distributed tens of thousands of copies, with their own program logos. The D.C. program used AIDSCOM's English and Spanish condom brochures and produced a version with three Asian languages.

**Lessons Learned:** The following are the lessons learned:

- The AIDSCOM brochure can reinforce skills and knowledge acquired through face-to-face condom skills-building sessions. The brochure and demonstration used in combination is the most ideal training method.
- Materials developed for one region can be culturally appropriate and effective in other regions.

**Conclusions:** It is not surprising that a demonstration was slightly more effective than the brochure in improving skills. It is important to note, however, the reinforcing role that the condom brochure played when used in combination with a live demonstration. The AIDSCOM condom brochure is an example of transfer of knowledge and skills to diverse cultural settings. The brochure has been widely available in Latin America, the Caribbean, and Africa. The brochure is inoffensive, and people on every continent seem to accept the gray skin tones as *their* skin tones. Heterosexual men and women presume the brochure has been designed for them; gay men believe it has been designed for them.

**Field Note #15: A Cross-cultural Study:  
The Impact on U.S. Audiences of a Dramatic Film  
Designed for Continental Africans**

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**Background:** *It's Not Easy* is the first AIDS film produced in Africa. It uses Ugandan actors to humanize the face of AIDS. The film was produced to be used by continental Africans as part of their AIDS in the Private Sector communication program. The aims of this program and, subsequently, the purposes of the film are to clarify basic facts about HIV/AIDS, promote acceptance of people with AIDS in the workplace, and encourage safer sexual behavior. *It's Not Easy* was co-produced by the Federation of Ugandan Employers, the Experiment in International Living (now known as World Learning)/Uganda, and Uganda Television. The film was made possible by funding from the U.S. Agency for International Development/Kampala and technical assistance from the AIDS Public Health Communication Project (AIDSCOM), the Academy for Educational Development, and The Johns Hopkins University.

After a U.S. premiere hosted by members of Congress, it was recommended that the appropriateness of the film for U.S. audiences, particularly African-Americans, be explored. As a result--with the assistance of the National Urban League and the American Red Cross--the hypothesis that materials targeted for audiences of a developing country can be effective in a developed country was tested.

**Objectives:** The goal was to test the cross-cultural appropriateness of the African AIDS film *It's Not Easy* for U.S. audiences, particularly African-Americans.

**Method:** A convenience sample of 490 respondents in seven cities throughout the United States participated in the study. The respondents were 47 percent African-American, 32 percent White, 4 percent Hispanic, 1 percent Asian, and 14 percent unreported. Nearly 75 percent were female and over 50 percent of the sample lived in Akron, Ohio, and Oakland, California. Respondents were evenly distributed among those with a high school education or below, those with some college education, and those with an undergraduate degree. Twenty-six percent did not indicate their level of education.

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AIDS educators from the American Red Cross and National Urban League served as facilitators for each testing session, which lasted from 2 1/2 to 3 hours. A facilitator's study guide was developed with specific instructions to ensure consistent testing of the film. Each session consisted of 1) a brief overview of the study; 2) administration of the AIDS Opinions Test (pretest); 3) showing *It's Not Easy*; 4) administration of an immediate post-test; and 5) a discussion about HIV/AIDS and the film and distribution of AIDS brochures. The AIDS Opinions Test consisted of 36 questions in a 5-point agree/disagree format and assessed knowledge about HIV/AIDS (transmission, risk reduction, support and compassion, workplace issues, information-seeking, and discussion). The post-test asked the same 36 questions, plus eight questions about reactions to the film in a 5-point agree/disagree format and 12 questions about demographics.

To conduct an analysis, all 5-point scaled items were coded to range from -2 (strongly disagree) to +2 (strongly agree). Missing responses were coded as 0 for no opinion. Race was dichotomized between African-Americans and non-African-Americans. Education was coded to three levels--up to high school graduate, some college, or college graduate and above.

**Results:** Significant change over time occurred on 32 of the first 36 items. As a rule, subjects agreed with items that were "correct" according to the film and more strongly agreed with those same items after seeing the film. They similarly disagreed with "incorrect" items and more strongly disagreed after the film.

In addition, significant race-by-time effects occurred on four of the first 36 items. These effects varied. For example, in response to "A person who has the AIDS virus can still be a productive worker," African-Americans began with a less strong agreement and ended with a slightly stronger agreement than non-African-Americans. In response to "A person infected with the AIDS virus can live for many years," African-Americans and non-African-Americans began at the same level of agreement; African-Americans increased in intensity and non-African-Americans stayed about the same.

A significant race-by-education-by-time effect occurred on five items. These included: 1) You can tell by looking whether a person is infected with HIV; 2) You can get HIV from having sex with someone with HIV; 3) Religious groups should start AIDS education programs; 4) I would help a friend with AIDS; and 5) Persons with AIDS can live for many years. In general, the greatest change occurred for the more educated African-Americans.

In addition, African-Americans reacted more positively to the film; they liked the film, learned a lot from the film, and identified with the film more strongly than non-African-Americans. Both African-Americans and non-African-Americans believed the film was appropriate for all races.

**Lessons Learned:** The following are the lessons learned:

- The film *It's Not Easy* is appropriate for U.S. audiences.

- The film increased both knowledge about sexual transmission and behavioral intentions.
- The film seemed especially appropriate for African-Americans, who liked the film and thought they learned more from the film than non-African-Americans.
- The film had a more positive impact on African-Americans than non-African-Americans regarding beliefs about people with AIDS, sexual transmission of AIDS, and attitudes about staying with one sexual partner.

**Conclusions:** A cross-cultural study of the impact on U.S. audiences of the African AIDS film *It's Not Easy* indicated that the film is appropriate for U.S. audiences, particularly African-Americans. The study confirmed the hypotheses that materials targeted for audiences of a developing country can be effective in a developed country.