

# CAPTIONS

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## *Communities and AIDS Prevention*



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## Phase I HIV Vaccine Trials to Begin

Trials to assess the safety of candidate HIV vaccines and their ability to stimulate the immune system will soon begin in Brazil, Rwanda, Thailand and Uganda with support from the World Health Organization (WHO). These trials, which will involve a small number of volunteers, are the first step in a three-phase process to determine the safety and efficacy of vaccines.

WHO's HIV vaccine development strategy focuses on the developing world, Dr. Peter Piot, the director of the WHO Global Programme on AIDS's Division of Research and Intervention Development explained at the recent Biotech '94 Conference in Florence Italy. "While encouraging the conduct of all phases of vaccine trials in industrialized countries," he said, "we consider it of paramount importance that the vaccine be tested in populations where they are most urgently needed and will be most used."

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## US \$1 Million Challenge Announced for STD Diagnostics

The Rockefeller Foundation is offering a US \$1 million prize for the development of a low-cost, rapid and easy-to-perform diagnostic test for chlamydia and gonorrhea that is appropriate for use in the developing world and other resource-poor areas.

An estimated 50 million new cases of chlamydia and 25 million new cases of gonorrhea occur worldwide each year. Untreated, chlamydia and gonorrhea can lead to infertility, potentially fatal ectopic pregnancy and infant blindness. Both infections can be cured easily and inexpensively but are extremely difficult to diagnose because the majority of infected people have no symptoms.

Current diagnostics are expensive and slow, and require incubators and other equipment not always available in many parts of the world. The cost of existing diagnostic tests for chlamydia and gonorrhea is, on average, four times the cost of treatment. For women the tests also require a pelvic examination, which is uncomfortable and unacceptable in many cultures.

The foundation will award its Rockefeller Science and Development Prize to the individual or group who develops a rapid (20 minutes or less), reliable test or tests for asymptomatic chlamydia and gonorrhea. The test must be suitable for use in areas with limited electrical power, no refrigeration and minimal, if any, laboratory equipment, and should not require a pelvic exam. It must be possible for primary health care workers who have no more than a primary-school education to conduct the test and interpret the results after no more than two hours training.

Both for-profit and non-profit organizations are eligible for the prize. Entries will be accepted until March 1, 1999, or until a winner is named. For information contact the STD Diagnostics Challenge, The Rockefeller Foundation, 420 Fifth Avenue, New York, NY 10018, USA.

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## Female Condom Update

The U.S. Food and Drug Administration has given verbal approval for the United Kingdom-based Chartex manufacturing factory to produce female condoms for sale in the United States. Once written approval is received, Wisconsin Pharnacal will start shipping the female condom to the U.S.

The female condom is not yet available for sale in developing countries, but several organizations are conducting further research to accelerate its availability and accessibility for

prevention of HIV and sexually transmitted diseases (STDs) worldwide. For example, the World Health Organization's Global Programme on AIDS will carry out a study on sexual negotiation in the use of the female condom and its acceptability and efficacy at a site in Thailand. Family Health International is conducting several studies of male attitudes toward the female condom and planning an efficacy study in Cameroon examining the device's ability to protect against STDs.

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## AIDS Threatens Child Survival Gains

Increasing infant and child mortality from AIDS is threatening 3 years of improvement in childhood survival in developing countries, according to a recent report by the U.S. Census Bureau. The report, which looks at Brazil, Thailand, Haiti and 13 sub-Saharan African countries, warns that childhood mortality in these countries could triple by the year 2010 unless there is a sharp decline in the rate of HIV infection. Until the mid-1980s, developing countries had seen marked improvement in the survival rates of children from birth to age 5.

Compiled by the Census Bureau's Center for International Research, the report also predicted that AIDS could double the natural death rate by 2010 in all of the countries studied except for Thailand, where the epidemic could triple the expected mortality rate.

The epidemic will not cause a decline in population growth in most developing countries, but is expected to slow the rate of population growth. In sub-Saharan Africa, for example, most adult AIDS mortality occurs after the average age of childbearing (about 30 years), so fertility levels will remain high. The populations of African countries will continue to grow, but not as fast as they would have without AIDS.

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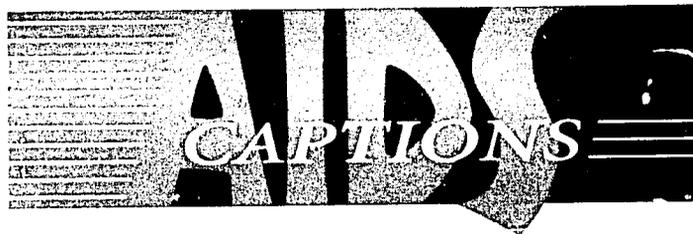
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COVER PHOTO: A MEN'S VILLAGE MEETING IN SENEGAL. Jeremy Hartlet/Panos



Dr. Thomas Coates, Director of the Center for AIDS Prevention Studies, University of California at San Francisco.

# Communities and AIDS Prevention: *What Works*

by Thomas J. Coates

The HIV infection epidemic issued an important challenge to the public health community: business could not (and still cannot) be conducted as usual. Public health workers cannot rely only on their usual channels (clinics, schools and other institutions) for reaching people, paying only lip service to the idea of community outreach; nor can they continue to work only with those who are easy to reach. Instead, they must begin to work aggressively in and with communities, particularly those that are hard to reach.

Because HIV can spread so quickly through many populations, interventions have to influence a sizable proportion of these populations rapidly enough to prevent communities from becoming saturated with HIV. It is essential to reach individuals at highest risk for HIV early in the epidemic to prevent such saturation. Community-level interventions are an important avenue for realizing this goal.

Behavioral research demonstrates that individuals are much more likely to initiate and maintain low-risk behaviors when a variety of channels are used to inform and motivate. Inherent in the community-level approach is the recognition that interventions can be directed simultaneously at individuals, at small groups and neighborhoods, and at the entire community through channels of influence indigenous to the community.

Reaching the entire community with consistent messages is particularly important because experience shows that individual behavior change cannot be sustained unless it is supported by a

social environment that encourages healthful behaviors. The objective of many community-level interventions is to influence social networks so that safer practices are valued and expected by their members. As risky behaviors become less socially accepted in a community, rewards for healthy behavior (and sanctions for risky behavior) become persistent and inescapable. In a Nigerian town, for example, commercial sex workers who participate in a community-based AIDS prevention program will band together to boycott a client who refuses to use condoms (see story p. 19).

Four approaches to community-level change have been found to be effective: outreach, community mobilization, diffusion of innovation, and social marketing. All of these approaches use community members as educators, outreach workers, leaders and distributors of condoms. The difference among the four approaches to community-level change is in how these peer leaders function and what they do. Of course, many programs may combine elements of more than one approach to community-level change.

## Outreach Programs

Outreach programs may be needed to reach special populations that either do not constitute a cohesive community, do not come together as a community, or do not regularly use services such as health care facilities. Outreach interventions using peer educators have been implemented successfully in many parts of the world for a variety of populations, such as injection drug users, commercial sex workers and truck drivers.

Community-based interventions need greater political and financial support to realize their true potential.

In Zimbabwe, for example, peer education and outreach programs, combined with condom distribution, increased consistent condom use among commercial sex workers from 5 percent in 1989 to almost 50 percent by early 1992.<sup>1</sup> As a result of a similar program in Ghana, reported consistent condom use among sex workers rose from 6 to 71 percent in six months.<sup>2</sup>

These programs are successful because they take the intervention to the people who need it. Outreach workers are chosen from the target population and know where and how to reach people. Educational messages and condoms can be delivered to individuals in the streets, in their homes, or in bars, brothels and drug users' "looting galleries." Peer outreach workers are able to reach large numbers of people in a short time. Their presence in a community also creates awareness that something important may be happening in that community.

#### Community Mobilization

Community mobilization is another strategy for reaching multiple segments of a community (see p. 10). The objective of this strategy is to mobilize various segments of a community to deal with a problem (in this case, HIV prevention) and to involve community agencies in attempts to influence people to engage in less risky behavior. Such programs, for example, have been effective in reducing unintended pregnancy among never-married teens and pre-teens in the United States in the state of South Carolina.

The South Carolina intervention began with a town meeting to get as many people as possible interested in,

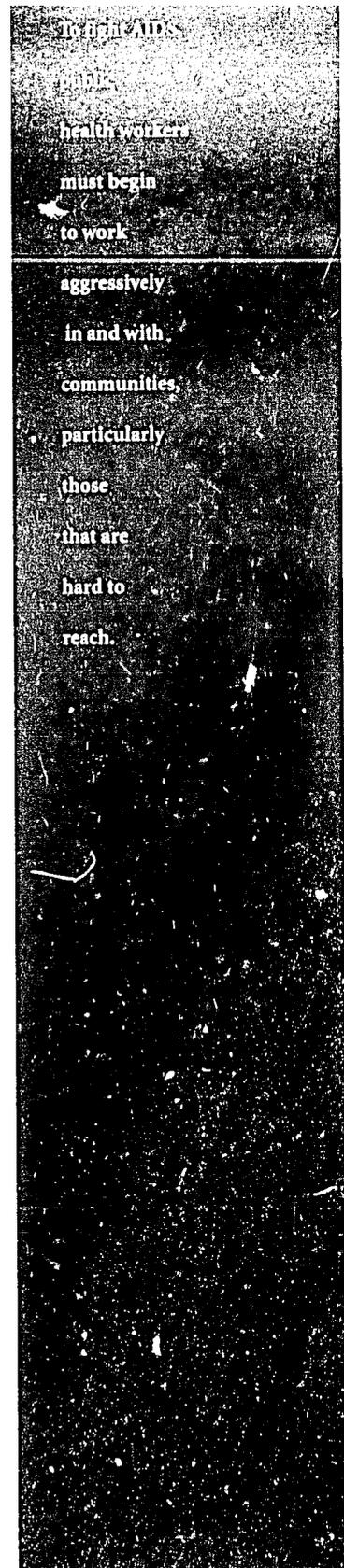
and thinking about, the problem of adolescent pregnancy. This was followed by the creation of advisory groups representing the different sectors of the community. Community agency employees, schoolteachers and administrators, members of religious groups and parents all learned about the problem, how to communicate about sexuality, and how to encourage safety. The schools taught about sexual communication and methods for avoiding pregnancy. As a result of these efforts, the estimated rate of pregnancy among adolescent girls (14-17 years) declined from approximately 65 pregnancies per 1,000 to 25 per 1,000.<sup>3</sup>

#### Diffusion of Innovation

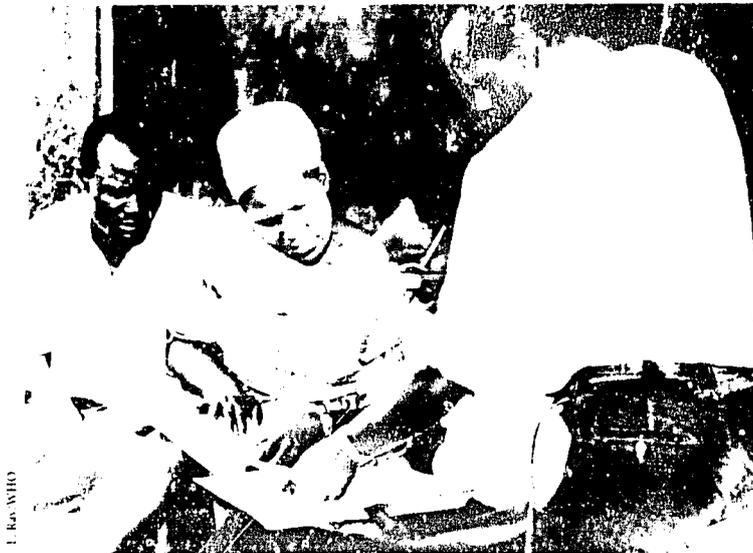
A third strategy, based on Everett Rogers' theory of diffusion of innovation, also uses channels of influence that already exist in communities. Trend setters and leaders set the tone for a community, and individuals generally follow their example.

Diffusion of innovation interventions attempt to identify and recruit these trend setters, persuade them to adopt behavioral changes, and assist them in practicing safer behaviors so they can serve as models for their peers.

Such a strategy has been used to reach gay men in small cities in the United States. One intervention took place in bars, which tend to be the major congregating points for gay men in these cities. Individuals identified as popular by their peers and by bartenders trained to observe social interactions were recruited to endorse behavior change. The leaders committed to change their own behavior and learned conversational skills for motivating their friends to change.



KENYAN AIDS CARE  
 ALL TRAINED AS  
 HEALTH EDUCATORS.  
 THE MOST SUCCESSFUL  
 AIDS INTERVENTIONS  
 USE COMMUNITY MEMBERS  
 AS HEALTH CARE  
 PROVIDERS AND  
 DISTRIBUTORS  
 OF CONDOMS.



J. E. RAY/WHO

Researchers surveyed bar patrons before and after the interventions in the intervention city and in two matched control cities. They found that the percentage of men who engaged in unprotected, receptive anal intercourse decreased from 27 to 19 percent in the target city, while little or no change was observed in the comparison cities.

Leaders, of course, come in many varieties. They can be elected leaders, individuals who are leaders by virtue of a position they hold in the community, or informal leaders who can motivate others through their personality or talents. Diffusion of innovation interventions can use all of these kinds of leaders to bring about change in groups of people who interact frequently.

#### Social Marketing

The fourth strategy, social marketing, uses the principles of marketing to

promote healthful behaviors and, for AIDS prevention, to make condoms more accessible and affordable to people in their communities (see p.27). Shopkeepers, pharmacists, hawkers, hotel employees and brothel managers serve as the sales agents for condom social marketing and are often trained to provide AIDS education to people in their communities. Community events are used as a showcase for activities to promote safer sex, including dramas about AIDS prevention, games and contests.

Community-level interventions using these four approaches have proved successful in organizing communities to solve many problems. These approaches are also effective in reducing high-risk behaviors and in preventing new HIV infections.

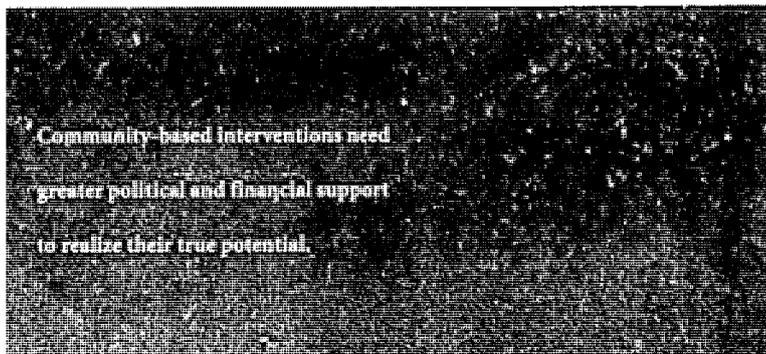
The HIV epidemic engenders pessimism. People die prematurely, vaccines are a long way off, and

therapeutic treatments are not very effective and not available to the vast majority of people who are infected with HIV. The success of community-level intervention has been encouraging. What we need now is the political will, together with the economic resources, to do the job properly. These strategies can work, but they will never realize their true potential without the political and financial support to ensure that they are applied in communities throughout the world.

*Dr. Thomas J. Coates, Ph.D., is director of the Center for AIDS Prevention Studies at the University of California at San Francisco.*

#### References

1. Effective Approaches to AIDS Prevention. Report of the meeting, 26-29 May 1992. Geneva: World Health Organization.
2. Asamoah-Adu, Alexander, Sharon Weir, et al. Evaluation of a targeted AIDS prevention intervention to increase condom use among prostitutes in Ghana. *AIDS* 8(2):239-246, February 1994.
3. Vincent, M.L., A.E. Cleary and M.D. Schlacter. Reducing adolescent pregnancy through school and community-based education. *Journal of the American Medical Association* 257(24):3382, June 26, 1987.
4. Kelly, J.A., J.S. St. Lawrence, Y.E. Diaz, et al. HIV risk behavior reduction following intervention with key opinion leaders of the population: An experimental analysis. *American Journal of Public Health* 81:168, 1991.



# NGOs Fight Against HIV/AIDS

by V. Chandra Muzli,  
World Health Organization

NGOs  
must move  
from confrontation  
to real collaboration  
with governments  
without  
"selling out."

- In 1981, 40 men gathered in the apartment of New York writer Larry Kramer to talk about how they could respond to the new epidemic in their midst. That day they created the Gay Men's Health Crisis, the world's first AIDS Service Organization (ASO).
- Six years later, a small group of men and women infected or affected by HIV met in Noerine Kaleeba's office in the physiotherapy department of Mulago Hospital in Kampala, Uganda, to discuss how to react to this new crisis in their lives. The AIDS Support Organization (TASO) was born.

In many countries, the first significant nongovernmental response to AIDS was from groups of volunteers and activists who formed their own organizations to provide care for their sick friends, educate their peers and advocate for more attention and funds. In fact, by the mid-1980s, when governments began to establish national AIDS control programs (NACPs), there was already a truly international volunteer response consisting of nongovernmental AIDS care, support and prevention programs in many countries.

At about the same time, existing nongovernmental organizations (NGOs) began identifying a need for such services in their target communities and taking up AIDS work in addition to their other activities. In Zambia, for example, a charismatic Australian missionary named Ian Campbell, chief medical officer of the Chikankata Salvation Army Hospital, saw even in 1987 that hospitals would not be able to handle the load of AIDS patients. Under his direction, the hospital began to involve families and the wider community in providing home-based care to people with AIDS.

## The Role of NGOs

By 1991, WHO/GPA had identified more than 200 NGOs working on AIDS issues in Africa; the Pan American Health Organization estimated that 500 NGOs were fighting the epidemic in Latin America.<sup>1</sup> Today, even more NGOs in these regions are working in AIDS care, prevention and advocacy. With the pandemic making rapid in-roads

into Asia, increasing numbers of NGOs in that part of the world are also getting involved in AIDS interventions.

In its broadest possible sense, the term NGO means any organization that is not part of a government structure. This could include "self-help" groups founded and controlled by a distinct community sharing a collective interest; volunteer organizations that bring together people with shared values, vision and commitment; international NGOs that provide technical, financial and moral support to local organizations; and GONGOS (government-organized NGOs) created to pursue specific objectives.

ASOs and other NGOs that have expanded their activities to include AIDS work have a wide variety of organizational styles and missions. At one end of the spectrum, NGOs provide services such as counseling, care and support to people with AIDS and their families. NGOs in Africa are particularly active in these areas. Many (but not all) are mission hospitals such as the Chikankata Salvation Army Hospital in Zambia and the Chi'ovu Mission Hospital in Uganda. Church-based groups are also beginning to play a front-line role in countries in other regions. In India, for example, the Christian Medical College in Vellore, Tamil Nadu, has perhaps the most comprehensive AIDS program in that country.

At the other end of the spectrum are NGOs who seek to influence the broader political and economic environment. The Brazilian Interdisciplinary AIDS Association (ABIA),

for example, has been fighting for the rights of people with HIV/AIDS, initially as an activist organization and more recently working in collaboration with the NACP in that country. Although ABIA, like many NGOs, is involved in prevention education as well, its most notable contribution has been, and continues to be, advocacy for those with HIV/AIDS.

The number of NGOs and the range of services they provide in a particular country can be seen as either a positive indicator of a decentralized grassroots-based response to AIDS or as a negative indicator of the failure of the government to adequately provide services and support community needs. According to an analysis by the Global AIDS Policy Coalition, however, the countries with the weakest overall NGO response to AIDS are not those with the lowest GNP (gross national product) per capita, but rather the countries that score most poorly on indices published by the United Nations Development Programme, Amnesty International and others, reflecting overall levels of freedom, gender equality, literacy and human development.

#### NGOs' Contributions

Because of their close contact with target communities, NGOs have been able to identify and address community members' needs. Because of their flexibility, they have been able to react quickly to fill gaps in health and social services.

At the community level, NGOs have been able to mobilize their target communities to respond effectively to the AIDS crisis. At the national level in many countries, they have helped fight denial and complacency and have succeeded in keeping AIDS on the agenda. Their most valuable role, however, has been to experiment with innovative approaches to prevention and care and to generate a variety of proven, replicable models.

NGOs have also been able to spur governments to action, as the experience of Chikankata Salvation Army Hospital illustrates. In the five years since this Zambian hospital instituted the concept of home-based care of people with AIDS in Africa, several other models of home care have emerged, and scores of governmental and nongovernmental organizations have become active in such work in virtually every country in sub-Saharan Africa. In fact, stimulating and sup-

porting home- and community-based care is now an integral part of national government policy in all African countries.

It is worth remembering that this movement to community-based care began with one small mission hospital providing a service to the population in just one of the country's 58 districts. By winning government endorsement, however, the hospital was able to help rewrite policy and reorient health services to respond to the changing needs of the entire country's population. Government support has helped ensure wide replication of the model and increased the likelihood of long-term viability.

NGOs and AIDS in the Second Decade  
Clearly NGOs will continue to be at the forefront of the response to AIDS in most countries. But what will be their role in the second decade of the HIV/AIDS epidemic?



A GHANAIAN FAMILY,  
BECAUSE OF THEIR CLOSE CONTACT  
WITH TARGET COMMUNITIES, NGOs HAVE BEEN  
ABLE TO IDENTIFY AND ADDRESS  
COMMUNITY MEMBERS' NEEDS.

Paul Amos/WHO



**MINERS IN ZAMBIA.** THE COPPERBELT HEALTH EDUCATION PROJECT PROVIDES PREVENTION, CARE AND SUPPORT TO PEOPLE IN ALL EIGHT DISTRICTS OF THE COPPERBELT PROVINCE, WHERE COPPER MINING PRODUCES 80 PERCENT OF THE COUNTRY'S EXPORT EARNINGS.

At least some of the first group of NGOs established to address HIV have burned out. But many have dealt successfully with the countless problems of starting up, identifying a role, developing a plan of action, obtaining the necessary approval and funds, and learning by doing.

Today many of the older NGOs that overcame these problems are now facing a new challenge: how to live with success. My experience with the Copperbelt Health Education Project in Zambia<sup>3</sup> is one example of the pitfalls encountered by successful NGOs.

I started the Copperbelt Health Education Project in 1987 with one field worker and one ancient, manual Olivetti typewriter in a spare bedroom of my flat. Today the project provides prevention, care and support to people in all eight districts of the Copperbelt Province and has about a dozen full-time staff members, project vehicles, a battery of computers, offices and storerooms, an advisory committee and a large and growing budget.

Success changed our project in many ways. To respond to the growing need around us, we had to expand the scope and coverage of our work, but we were determined to do so efficiently and professionally. We had to get professional advice to strengthen our filing and accounting systems. Univer-

sity-trained researchers, administrators and accountants joined the project as full-time or part-time staff, and sometimes there was friction between these newcomers and the old guard who had set up the project. In the early years, we were a close-knit team. When I left in 1991, we had an organizational chart, job descriptions and specified lines of communication.

#### The Challenge

The challenge facing NGOs in the next few years, O'Malley writes, is "to recognize their strengths as well as their limitations and to demonstrate their efficacy in confronting a new, more differentiated and widespread pandemic."<sup>4</sup> They will need to do their work more efficiently and cost-effectively in a climate of shrinking resources and interest fatigue.

Older NGOs have the additional responsibility of tapping and channeling the energy and enthusiasm of new groups. Sometimes this can be very difficult. In Uganda, for example, the government and more established NGOs are pursuing a policy emphasizing community development and support to extended families providing care to the increasing number of children whose parents have died of AIDS. On the other hand, NGOs have set up as many as 60 different orphanages, threatening to undermine efforts

to empower communities to provide foster care for the many children who will never be cared for in an institutional setting.<sup>5</sup>

Relationships between older and new NGOs can be tricky. New NGOs may resent and even reject any suggestions. Some may accuse the more established NGOs of gauging up on them with the government.

But cooperation between government and NGOs — and among NGOs — is essential to mounting a coordinated, effective response to the AIDS pandemic. In some countries, such cooperation may never happen, but we need to start by sharing information, experience and expertise.

NGOs must move from confrontation to real collaboration with governments so that there is real community input into the policy development process. Yet they must do so without selling out and losing their identity and respect, which enable them to respond effectively to the needs of target communities. Success in containing HIV/AIDS may depend on NGOs' ability to achieve this difficult balance.

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#### References

1. O'Malley, Jeff. AIDS Service Organizations in Transition. In: AIDS in the World. J. Mann, D.J.M. Tarantola and T.W. Netter, eds. Cambridge, Massachusetts: Harvard University Press, 1992, pp. 774-787.
2. Coalition Building: NGOs at Work. In: AIDS in the World, pp. 305-311.
3. All Against AIDS: The Copperbelt Health Education Project, Zambia. Strategies for Hope Series No. 7. London: ACTIONAID (in association with AMREF and World in Need), 1993.

# AIDSCAP:

## Reaching Communities Through Local Organizations

In more than 30 countries in Africa, Asia, Latin America and the Caribbean, the HIV prevention programs of the AIDS Control and Prevention (AIDSCAP) Project rely on the proven ability of nongovernmental organizations (NGOs) to reach community members.

More than 70 percent of AIDSCAP activities are carried out by local community-based organizations and other NGOs, as well as U.S.-based private voluntary organizations (PVOs).

This emphasis on working with NGOs reflects the priorities of the U.S.

Agency for International Development, which funds AIDSCAP.

"Community-based organizations offer an important way to reach diverse population," said Dr. Helene Gayle, USAID's HIV/AIDS coordinator. "They have the greatest capacity to develop programs on the ground, to address different populations at risk, to mobilize communities and to reach people and talk to them about real issues."

Many of these groups have been working with and in communities for years, AIDSCAP Director Peter Lamptey said. "They have a thorough understanding of the cultural, political, social and economic climate of local communities."

AIDSCAP builds on this knowledge and experience by helping NGO staff members strengthen their technical and managerial skills. Improving local capacity in program design, implementation and evaluation is the central objective of the AIDSCAP program, Dr. Lamptey explained.

"Donors and local governments must continue and increase their support for AIDS prevention, but their efforts will not succeed without active community involvement," he said. "Ultimately, success in containing the epidemic will depend on whether community-based groups can expand, improve and sustain AIDS prevention efforts."

AIDSCAP works with more than 100 PVOs and NGOs to carry out comprehensive programs to reduce sexual transmission of HIV. These groups reflect the range of organizations who are taking on AIDS prevention, from local community development and health NGOs to women's associations, trade unions, and local church, youth and community groups.



A GROUP OF WORKERS IN A FACTORY EMPLOYED WITH SUPPORT FROM AIDSCAP, THE ASIAN INSTITUTE FOR HEALTH AND DEVELOPMENT OF MAHIDOL UNIVERSITY IS USING INFORMATION FROM SEVERAL OTHER SOURCES TO DESIGN HIV PREVENTION PROGRAMS AT FACTORIES IN FOUR DISTRICTS IN BANGKOK.

■ AIDSCAP partners in Tanzania include the African Medical and Research Foundation, the Health for All Volunteers Trust, a consortium of 21 NGOs known as TACOSODE, and a grassroots organization known as WAMATA (Waliokatika Mapambano Na AIDS Tanzania). One example of the collaboration between AIDSCAP and a local NGO, a workplace AIDS prevention project carried out by the Organization of Tanzanian Trade Unions through its member unions in 28 companies, has already trained more than 6,000 peer educators and educated more than 60,000 workers.

■ In Brazil AIDSCAP works with Grupo Pela Vidda, the Institute for Religious Studies, the Brazilian Union Against STDs, Childhope and the Organization for the Support of HIV-Positive People, among others. In Rio de Janeiro, AIDSCAP-supported outreach efforts by the Associação Brasileira Interdisciplinar de AIDS (ABIA) have reached more than 40,000 men who have sex with men through 277 trained peer educators.

■ In Thailand AIDSCAP collaborates with the Thai Red Cross, Chiang Mai Pharmacists' Association, the ASEAN Institute for Health and Development, the Planned Parenthood Association of Thailand and World Vision, as well as national and municipal government agencies. AIDSCAP is also improving the AIDS prevention efforts of 40 Thai NGOs by giving the NGOs Against AIDS Consortium technical support in policy advocacy and information dissemination.

CASCO



A VOLUNTEER HEALTH EDUCATOR DISCUSSES AIDS PREVENTION WITH THREE YOUNG MEN IN A BARBERSHOP IN SANTO DOMINGO IN THE DOMINICAN REPUBLIC. TWO LOCAL GROUPS, COORDINADORA DE ANIMACION SOCIAL URBANA (CASO) AND INSTITUTE DOMINICANO DE DESARROLLO INTEGRAL (IDDI), ARE JOINING FORCES TO EXPAND THIS AIDSCAP-SUPPORTED ADOLESCENT HIV PREVENTION PROJECT TO INCLUDE FAMILIES AND OTHER MEMBERS OF THE COMMUNITY.



Photo Courtesy: AIDSCAP

A SCENE FROM A PERFORMANCE OF *Blitz*, AN AIDS EDUCATION DRAMA BY THE AIDSCAP-SUPPORTED MICHIZI THEATRE TROUPE IN KENYA. AIDSCAP IS COORDINATING THE THEATRE TROUPE'S COLLABORATION WITH A USAID-FUNDED CONDOM SOCIAL MARKETING PROJECT AND WITH LOCAL NGOs WORKING IN HIV PREVENTION.

# Community Mobilization for AIDS Prevention in Bangkok

by Chamantong Tanasugarn, Mahidol University,  
and Pawana Wiemawee, AIDSCAP

A sprawling city of 8 million people with an increasing HIV seroprevalence rate, Bangkok presents a formidable challenge to AIDS prevention program planners. How can we know where and how to reach people with relevant prevention measures in what often seems like an anonymous urban culture? And how can we ensure that prevention messages will be relevant to all the diverse populations at risk?

Community mobilization<sup>1</sup> offers an approach to defining and working with large urban populations through social networks. In Thailand the AIDS Control and Prevention (AIDSCAP) Project contracted with the Faculty of Public Health (FPH) of Mahidol University to work with the Bangkok Metropolitan Administration (BMA) to apply community mobilization methods to AIDS prevention. This pilot project is part of AIDSCAP's larger Comprehensive Bangkok Program (CBP), whose goal is to check the sexual spread of HIV among the 1.5 million people ages 15 to 29 in Bangkok.

## Social Networks and Community Mobilization

Social networks are the engine of community mobilization. In this context "networks" are defined as groups of individuals who meet and socialize regularly through work or leisure. The size of networks may range from just a few individuals (for example, a pharmacy owners' club) to dozens or even hundreds of people (assembly-line workers).

Social networks have been instrumental in efforts to convince their members to adopt safer behavior to prevent HIV. Notable examples include the San Francisco gay community in the mid-1980s, a street outreach intervention project with injecting drug users in Chicago<sup>2</sup> and a city-wide prevention program for Bangkok heroin addicts in the late 1980s. The networks provide the means by which network members acquire information and skills and adopt new behavioral norms. Eventually a social consensus is reached, and safer behavior is adopted and may be maintained.<sup>3</sup>

The methodology of community mobilization varies somewhat, but most applications include the following steps:

- Identify a local group or committee as the potential stakeholders in the long-term effort.
- Conduct a community network diagnosis.
- Strengthen community networks.
- Work with community members to design and carry out interpersonal outreach and mass communication programs that target the networks.

The foremost application of community mobilization techniques was the Communities That Care project to attack drug abuse in U.S. cities.<sup>4</sup> The authors describe a preparation process that may take as long as a year.

With the HIV epidemic, however, time is short. Fortunately, in Bangkok the preparation process was accelerated



Zana/WHO

by the BMA's independent formation of District AIDS Committees (DACs) in each of the city's 36 districts. District administrative officials had been appointed to each committee along with health center staff, police chiefs, and representatives of business, NGOs and nighttime entertainment establishments. The existence of these committees allowed the project team to move quickly to the next phase of the process: network diagnosis.

## Conducting a Community Network Diagnosis

**Step 1:** Contact the local district steering committee and community representatives.

Project staff first identified key members of the District AIDS Committees in the six pilot districts, including the chairperson of the DAC, the district's health section officer and the community development section chief. These people were asked how they perceived the threat of AIDS in the community and how they would plan a program.

This process is important to tap local wisdom early on and create a sense of ownership among local officials. It also helps program planners assess local leaders' understanding of AIDS prevention and identify potential barriers. For example, one common solution proposed by local officials was widespread HIV testing. By identifying this bias early, the project team was able to persuade local leaders to support more constructive and cost-effective prevention strategies.

**Step 2:** Create teams of resource people to work with local committees and obtain clearance to appoint these resource people to the committees.

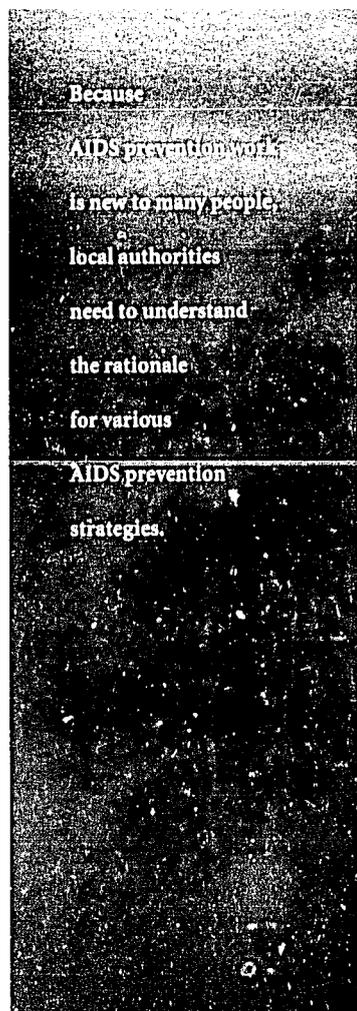
Because AIDS prevention work is new to many people, it is not sufficient to orient local leaders and AIDS committees to project goals. DAC members and local authorities also need to understand the rationale for various AIDS prevention strategies. To educate them about AIDS prevention strategies, the project trained six teams of three staff members, each assigned to one of the six pilot districts. Thai AIDS experts gave weekly presentations to the six teams, enabling them to present this information to the local groups and cite reputable sources.

After several meetings and discussions, project managers convinced the BMA's top policy makers to appoint a representative of the pilot project to each of the six DACs. These links were essential to the remaining steps of a community network diagnosis and to the entire mobilization process.

**Step 3:** Map the communities in each district.

Before community mobilization could occur, the project teams and DACs needed a systematic way of identifying existing or potential networks. In the six districts of the CBP pilot area, the mapping process required two months and relied on secondary and first-hand information gathering.

With the help of the DACs, the project team obtained area maps, which were enlarged and systematically filled out using symbols to represent



places of employment, low-income residences and popular gathering sites. Local post office personnel were particularly helpful in this phase, but ultimately the project teams had to canvass the district on foot and by motorcycle taxi to verify and update the map entries.

**Step 4: Conduct key informant interviews and focus group discussions.**

Ideally a complete community network diagnosis should reveal the number of people in each work site or gathering place and the names of local leaders and respected peers. In the one year available to this pilot project, it was not possible to do such a detailed assessment. Instead, with the help of the DACs, one or more key informants were chosen from each type of work site and gathering place.

represented such diverse locations as beauty salons, pharmacies, slum housing projects, factories, commercial sex establishments and bus terminals.

Topics covered included network definition, community development needs, the threat of AIDS and the potential for group activities.

These discussions also provided valuable insights about whether members of different networks might perceive themselves to be at risk for HIV. Bus terminal workers, for example, had the impression that the mostly married minibuss drivers were at low risk for contracting HIV because their wives either ride with them in the bus or keep a close watch. The younger fare collectors are considered at higher risk because "they are single and like to visit the snooker halls," which have young, female score keepers.

Male and female construction and factory laborers also did not perceive HIV as a risk for members of their network. "AIDS is a disease of the ignorant and younger generation," they said.

**Step 5: Construct a set of network maps that portray how individuals interact within networks and how networks are linked together in the broader community.**

The project teams, along with key DAC members, synthesized the data from the physical maps and the key informant interviews to redefine each district in terms of existing and potential networks. An example of a network map for selected groups is shown in Figure 1.

As might be expected, relationships varied from superficial to casual to close. Because employed persons working in Bangkok spend so much time at the work site, there is little distinction in a social network between work-related and personal interaction. In Thai society in general, work and personal relationships blend to a greater degree than in the West. Meals and drinking provide important opportunities for closer interaction.

The maps helped the project team visualize another important feature of the Bangkok networks: they overlap. Figure 2 shows a composite picture of how the networks might intersect through common contacts identified in the network diagnosis. These network intersections provide clear pathways for information and norms to travel and be reinforced through frequent interaction.



DRIVERS OF MOTORCYCLE TAXIS THOUGHT THE RISK OF AIDS WAS MORE OF A PROBLEM FOR ADOLESCENTS THAN FOR THEMSELVES.

Elizabeth Gould, M.D., MPH

Though not comprehensive, interviews with key informants enabled the project team and the DACs to make educated guesses about the number and size of potential networks for diffusing information about prevention options and images of a new social norm that reinforces low-risk behavior for HIV/AIDS.

Approximately 20 to 30 key informants were interviewed in each of the districts. The informants

The drivers and queue managers of motorcycle taxis, which are organized in hundreds of queues around the city, thought the risk of AIDS was more of a problem for adolescents than for their older-age network. "Cycle taxi drivers aren't promiscuous; they prefer to drink," key informants from this network explained. Women passengers, however, said they resist the advances of cycle drivers because they perceive these men as promiscuous.

## Converting the Information into Action

How does such information feed into an AIDS prevention program like the Comprehensive Bangkok Program? A social network analysis in this context should explain the relationships among network members so that informal leaders and groups that might be at risk for HIV can be identified. Members of these groups can play a role in suggesting strategies to reduce their risk."

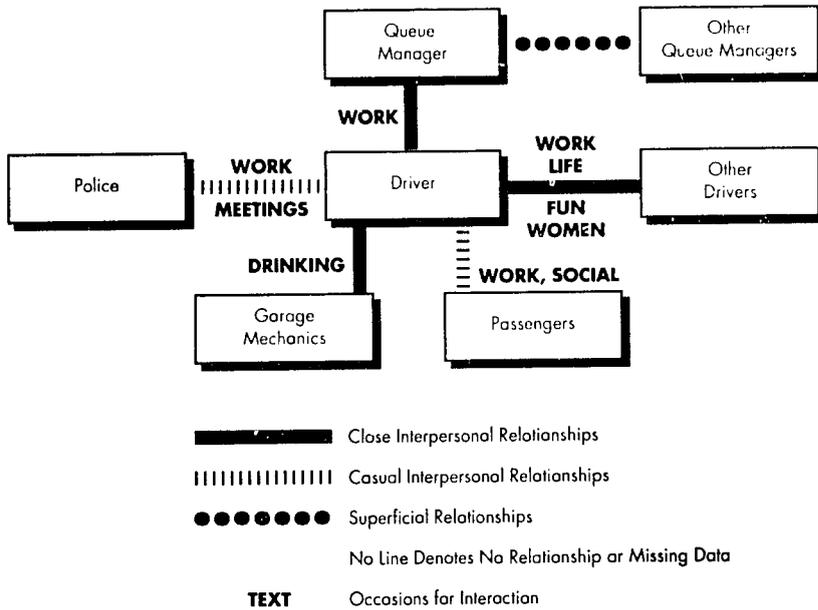


FIGURE 1  
SOCIAL NETWORK: MOTORCYCLE TAXI QUEUES

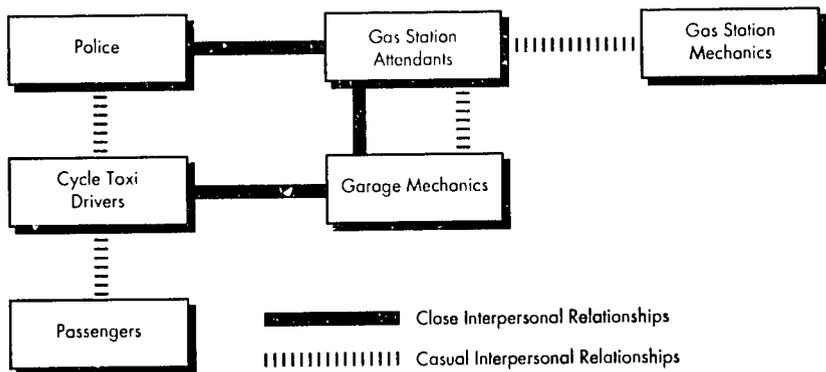
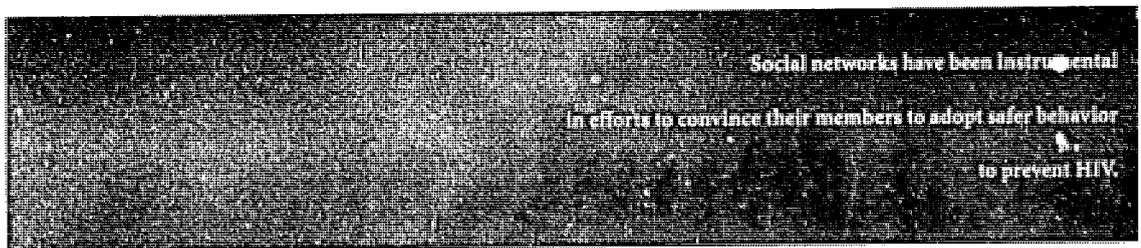


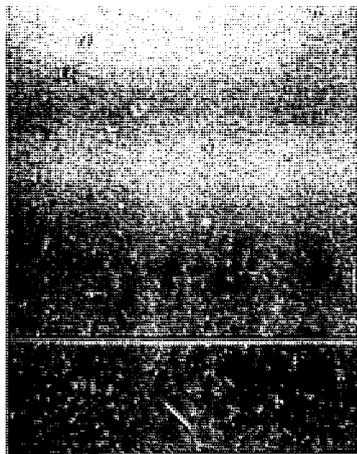
FIGURE 2  
SOCIAL NETWORK: COMPOSITE OF NETWORK LINKS

In the CBB, key informants were asked to suggest ways of approaching their networks to strengthen the network and promote AIDS prevention activities. They recommended times, locations, group sizes and formats for these activities.

Several informants volunteered ideas for attracting people to AIDS prevention meetings or events. A gas station manager suggested asking the emergency rescue group to make presentations in the evenings at gas stations to explain how to prevent infection when handling traffic accident victims. A gas pump attendant advised serving whiskey to ensure attendance. On a more serious note, factory workers and members of other groups thought it would be effective to have a person with AIDS speak to their coworkers.

This information was used to organize and schedule network-strengthening activities and is now being used to plan outreach education and mass media messages. While the community network diagnosis and DAC strengthening was being conducted (mid-1993), AIDSCAP was contracting with other agencies to provide outreach education to factory workers, low-income service workers, slum residents and commercial sex workers. These outreach activities are the technical, HIV/AIDS communication services provided through the networks identified and strengthened by the community mobilization process.

Tony Bennett/AIDSCAP



A WOMAN PASSES OUT ARTIFICIAL FLOWERS WITH CONDOM "BLOOMS" AT A COMMUNITY MEETING AS PART OF AN ICE-BREAKING GAME DESIGNED TO CREATE A MORE ATTRACTIVE IMAGE OF THE CONDOM.

## Strengthening Networks

The DACs, with technical support and guidance from the project team, worked to create and strengthen social networks in a number of ways. Through the local district office, the project arranged group meetings at convenient times and places for members of different networks. These meetings included group-strengthening exercises, such as small group discussions and interactive exercises to explore "myths and musts" about HIV/AIDS. Participants were encouraged to hold their own informal follow-up meetings.

The project organized other group activities designed to strengthen network communication and solidarity, including occasional parades, creation of group T-shirts and site visits to AIDS wards. One district arranged a visit for local vocational students to a Buddhist temple that serves as an AIDS hospice. The emotional impact of such an activity can forge enduring bonds.

## Lessons Learned: What we might have done differently

- The plan for this pilot project called for a three-month community mobilization process. But the community diagnosis step (which included mapping the community, observation and key informant interviews) required more time and effort than program planners had estimated. In this setting, with a target population of 250,000 to reach and an urgent problem to address, it would seem appropriate to set aside six months for network diagnosis, mapping and strengthening activities.
- Network strengthening activities should not turn into AIDS lectures. There was a tendency among the DACs to prefer one-way, factual communication on AIDS. Instead, other topics that might be relevant to the audience, such as work-related conditions and regulations or new services that might help them in their jobs, should be covered first, followed by interactive group exercises to create awareness about HIV and risk behaviors.
- The groups that will provide the outreach communication interventions should be brought in as soon as the DACs are formed and functioning to familiarize DAC and community members with these technical agencies and pave the way for outreach activities.

## Encouraging Results

- Members of the six DACs became more aware of the principles of AIDS prevention and their key members became active coordinators as a result of this project. This enabled NGOs to gain access to small factories, garages, entertainment establishments, construction sites and other network gathering places.
- The community mobilization effort provided a focal point for the AIDS implementing agencies to get to know each other and to feel part of a team, avoiding duplication of effort and mixed messages.
- A seminar that brought the six DACs together with the NGOs contracted to do AIDS communication and STD control boosted morale tremendously. A tangible feeling of being part of a larger effort emerged, and participants gained a better understanding of how their various projects fit together to achieve the common goal of promoting more responsible sexual behavior and slowing the spread of HIV.

An assessment of the impact of the community mobilization project in bringing together social networks, local AIDS committees and technical agencies must await the larger evaluation of the AIDSCAP Thailand program. But preliminary results of an evaluation of the pilot project suggest that community mobilization is an effective way of laying the groundwork for outreach efforts and identifying ways of reaching target audiences with HIV/AIDS prevention efforts.

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### References

1. Carlaw, R. W. et al. Organization for a community cardiovascular health program: experiences from the Minnesota heart health program. *Health Education Quarterly* 11:243-52, 1984.
2. Farquhar, John et al. Community education for cardiovascular health. *The Lancet*, pp. 1192-1195, June 4, 1977.
3. Hawkins, David et al. *Communities That Care*. San Francisco: Jossey-Bass, 1992.
4. Tweneboah-Kodua, A. et al. Ghana Social Mobilization Analysis. *Health Education Quarterly* 18(1):125-134, 1991.
5. Murray, David. Dissemination of community health promotion programs: The Fargo-Moorhead Heart Health Program. *Journal of School Health* 56(9):375-381, November 1986.
6. Wiebel, Wayne et al. Positive effect on HIV seroconversion of street outreach intervention with IDU in Chicago: 1988-1992. Paper presented at the IXth International Conference on AIDS, June 6-11, 1993.
7. Yos, Santasombat et al. Ethnographic research on Bangkok IV drug users: community outreach supervision in the AIDS intervention campaign for IVUDs. Faculty of Sociology and Anthropology, Thammasat University. Unpublished manuscript, May, 1990.
8. Romer, D. and R. Hornik. HIV Education for youth: the importance of social consensus in behaviour change. *AIDS Care*. 4(3):285-303, 1992.
9. Israel, B. Social networks and social support: Implications for natural helper and community level interventions. *Health Education Quarterly* 12:66-80, 1985.



UGANDA: COMMUNITIES OFTEN FEEL POWERLESS TO COMBAT AIDS.

SABIR UNO/EI

# Empowering Communities to Fight AIDS Through Participatory Evaluation

by Anne Coghlan, Cornell University, and Margaret Kabandu and Mary Jane Musungu, TASO

In response to an invitation to hear and comment on the evaluation results from a community-based AIDS program, more than 300 people gathered in the trading center of Biharwe in southwestern Uganda. The elders sat in the front, middle-aged women stood behind them, and young men leaned in through the windows. All listened intently to the man standing in the middle of the community building.

"We asked people if they agreed that many men in this community are now using condoms," said TASO Community Trainer Samson Baryajunaki. "How many of you agree with this statement now?"

Very few people raised their hands. "Ah, I see you're shy," Mr. Baryajunaki said. "Well, over a year ago, 26 percent of those we asked told us they agreed

that many men are now using condoms. When we asked again several months ago, after the program had been operating in Biharwe for almost a year, 36 percent agreed. What do you think of this? Why was there a change and what does it mean for Biharwe?"

A village elder rose. "From these and other results you have given us," he said, "You should continue to give us condoms."

This dialogue about condom use occurred during a field test combining participatory evaluation methods with more traditional techniques to assess the progress of The AIDS Service Organization (TASO) Community Initiatives program in Uganda. Evaluation presentation and feedback sessions like the one in Biharwe were one of several participatory methods used to give evaluators and community

members a better understanding of the programs' strengths and weaknesses, and to encourage greater community involvement in improving the program.

## Evaluating the TASO Community Initiative

Approximately 1.5 million people in Uganda, or roughly 8 percent of the entire population, are infected with the HIV virus.<sup>1</sup> Estimated HIV prevalence ranges from 25 to 30 percent in the capital city of Kampala and is as high as 50 percent in some trading centers along the main highway, but as low as 1 percent in some rural areas.<sup>1,2</sup>

Given the prevalence of HIV infection in Uganda, the devastating impact of AIDS and limited government resources, it is essential that communities be involved in promoting

sexual behavior change, caring for people with AIDS and building capacity to sustain AIDS programs. Yet Ugandan communities often feel powerless in combating AIDS.

To empower people within their own communities to prevent the further spread of HIV and better support people with AIDS, TASO launched The Community Initiatives (TCI) program in 1990. Under this program, TASO trainers help community leaders form a village AIDS committee and identify community needs and objectives. Local leaders then select community AIDS workers (CAWs), who receive training from TASO in AIDS prevention education, counseling and care. These community volunteers conduct formal and informal educational sessions with groups and individuals, visit homes to provide counseling and assistance with care, distribute condoms and refer people for HIV testing and medical treatment.

During 1993 we field tested and revised an evaluation plan in two of the 17 TCI-supported communities. Process factors to be investigated included whether implementation conformed with the original program plan, whether the targeted number of people had been reached by various interventions, and what communities and participants thought of the program. The outcomes of program interventions would be assessed by examining changes in knowledge of HIV/AIDS, attitudes toward AIDS prevention measures and people with AIDS, community involvement and self-reported sexual behavior.

The primary data collection methods were a knowledge, attitudes and practices (KAP) survey, followed by focus group discussions and individual interviews with key informants. To further empower communities to combat AIDS and to generate richer data, we also used several participatory methods that involved community members in data collection, analysis and interpretation.

#### Community Involvement in Data Collection

Because of the need to maintain confidentiality and the technical skills required, community members did not conduct the survey interviews, but they

were involved in data collection in other ways. For example, to select households to be included in the KAP survey, we numbered all the houses, wrote those numbers on slips of paper, and asked a certain number of community members to pick one of the folded-up slips from a bowl. This involvement helped people understand the concept of random selection and dispelled their suspicions that TASO only visits those who have the stigmatized "slim" disease.

Community members also served as escorts for TASO interviewers, helping them gain entry into people's homes. Although the impact of both of these techniques has not been fully evaluated, we believe they helped lower the refusal rate, as well as developing new supporters of the program.

#### Community Participatory Assessment

In a community participatory assessment, community members review program objectives, determine which of those objectives have and have not been achieved, and plan what they need to do in the future. For our field test we also hoped to use the assessment as a qualitative method of inquiry, so we conducted it as one of several focus group discussions. However, by guiding the discussion too much, we failed to facilitate the participant's through a process of critical reflection. We now see that community participatory assessments should be a separate event that participants conduct by and for themselves.

#### Participatory Data Analysis and Interpretation Sessions

After the data were collected and analyzed by TASO headquarters staff, the preliminary results were given to the community trainers. We spent three very intense days with the trainers reviewing basic data interpretation procedures, interpreting the data and reaching consensus about how to best answer the various evaluation questions.

Interpreting the data with the community trainers enhanced the evaluation — and the program — in a number of ways. The trainers' knowledge of local languages, customs and sexual practices enabled us to expand and verify both the qualitative and quantitative data, which gave us a

much richer understanding of the program within specific communities. The trainers also identified problem areas in their own work and possible solutions.

Community trainers gained valuable technical skills through their participation in data analysis and interpretation. In fact, one trainer asked, "How can I find out more about these significance tests you keep talking about? TASO should train us more in this work so we can do it ourselves."

#### Evaluation Presentation/Feedback Session

After the data were interpreted and a preliminary report written, we wanted to return the results to the community. To do so, we worked with community trainers in each field test community to organize evaluation presentation/feedback sessions like the one described in Biharwe. These sessions were designed to inform community members of evolving and more positive sexual norms, show them the value of the program, and enable them to use the results to improve the program. Community feedback during these sessions would also help us further verify and enrich the collected data.

Both events were major mobilizers, drawing an average of more than 300 adults. People were curious to learn what the program was doing and to hear the results of the survey and interviews. Presenters began by asking the audience to predict the results of a particular question, then gave the actual results obtained through the evaluation exercises. Finally, the audience was asked to interpret what the results meant for the community.

People learned that there was greater change among program participants than non-participants and that the program was indeed achieving some of the community's objectives. They also learned that the program needed greater community responsibility and support. At the end of each session, many people pledged additional support to the program.

#### Lessons Learned

Through this process of encouraging audience participation, informing them of results and eliciting feedback, we achieved many of our objectives. The evaluation presentation/feedback

sessions affirmed the work of the community implementors, allowed us to disseminate more knowledge about changing sexual norms, and fostered greater community ownership of and support for the program.

We did not succeed, however, in helping community members transform their newly gained knowledge and enthusiasm into a concrete plan of action. A large community meeting did not provide the appropriate forum for such planning, and we had not planned any smaller follow-up meetings. In August 1994 we hope to facilitate community planning based on evaluation results by combining participatory data analysis, an evaluation presentation/feedback session and community participatory assessment into a week-long evaluation event in two more TCI communities.

This year's evaluation event will begin in each community with a meeting with community trainers, village committee members and CAWs to interpret the evaluation data. Together we will decide how to return the results to the community at large. Whatever method is chosen, the village committee members and community trainers will present most of the information themselves.

The day after this event, village committee members will hold a community participatory assessment with the CAWs and other community leaders. In this assessment, they will review the evaluation findings, critique

their own progress, identify the problems they face, reformulate objectives if necessary, and devise a new plan of action.

During the 1993 field test, we began to experience the advantages of merging participatory evaluation methods with more traditional

evaluation techniques. Building on what we have learned through this experience, TASO hopes to devise a model that can be used in all the TCI-supported communities, as well as by other community-based AIDS organizations, to further empower communities in their fight against AIDS.



TASO INTERVIEWERS AND LOCAL ESCORTS PREPARE TO VISIT HOMES.

Anne Coghlan/Cornell University

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#### *References*

1. Barnett, T. and P. Blaikie. AIDS in Africa: Its Present and Future Impact. New York: The Guildford Press, 1992.
2. Wawer, M.J., D. Serwadda, et al. Dynamics of the spread of HIV-1 infection in a rural district in Uganda. *British Medical Journal* 303:1303-6.



SEX WORKERS ARE TRAINED TO EDUCATE THEIR PEERS ABOUT THE IMPORTANCE OF CONDOM USE AND HOW TO GET THEIR CLIENTS TO USE THEM.

Upong/University of Calabar, Photo Department

## Women of Courage: Commercial Sex Workers Mobilize for HIV/AIDS Prevention in Nigeria

By Eka Esu Williams, Calabar AIDSCAP Project

A widow in her forties, Monica works as a prostitute in the hotel where she lives with her three children. When her husband died 11 years ago, his family could offer Monica and her children no support. She tried to find work, but had never been to school and had no skills, so she had to turn to commercial sex work. Monica still prays for a time when she will not need to depend on sex work to feed her family.

But Monica finally has some hope that her life will improve. Last year she graduated from a vocational training program, where she learned to read, write and bake. In one of her classes she also learned how to protect herself from HIV infection. Now she sells

cakes in the neighborhood around the hotel. The money she makes is not enough to support her family, but this extra source of income does allow her to refuse clients who will not use condoms.

Monica acquired her new skills through a vocational program for commercial sex workers (CSWs). The program is operated by Nka Iban Uko (Women of Courage), a nongovernmental organization established by CSWs with help from advocates and training specialists from the Calabar Project and financial support from the Cross River State AIDS Committee and the USAID-funded AIDS Control and Prevention (AIDSCAP) Project.

Now part of AIDSCAP's HIV prevention program in Nigeria, the Calabar Project started working informally with CSWs in 1987. With funding from the University of San Francisco's Center for AIDS Prevention Studies, the project conducted a small knowledge, attitude and behavior study that year. In 1988 formal project activities began as a community-based intervention to help prostitutes protect themselves against HIV. As it became evident that CSWs' vulnerability to HIV infection stemmed from their low self-esteem and lack of skills and economic opportunities, the project expanded to include literacy and vocational training and advocacy for

better working and living conditions. By 1993 the majority of CSWs in Calabar and the nearby border town of Ikom reported using condoms with all their clients.

#### HIV and CSWs in Nigeria

In the 1980s HIV/AIDS was far from the thoughts of many Nigerians. Most people were uninterested in what was considered a gay disease, or one common among CSWs in other parts of Africa. Few people in Nigeria knew anyone with HIV/AIDS.

The early association of HIV/AIDS with CSWs was unfortunate because it gave people another reason to stigmatize these women. Socially and culturally it was difficult for health and community workers to reach out to CSWs.

CSWs in Nigeria are harassed by the police, exploited by their managers and shunned by their communities. They accept this treatment as part of their work. In the hotels where they live and work, the decisions of the owners, managers and clients are paramount. The women are sure to lose any dispute because the hotel owners and managers, who want to encourage a continuous flow of men into the hotels to ensure that drinks are sold and that women pay their room rents regularly, will always side with a client.

Their inability to fairly negotiate with clients, hotel managers and law enforcement agents, coupled with societal stigmatization of prostitution, lead to very low self-esteem among CSWs. They see themselves only as society perceives them, commonly referring to one another as "ashawo" (a derogatory local word for CSWs) and to their children as "ashawo pikin."

Most prostitutes in Calabar are in their early twenties and thirties, though some are in their teens and others are between 40 and 60 years old. For most, commercial sex work is not a vocation of choice. Many of the women say they are desperate to support themselves



Ukpong University of Calabar, Photo Department

THE PROJECT CONCENTRATED ON REACHING CLIENTS ONE-ON-ONE THROUGH THE SEX WORKERS THEY SPENT TIME WITH.

and their families as a result of widowhood, divorce, lack of economic alternatives, or other social problems such as infertility and abandonment. To earn a living, they depend on their ability to attract a large number of clients — something they frequently pray for.

#### Gaining Acceptance

Before the Calabar Project could undertake an intervention with CSWs in Calabar and Ikom, we had to overcome some resistance. First, to gain access to the CSWs, we had to convince the hotel owners and managers that it was in their best interest to allow us to talk to the women.

We began by talking to the owners and managers about the potential damage to their businesses if CSWs were believed to be spreading HIV. Another persuasive point was that our condom promotion efforts would reduce problems with clients seeking refunds because they would claim (sometimes fraudulently) that a CSW had given them an STD. These claims usually resulted in fights between clients and prostitutes, which attracted police attention and discouraged business. Over time, the owners and managers accepted that the project could help them deal with these problems and perhaps increase their income.

We also had to win the women's confidence. At first they were indifferent or openly hostile to the project staff. Ignorant or misinformed about HIV/AIDS, fearing more harassment or a threat to their livelihood, they refused to talk to us. On one occasion we were chased from a hotel by a CSW who wanted us to leave because her girls "needed the vitamins and food (believed to be found in semen) and not condoms, which would dry them up."

Project staff began attending hotel owners' association meetings to advocate for the CSWs' welfare. As we helped them cope with some of their community problems, such as police harassment and lack of access to health services, the women became more receptive to learning about HIV prevention. They realized that we were genuinely interested in their overall welfare and began to take our message seriously.

Some advocacy efforts also improved the women's ability to protect themselves against HIV infection. For example, we negotiated with hotel owners to keep room rents stable for one year. This enabled the women to increase their charges for sexual services as a strategy for reducing the number of clients they saw and

**A customer refusing to use condoms is likely to be rejected by all the sex workers in a hotel.**

ensuring compliance with condom use while maintaining adequate income.

Although we started working with the CSWs in Calabar in 1987, formal project activities did not begin until the end of 1989, when we secured funding from the USAID-funded AIDSTECH Project to provide full-scale AIDS education, condom promotion and STD services. In this 18-month period project staff developed strong relationships with community members while offering informal HIV/STD prevention education. These relationships with the CSWs and other key members of the community were vital to the success of the project.

#### The Calabar Project

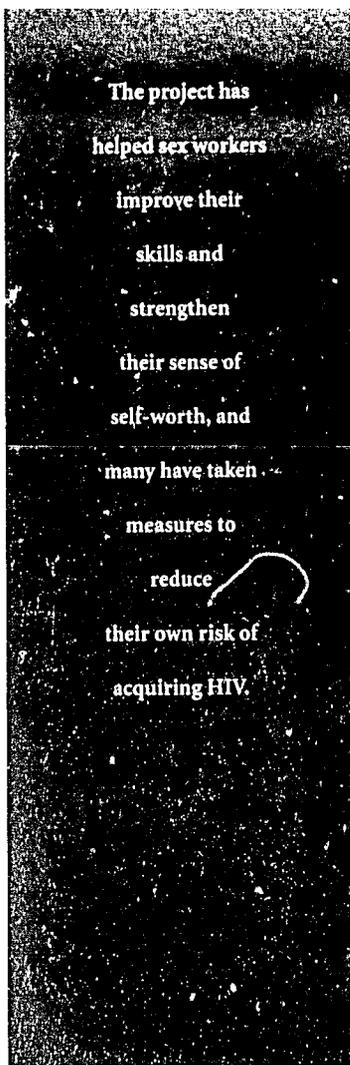
Once we had overcome their initial hostility and disinterest, we found that CSWs, hotel owners and managers, and a few clients were keen to know about HIV/AIDS and STDs and to have access to condoms and STD services.

In consultation with the CSWs and their clients and the hotel owners and managers, the Calabar Project was designed to provide health education through on-site educational sessions, group discussions, film shows, distribution of educational materials and outreach by male and female peer educators.

Peer educators were chosen from among the CSW leaders in each hotel. In most hotels the CSWs elect a chairlady and two officers. The chairladies and their officers were trained to educate the CSWs about the importance of condom use and how to get their clients to use them.

Clients proved harder to reach than CSWs. They did not congregate in large groups, and follow up was impossible because they refused to give their names. To overcome these obstacles, we concentrated on reaching clients one-on-one through the CSWs they spent time with. We also encouraged managers to provide information and education to small groups of clients in the hotel bars.

During the early years of the project peer educators and outreach workers distributed free condoms at all project sites and at the project's STD clinic. They promoted the health and economic benefits of condom use, emphasizing the savings CSWs would realize from using condoms regularly



instead of having to buy expensive antibiotics. (More than half the women reported taking antibiotics daily to prevent STDs.)

These condom promotion efforts were successful, but inadequate supplies of affordable condoms hampered early efforts to expand the Calabar project to other cities. To overcome this obstacle, we instituted a cost-recovery program, allowing chairladies to make a small profit from selling condoms, and established links with Population Services International's social marketing program to ensure a more reliable, accessible supply.

In addition to health education and condom promotion, outreach workers and peer educators encourage CSWs and their clients to attend the project's clinic for STD diagnosis and treatment. The number of patients at

the clinic every month increased steadily from 16 in the first month to its peak of 161 nine months later.

#### Women of Courage

As the project progressed the CSWs became increasingly aware of their vulnerability to HIV infection. They recognized the need to use condoms to protect themselves but found it difficult to convince their clients to use condoms. Powerless to negotiate condom use with their clients and anxious to improve their self-esteem, many CSWs expressed the desire to develop vocational skills in order to reduce their dependency on commercial sex and particularly to exclude non-condom-using clients.

Most of the women were handicapped by their inability to read and write, and found it difficult to understand some of the complex issues related to HIV/AIDS. For example, they believed that because HIV/AIDS and STDs were transmitted in the same way, the same treatments would be effective against both. The concept that AIDS has no cure was difficult for them to grasp, as was the idea of a long incubation period without overt symptoms.

In response to these needs, we helped the women form Nka Iban Uko, a group made up of CSWs, community advocates and vocational specialists, and started a training center in Calabar in 1993. The center gives CSWs, particularly young girls, opportunities to acquire skills through vocational training and to learn how to read and write.

Training in literacy and vocational skills, including soap making, baking and cooking, dressmaking, needlework and beadwork, is provided by civil servants as a contribution from the Adult and Nonformal Education Unit of the Ministry of Education. They use a health curriculum to teach reading and writing so the CSWs can learn about HIV/AIDS and STDs, use of condoms, genital hygiene and other health concerns at the same time.

In its first year the Nka Iban Uko Center graduated 25 women in literacy and vocational courses. Forty women have enrolled in the 1994 program, and some of the 1993 graduates have expressed a desire to learn more skills.

LITERACY CLASSES OFFERED BY WOMEN OF COURAGE,  
THE SELF-HELP GROUP FORMED BY THE SEX WORKERS,  
USES A HEALTH CURRICULUM TO TEACH  
READING AND WRITING.



Ukpong/University of Calabar, Photo Department

### Making Progress

Since 1987, the Calabar Project has reached thousands of CSWs and their clients with HIV prevention messages and condoms. Although some of the women have moved to other cities, approximately half have remained with the project. These women are a valuable resource for ensuring that the project continues. New CSWs are routinely informed about HIV/AIDS, STDs and clinic services, and condoms are readily available to hotel-based workers and their clients.

Data from surveys and clinic records suggest that our efforts to help protect these women and their clients from HIV infection are succeeding. Within the first year of the intervention the percentage of women never using condoms fell from 25 percent to 3 percent. In our most recent survey, conducted in 1993, more than 60 percent of the women reported condom use in all sex acts.

Compliance with condom use increased as the CSWs became a more cohesive community and learned to work together to identify and pursue common goals. It can be very difficult for an individual prostitute to negotiate condom use, but today in Calabar, a customer refusing to use condoms is likely to be rejected by all the CSWs in a hotel.

The Calabar Project does not emphasize the need to leave prostitution. However, we find that some women are so concerned about their continuing safety that they seek assistance in setting up other businesses. We try to encourage the women

to establish businesses in small groups to increase the likelihood of success. Some training center graduates now supplement their incomes by selling their own cookies, cakes and soap.

Overall this HIV/AIDS intervention project and its vocational training and literacy programs have increased the confidence and self-esteem of CSWs in Calabar. They have demonstrated their ability to articulate and present their perspectives and needs to others as a community and to educate their peers and clients about HIV/AIDS

and other STDs. They have also improved their skills and strengthened their sense of self-worth, and many have taken measures to reduce their own risk of acquiring HIV.

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*Eka Esu Williams, Ph.D., is a senior lecturer in the department of biological sciences at the University of Calabar in Nigeria and field manager of the Calabar AIDSCAP Project. She is also a founding member and the current president of the Society for Women and AIDS in Africa.*

# Improving NGO Collaboration in AIDS Prevention in Rural Haiti

by Valerie Stetson and Maryse Narcisse-Prudent, *Save the Children*



AS THE EPIDEMIC SPREADS TO RURAL AREAS AND AFFECTS WOMEN AT THE SAME RATES AS MEN, A NEW FOCUS IN PREVENTION IS NEEDED.

Perkel/UNICEF

For Jocelyn Gracia, a young single mother in the rural village of Cange in Haiti's Central Plateau, moving to Port-au-Prince "was a way out." Cange's eroded, mountainous slopes offer little sustenance to the area's peasant farmers. With no other source of employment, Jocelyn "saw how poor we all are, how the old people were finished."

In Port-au-Prince she met a driver who helped her get a job as a maid and fathered her second child. After losing her job, she was befriended by a soldier, who supported her and her children. But Jocelyn became ill with AIDS and returned to Cange to die among her relatives.

Jocelyn's story is tragically familiar. What makes it unique is that Jocelyn is the heroine of an AIDS prevention video produced by Zanmi Lasante (Health Friends), a local nongovernmental organization (NGO), with women health agents from Cange. These women helped develop the script for the video, which is based on a true story, and portrayed many of the main characters.

Entitled "Chache Lavi, Detwi Lavi" (literally "looking for life, destroying life," in Haitian Creole), the video was designed for use in AIDS education sessions with rural women. The story of how AIDS affected one woman from their own area stimulates discussions about questions surrounding AIDS in their communities. As the discussion evolves, it soon becomes clear that vulnerability to HIV infection and the

ability to prevent it are linked to broader issues of peasants' access to land, political problems and male/female power relationships.

After watching the film, one group of rural women insisted that Jocelyn was not promiscuous. "Poverty forced her to go from one partner to the next searching for a way to support herself and her children," they explained.

The women also discussed a common dilemma. "We know we have to use condoms. But men refuse. When we ask our husbands or partners to use them, they think we have a lover." They were determined that things would be different, somehow, for their children, and vowed to talk to their children about AIDS. "Even if they are too poor and vulnerable, we have to try," they said.

"Chache Lavi, Detwi Lavi" addresses issues that many health and development specialists in the Central Plateau are grappling with, but until recently the video was unknown to other NGOs in the region. This is because political instability, extremely poor roads and inadequate communi-



THE WOMEN VOWED TO TALK TO THEIR CHILDREN ABOUT AIDS.

Winter UNICEF

cation networks inhibit effective collaboration among the NGOs. Zanmi, which covers an area with a population of about 30,000, is one of about 10 NGOs located in the Central Plateau region. Collectively these NGOs reach 500,000 people.

Many of the local NGOs are headed by Haitian physicians and public health specialists. Recognizing the need for a systematic and strategic approach to AIDS prevention in the

Maissade District of the Central Plateau since 1986 in a community development program that includes health, nutrition, women's literacy training and income generation. To organize the coalition, we used the same community development process that we usually apply to community-based rural development projects with village development committees and leaders. This process includes:

- an inventory of NGO service needs and resources,
- joint collaborative planning to develop project activities,
- clear designation of the roles and responsibilities of Save the Children as coalition coordinator and the NGOs as coalition members, and
- establishment of a monitoring process.

Based on the needs and resources inventory of NGO services, Save the Children worked with NGO leaders and field managers to design activities that would appeal to both the individual interests of the NGOs and to their desire to work collectively.

Women — particularly adolescent girls — are the coalition's target audience. "Until now, most AIDS prevention work in Haiti has been done in urban areas," said Dr. Eddy Génécé, AIDSCAP resident advisor in Haiti. "As the epidemic spreads to rural areas and affects women at the same rates as men, a new focus in prevention is needed."

The 10 participating NGOs and PVOs — Save the Children, International Child Care, Comité de

Vulnerability to HIV infection is linked to broader issues of peasants' access to land, political problems and male/female power relationships.



WOMEN — PARTICULARLY ADOLESCENT GIRLS — ARE THE COALITION'S TARGET AUDIENCE.

region, they began to discuss the possibilities for collaboration with Save the Children, a U.S.-based private voluntary organization (PVO), in 1992.

That year Save the Children developed the "NGO Coalition for the Prevention of AIDS and Sexually Transmitted Diseases (STDs) in the Central Plateau," a project funded by the USAID-funded AIDS Control and Prevention (AIDSCAP) Project. The coalition will coordinate the activities of local NGOs and PVOs to orchestrate a comprehensive regional AIDS prevention program.

Save the Children has been working with community groups in the

Winter UNICEF

Bienfaisance de Pignon, Caritas, Zanmi Lasante, MARCH, Profamil, Dispensaire et Maternité de Lajeune, Service Oeucmonique d'Entraide and ODEKKA — already reach women and adolescent girls through various community organizations and out-reach efforts. They provide most of Central Plateau's services in immunization, diarrheal disease treatment and nutrition. Many promote women's empowerment by organizing women's clubs that offer members access to credit, literacy training and health education.

Under the NGO coalition project, Save the Children provides technical assistance, training and materials to NGO and Ministry of Health staff in the region. Save the Children staff will collect and revise or develop training and communication materials for the NGOs to distribute and use. They will also work with AIDSCAP subcontractor Population Services International to help NGOs improve their condom distribution systems and to conduct a pilot condom social marketing project in the Central Plateau.

Since it began in June 1993, the coalition has worked to improve STD services in the region. Algorithms for treating STDs without laboratory diagnosis, which is not available at many clinics in the Central Plateau, were developed and approved by NGO and Ministry of Health representatives. The project also sponsored a group of 15 NGO physicians, nurses, laboratory technicians and health trainers to attend a training course in STD services and counseling at the national Cornell-Gheskio Institute.

These efforts are giving medical professionals in the region access to current information about STDs for the first time in many years, said Paul Farmer of Partners in Health, a coalition member.

"When you see doctors and nurses who are really isolated in the middle of central Haiti begin to share an understanding of the dynamics of STD transmission, appropriate algorithms and the latest information on drug resistance, it's really very exciting," he said. "They've been cut off from this kind of information — deprived of it, really —

because of the breakdown in the health care system."

The coalition is also training NGO staff in AIDS prevention approaches and methods. Twenty NGO representatives participated in a training-of-trainers workshop in May. They in turn will train about 120 health staff from the region, who will contact 10,000 women through women's and mother's clubs or home visits.

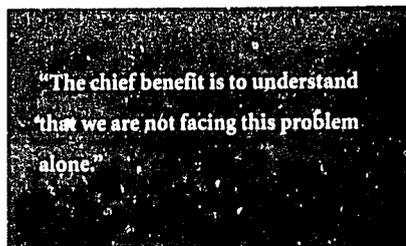
The coalition meets quarterly to monitor its members' activities and make program adjustments when necessary. At these meetings the coalition coordinator reports on follow-up measures taken to address resolutions or questions raised at the previous meeting, and activities carried out during the preceding quarter are compared to the targets set in the annual plan.

These quarterly meetings are the coalition's main mechanism for monitoring and evaluation, but they also provide a forum for the members to share information. In a country where there is no concerted government response to AIDS, Dr. Farmer said, such opportunities are particularly important.

"The chief benefit for the organizations involved in the coalition is to understand that we're not facing this problem alone," Dr. Farmer said.

Coordinating the activities of so many organizations would be difficult under the best of circumstances. In Haiti, political instability and logistical difficulties such as fuel shortages add to the challenges of communication and coordination. For example, the most recent quarterly meeting of the coalition was held at a Port-au-Prince hotel because none of the Central Plateau meeting sites had enough fuel for generators. It is also difficult to contact the member NGOs because many of them do not have radios — the only reliable method of communication in the countryside.

Despite these obstacles, the coalition has proved a promising mechanism for mounting a coordinated attack against AIDS in the Central Plateau and for giving women in the region the information, skills and services they need to protect themselves and their families.



Perkell/UNICEF

*Valerie Stetson, co-director of Save the Children in Haiti, has worked in community development programs for over 10 years in Cameroon, Somalia, Burkina Faso and Senegal. Maryse Narcisse-Prudent, M.D., MPH, is the coordinator of Save the Children's NGO Coalition for the Prevention of AIDS and STDS in the Central Plateau. Dr. Narcisse-Prudent worked as an NGO primary health care manager in rural Haiti and was technical director of AOPS (a private health agency umbrella organization in Haiti) before joining Save the Children.*

# World AIDS Day: *A Time to Act*

In Haiti young people released hundreds of purple and gold helium balloons printed with the message "Think: AIDS is Still Here," while a major radio station devoted all its December 1, 1993, advertising time to HIV/AIDS prevention messages.

In Brazil 500,000 condoms were distributed as inserts in a major Brazilian newspaper.

In Ethiopia thousands of people participated in a 15-kilometer walk to promote AIDS prevention.

These are just a few examples of activities sponsored by the AIDS Control and Prevention (AIDSCAP) Project to commemorate World AIDS Day 1993 with its theme, "A Time to Act." The day's events ranged from the symbolic (a candlelight ceremony) to the practical (a food and clothing drive for people with AIDS).

For AIDSCAP staff and their partners throughout the world, the day was an opportunity to remind policy makers, the public — and themselves — of the urgency of the battle against HIV/AIDS.



William Addebron/AIDSCAP

WORLD AIDS DAY CELEBRATIONS IN HAITI

One day's events cannot have a measurable impact on the epidemic, noted Eddy Gènécé, AIDSCAP's resident advisor in Haiti, but could serve as a catalyst for long-term efforts to create the social environment necessary to support and sustain individual behavior change to prevent HIV infection.

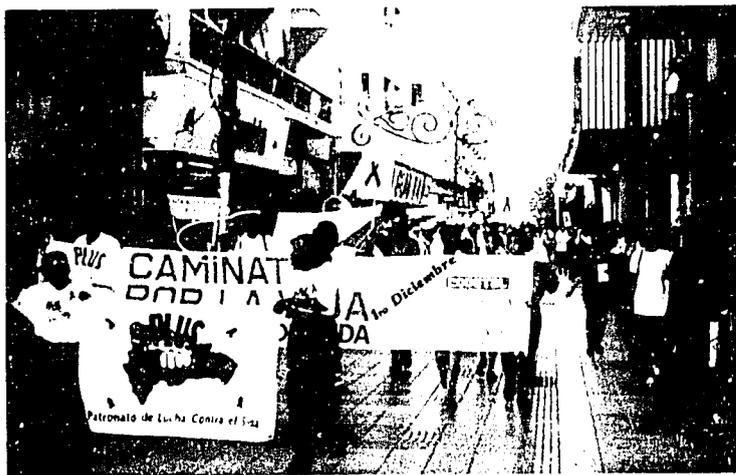
"World AIDS Day is a first step that must be followed by many others in order to progressively reinforce the social, cultural and legal foundation on which behavior change can be constructed," he said.

Groups and individuals working in AIDS prevention are already beginning to prepare the next World AIDS Day. The World Health Organization has chosen the theme "AIDS and the Family" for World AIDS Day, December 1, 1994.

For information, contact:  
 World AIDS Day  
 Public Information Office  
 WHO-GPA, 1211 Geneva 27  
 Switzerland  
 Phone: (41 22) 791 4765  
 Fax: (41 22) 791 0107



TANZANIAN YOUTH AT THE LAUNCH OF THE CONDOM SOCIAL MARKETING PROGRAM'S SALAVIA CONDOMS ON WORLD AIDS DAY  
 Avesha Mawoo



FIVE HUNDRED PEOPLE MARCHED THROUGH THE STREETS OF SANTO DOMINGO IN A "MARATHON FOR LIFE" ON WORLD AIDS DAY.  
 Cenevda Brito/AIDSCAP



# Social Marketing: *Making Condoms Available to Communities*

*An interview with Duncan Earle, AIDSCAP Private-Sector Officer, about the role of condom social marketing (CSM) in AIDS prevention and what has been learned through 24 years of Population Services International (PSI) experience with social marketing, including five years as a Family Health International (FHI) subcontractor/partner.*

**What is condom social marketing?**  
Social marketing is the application of commercial marketing techniques to achieve a social goal. In the context of AIDS prevention, condom social marketing is making condoms more accessible, more affordable, and therefore increasing their use and acceptability among target populations.

**What does CSM have to do with community-based AIDS prevention?**  
Social marketing can complement almost all community-based AIDS prevention activities in that it is a cost-efficient and often user-efficient and user-friendly distribution system for condoms.

Most community-based AIDS campaigns have at least some form of condom use message. We want to put forward a complete message that allows people to make responsible choices and remain as safe as they can. So, if we're out in a community saying, "You should abstain, you should be faithful, or if you can't do those two, you should use condoms," then it is beholden on us to make condoms accessible.

**What do you mean by accessible?**  
I use accessible as opposed to available. Condoms are available in many countries. They could be in a warehouse, they could be in a clinic. Accessible means that it's somewhere

where I know I can get it, where I'm willing to go to get it, and where I can afford it, personally as well as financially. Personal accessibility also involves embarrassment.

**What do you mean by that?**  
Public health programs, for example, usually distribute condoms through clinics, often family planning clinics. Typically family planning clinics are visited by pre- and postnatal women. And your average teenage or even young single man isn't particularly enamored of the idea of hanging out with a bunch of new mommies and pregnant women waiting to see a stern nursing sister and say, "Can I have some condoms, please?"

PSI and AIDSCAP [AIDS Control and Prevention Project] have been looking at a program in Lesotho, which has a culturally homogenous society. So much so that a small shop in a village may be run by everybody's uncle or aunt. So even getting into that outlet isn't necessarily going to make condoms accessible because an 18-year-old who's trying to be responsible doesn't want to go in and ask his aunt for condoms.

A DECEMBER PROMOTION MAXIMIZED CONDOMS.  
PSI/ZAMBIA RECORDED THE BEST  
FIRST-YEAR SALES (\$1,709,000) OF ANY  
PSI/AFRICA PROGRAM.



Population Services International



Population Services International

WOMEN BUY AND CONDOMS IN PREPARATION FOR THE PSI KENYA LAUNCH OF TRUST, A NEW CONDOM FOR AIDS PREVENTION. SALES OF TRUST HAVE RISEN STEADILY SINCE THE OCTOBER 1993 LAUNCH, NOW AVERAGE OVER 130,000 A MONTH.

How do you make condoms accessible in a situation like that?

In our market research we try to find out from potential users where they would feel comfortable buying condoms. In a lot of situations, hawkers are ideal. Hawkers are usually kids, and they are anonymous. The transactions take place very quickly on the street. There are hawkers everywhere in most of the countries we operate in, at least in Africa, where 95 percent of my work has been.

Where else do CSM programs sell condoms?

Bars, hotels and nightclubs are good outlets because a lot of high-risk behavior is not consciously premeditated. Although somebody may go out to a bar hoping to meet a potential partner, they don't necessarily plan the fact that they are going to have sex. So it's important that condoms be available when an impulsive decision is made. Social marketing is particularly well-suited to those kinds of situations because they often arise in bars and

hotels and nightclubs — places that sell other products, whether beer or cigarettes or candy — so it's not a quantum leap to add condoms to their product line.

How does social marketing work?

Social marketing uses commercial techniques and the resources of local private sectors to make products — in this case, condoms — more accessible, affordable and acceptable. How do we do that? Commercial marketing techniques means using market research to determine both consumer and trade likes and dislikes and practices. And when I'm speaking of trade I mean business people — wholesalers, distributors, retailers.

We want to motivate the local commercial distribution systems to carry the product. That means identifying the wholesalers who are used by the retailers where we want to sell the product. So if we want it in bars and hotels and kiosks, we have to find out where bars and hotels and kiosks in a particular area buy their goods.

Is it difficult to get commercial distributors to carry condoms?

Condoms are often a foreign product to the sales people we deal with, and there are all sort of reasons why they resist carrying the product, from religious ones to thinking it's not going to sell. We use good profit margins or favorable credit terms to motivate them to sell condoms.

We also do a lot of what we call assisted sales, where we'll get a wholesaler to carry a product, but then we'll have our own dedicated sales staff who will hook up with that wholesaler and motivate his retailers to carry the product. They actually sell the wholesaler's product for him.

The key motivation in social marketing is volume. That's the motivation for our donors and for the people who are selling it. You can buy a pack of condoms for the equivalent of three or four U.S. cents. Although the price per unit is low, if a retailer thinks he can move 100 or 200 packs, then it becomes real money.

Do you do much advertising and promotion?

We use advertising and promotion as much as we can. In many places there are restrictions on the advertising and promotion of contraceptives, and condoms in particular.

Even so, when we're launching a product, we do a lot point-of-purchase advertising, which means putting signs at new outlets to alert the public that this product is for sale. In our market research we also look at what kinds of brand names, logos and art work will make condoms attractive and acceptable to people and motivate them to want to use them. And we use those elements — the branding and the packaging, which result in the graphical representations you use in advertising — to address what we call resistance points.

What are resistance points?

People have a thousand and one reasons not to use a condom. And they vary from loss of pleasure or desire for skin contact to misconceptions about them falling off and getting lost in the woman's vagina and making her infertile. And of course there are a lot of issues around trust — I don't trust a partner who wants me to use a condom, or she doesn't trust me. So PSI has several brands called Trust. There's also a brand called Lovers Plus in South Africa and Botswana.

Where does the social part of condom social marketing come in?

The social side comes largely in the fixing of the prices and in some of the partners that we choose for distribution. We price our products to be affordable to the poorest members of the cash economy.

How do you know what is affordable?

We use some rough formulas to try to make sure our prices are affordable. For example, the price of 100 condoms should not exceed 1 percent of per capita GNP [gross national product].

But the main things we look at are the prices of other products on the market — matches, cigarettes, candy, aspirin, soap — what people are willing to pay for basic products they are buying.

It's debatable how low you can set the price. We have found that there are thresholds of pricing, that if you start raising your price above a certain level, you start losing consumers. In Pakistan PSI had to double the price a couple of years ago and our market was essentially cut in half as a result.

How do social marketing programs assure the quality of the condoms they sell?

We can't guarantee that condoms are never going to fail. But at the same time we want people to know that we care about quality assurance, that we're not distributing damaged products and that we're monitoring the quality of our product.

Most social marketing programs get their condoms free through USAID's procurement system. And USAID has quality control systems set up in their contracts with suppliers. That's true for maybe 70 percent of the condoms we distribute. The other 30 percent we buy on the open market or get from other donors. But we still follow quality control procedures for all those condoms.

FHI, WHO and the International Standards Organization have set up protocols on how to sample for testing. Usually you take 500 condoms from a lot of 50,000 to 250,00 and send them for testing.

How do we know whether CSM programs work?

If people — particularly poor people — are taking money out of their pockets to buy something repeatedly, there's a pretty good presumption that it's being used. Whereas with a free distribution campaign, lots of condoms might be given out, but there's very little way to measure whether or not those condoms get used.

So first we look at sales. We measure our sales once they leave our sales vans, but we know that's not necessarily a consumer sale. In a young program, 60 percent of that may have been what we call pipeline filling, where we're selling to new outlets. But then over time you can evaluate sales by doing consumer intercept studies, which is when you send interviewers to outlets to interview people who have just purchased the product.

The other thing we look at carefully is resupply. Say you sold to a particular outlet once, but you never sold to them again. Then there's no guarantee that those products were ever sold by that retailer, let alone used by a consumer. But if you're resupplying people frequently, and the lower down in the chain you track resupply, the more viable your data are in indicating consumer use.

Do evaluations look at cost-effectiveness?

We measure cost-effectiveness by the cost of delivering 100 condoms, which we would stipulate is the cost of delivering one couple-year of protection. So we take the total cost of running a program for a year and divide it by one hundredth of the number of condoms we distributed, and that's our cost of delivering a couple year of protection. We have demonstrated in a number of countries that we are actually more cost-efficient than the public distribution system.

Wouldn't social marketing be more cost-effective if you didn't spend so much money on packaging and advertising?

It wouldn't cost quite as much, but it wouldn't be as effective either. In places where condoms are known, they don't always have a good reputation. However, where they're not known, people are unsure about what they are, and thus can be persuaded of their efficacy.

You can do a lot with a brand name, for example. Some of the

slogans associated with Prudence condoms are so good that they've taken on a life of their own. The slogans have even been adopted as AIDS prevention messages in countries that don't sell Prudence. The classic message is "Confiance d'accord, mais Prudence d'abord," which means it's all right to be sure of yourself, but first of all you must act prudently.

After PSI had been selling condoms in Zaire for more than three years (and in the first nine months of the fourth year we sold 18 million condoms), we conducted consumer-intercept surveys. We'd ask people what a condom was and they wouldn't know, but when we asked them what Prudence was, they knew immediately.

A donor still might say, that's not a justification for spending all this money on packaging. If you sell 15 million condoms and your packaging costs one U.S. penny a condom, then you're spending \$150,000 on packaging. That seems like a big expense. But look at what you're getting for it. If you didn't have the packaging and the brand recognition, you wouldn't be distributing 15 million condoms.

Is it difficult to promote condoms, particularly in Africa?

PSI increased its condom sales in Africa from less than 1 million in 1988 to 66 million in 1992. There are, however, all sorts of legal, religious and cultural barriers to promoting condoms in Africa and in other regions.

What kind of legal restrictions do CSM programs face?

There's a law on the books in many former French colonies, for example, that was put in place in 1920 — La Loi de Mille Neuf Cent Vingt — that prohibits the sale of condoms outside of pharmacies. It also prohibits advertising and promotion of any contraceptive product. In Côte d'Ivoire, PSI helped change that law. We worked with the Ministry of Health and had the law repealed. In other countries we've been given instructions by the local governments to ignore such legal restrictions.

Other legal barriers include duties and customs' surcharges on imported condoms. When I was in South Africa

setting up a program I lobbied the government to get the customs surcharge repealed. As far as I know, that still has not happened.

Do you know how much the customs surcharge adds to the price of condoms?

In South Africa the customs surcharge and the value-added tax add 33 percent to the cost of bringing condoms in.

What kind of religious barriers do CSM programs face?

People of many religions are against contraception. And their strongest argument is that by promoting condoms we're promoting promiscuity, a notion that has not been supported by numerous surveys. In our consumer-intercept surveys, we find that people who adopt condom use and increase condom use are also decreasing their numbers of partners, which is a real credit to the whole AIDS program in that the entire AIDS prevention message is getting across.

How do you overcome these religious barriers?

We try to overcome them by involving religious leaders in our programs to the degree that we can, and to the degree that we can't, agreeing to disagree. In a lot of cases we'll work with the Catholic Church not to fight us. We acknowledge its message of abstinence and mutually faithful monogamy — a very important message — but we also try to get them to understand that there's a whole group of people who need other options.

We've also had to deal with Islamic resistance to condoms in some countries. Again, it's a matter of getting religious leaders involved in discussions, if not in decision-making processes, so that they understand what we're doing and that we believe their message is important. PSI pioneered this approach in Guinea by involving local imams in our AIDS prevention programs.

Including people in discussions is critical. Trying to avoid the issue is a mistake — we've learned that several times. And obviously you use your local resources to address the issue as best you can, such as the national AIDS

control program and the Ministry of Health and whatever other allies you have in the public health community.

Do social marketing programs educate people about AIDS? How much educating can they do?

They can do quite a lot. We use a lot of the techniques that everybody uses, plus some innovative ones. We do sampler brochures, and the only difference between our brochure and somebody else's is that we have a branded condom on it — but it conveys an AIDS education message. We use posters as point-of-purchase materials to say condoms are on sale here, but they often incorporate an educational message as well.

Our commercial marketing techniques also carry AIDS education messages. One example is a Soirée Prudence, where we sponsor an AIDS prevention night at a nightclub with contests, T-shirts and prizes. We'll have a raffle and an AIDS education theme as well, with condom blowing-up contests or condom-popping contests — things that demystify the product and make it humorous but also get a very important message across.

We also sponsor youth groups and soccer teams. We use any kind of media we can. Traditional media, theater groups, prostitute theater groups, radio — all of the things that AIDS educators use. And we try to collaborate with other AIDS education and awareness activities that are going on in a country.

Is CSM part of all AIDSCAP programs?

No, but it's part of many. It really depends on whether the local USAID mission and the local government want to use social marketing. Right now there is a social marketing program ongoing or in development in virtually every AIDSCAP priority country in Africa and Latin America and the Caribbean.

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*Duncan Earle is seconded from PSI to serve as the private-sector officer in AIDSCAP's Africa Regional Office in Nairobi, Kenya, and has worked in social marketing in 10 countries.*

## AIDS & Communities: *Lessons for Policy Makers*

by Bill Rau, AIDSCAP

Policy makers and program planners have much to learn from communities' experiences in responding to numerous crises, including the AIDS epidemic. But communities do not live in isolation, and no community-based program is unaffected by national and international events and policies. If HIV/AIDS prevention initiatives are to succeed, policies that inhibit the use of community skills and resources must be addressed. Considering community attributes and constraints will also help policy makers and planners ensure that resources and policy support are appropriately placed and most effectively used.

### Opportunities for Community-based Prevention and Care

The experiences of community-based organizations (CBOs) and nongovernmental organizations (NGOs) over the past two decades have demonstrated the strength that exists at the local level. While international and nationally supported projects often fail to meet their goals, community-based initiatives have proved more effective in mobilizing people, gaining their commitment to change and drawing upon their creativity. In Zimbabwe, over 1 million rural people have joined the Organisation of Rural Associations for Progress (ORAP) to address development issues that they identify and define. Through ORAP, communities have established local cottage industries, produced food for meals for the elderly and schoolchildren, and built water systems in drought-plagued areas. The Bangladesh Rural Advancement Committee (BRAC) provides the

organizational support for low-income groups to promote their development and welfare needs. Through literacy, income-generating, agricultural and other projects, BRAC has shifted resources and skills to tens of thousands of people.



COMMUNITIES ARE STRUGGLING TO COPE WITH THE BURDENS OF CARE, LOSE PRODUCTION AND DEATH.

Communities are also rising to the challenge of coping with the HIV/AIDS epidemic. The AIDS Support Organization (TASO) in Uganda provides care, counseling and support to more than 22,000 people with HIV infection or AIDS and their families. In Thailand, the Duang Prateep Foundation has trained more than 200 volunteers in Klong Toey, a poor Bangkok

neighborhood, to educate their peers about AIDS prevention and promote understanding and compassion for people who are HIV-positive.

The experiences of TASO, Duang Prateep and literally thousands of other community-based groups offer valuable lessons for communicating and working with communities in HIV/AIDS prevention and care. These groups provide the time and space for people to plan, coordinate and assume responsibilities in order to make HIV prevention a reality. Their affirmation of people's knowledge and skills is essential to designing acceptable yet explicit sex education programs for youth, strengthening women's sexual negotiating skills and promoting condom use.

### Constraints to Community Action

While communities are a viable unit for HIV/AIDS prevention efforts, they face numerous political, economic and social constraints to meeting their members' needs and representing their interests. Many of these constraints originate at national and international levels, but affect local communities nevertheless. Local people can do little to alter external constraints, although they frequently try. Such constraints are the domain of policy makers in government and business, social and donor organizations.

### Economic constraints

As a result of significant economic pressure on communities over the past 15 years, poverty has widened and deepened across the developing world. Even where aggregate economic figures point to growth in recent years, those data may disguise a widening disparity in income and wealth between classes. In many countries unemployment in the formal sector has risen while wages have fallen. At the same time, the prices of basic commodities have increased, and fees for formerly free health and education services add to the pressure on household incomes.

Women face the greatest strain as a result of these economic conditions. In Africa, 25 to 50 percent of heads of households are women. Caring for relatives who have AIDS or other illnesses demands the time of women, detracting from their own work, production, sales and caring for children. As more and more women move to urban areas, they may have to establish a relationship with a man in order to obtain housing and employment. A growing number of women are being pushed into the sale or exchange of sex for survival. Rural poverty has resulted in increased migration of men in search of work, creating more of the situations (men living away from home and women struggling to support their families alone) in which commercial sex is likely to occur.

Community-based care of people with AIDS is receiving increasing attention and will be even more important as hospitals become unable to cope with the upsurge in patients. However, the effectiveness of community-based care depends upon regular support from the staff of health facilities and their ability to meet the needs of patients and families. Already health services in many countries cannot cope with the increasing number of people with AIDS and opportunistic infections. In many parts of East Africa, more than half of all hospital beds are occupied by HIV-infected individuals. Communities, too, are struggling to cope with the burdens of care, lost production and death.

#### Wars and civil violence

Many of the wars of recent decades have been directed toward civilians. Millions of people in all regions of the world have had their lives disrupted by civil violence and war in the years since the advent of the AIDS epidemic. Homes have been destroyed, and farms, businesses, jobs and income lost.

In such circumstances, individuals, families and communities are less able to assert control over their economic, political and sexual lives. Health services break down or are strained almost to the breaking point by the treatment needs of victims of conflict. Distribution of commodities may collapse or occur only sporadically.

Each of these war-induced failures of essential systems limits the ability of individuals and communities to protect themselves against HIV.

One of the losses of warfare is a clear picture of HIV prevalence rates in war-torn areas. But tentative and very incomplete evidence from Cambodia, Mozambique, South Africa and Sudan all suggest that war contributes to high HIV/AIDS rates.<sup>4</sup> Not only are HIV and STD prevalence rates extraordinarily high among military personnel, but civilian populations affected by the internal wars appear to suffer from high HIV and STD prevalence rates.

#### Harassment

Many people who are HIV-positive or have AIDS face discrimination and harassment. In these circumstances, people who know they are HIV-positive tend to keep the information to themselves, living in isolation and fear. This makes it difficult, if not impossible, to establish supportive communities. Nor can communities begin to respond to prevention and care needs when fear keeps HIV and AIDS hidden and denied. Recently harassment has extended to people who work in HIV/AIDS prevention and care, threatening the efforts of social workers, peer educators and health-care providers to confront the epidemic.

#### Lessons for Policy Makers

There are many good reasons to engage communities in HIV/AIDS prevention. But community-based prevention and care will not be effective unless policy makers and planners address the economic, political and legal constraints that limit community involvement.

In this era of limited resources, a key question is how best to use community strengths to meet the needs of community members. Cost-recovery programs have allowed communities to maintain services they otherwise might have lost. However, such programs frequently result in exclusion of low-income groups from health services. Extensive experience with small-scale credit programs provides a model for community-managed cost-recovery schemes designed to keep resources within the community. Such systems could be adapted to help communities cope with the costs of AIDS.

Greater legal autonomy and targeted economic support to enable women to run farms and businesses can help mitigate the economic impact of caring for AIDS patients and losing family members. Alternative models for realistic forms of community-based care remain to be tested and shared. Legal protections such as confidentiality and security of job tenure can help reduce the stigma attached to HIV infection.

Larger issues such as wars and economic recession clearly are within the realm of national and international policy makers. Peace plans must address effective demobilization of soldiers, protection for civilians and the rebuilding of critical community and social service infrastructure. None of these are easy processes, as experiences in Cambodia, South Africa and Ethiopia indicate. However, when community-oriented groups are involved in decisions about reconstruction, they bring a deep knowledge and commitment that will enhance social cohesion and economic growth and equity. HIV/AIDS prevention, too, will find firm roots, even if prevention is not the most immediate priority for communities.

The lessons of community-based HIV/AIDS prevention and care — and other community-based development programs — present opportunities for enhancing the policy context of prevention. The involvement of NGOs and CBOs in HIV/AIDS prevention has become a tangible force for illuminating community strengths and advocating for members' needs. In turn, policy makers have the opportunity to take tangible action to slow the spread of the AIDS epidemic by listening to and working with communities and their representatives.

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#### Reference

1. A. Noya, C. Palha de Sousa and A. Barreto. Population Movements and the HIV Epidemic: The Case of Mozambique. Abstract #S/2H for the Epidemiological Society of Southern Africa, August 1993.

# Resources

**Lessons and Legacies: The Final Report of a Grants Program for HIV/AIDS Prevention in Africa (HAPA).**

A report on the experiences, challenges, successes and lessons learned by the private voluntary and nongovernmental organizations that implemented projects in seven African countries under the HAPA grants program with funding from the United States Agency for International Development. *Lessons and Legacies* examines four aspects of the project process: planning, management, implementation and sustainability. Available from the Johns Hopkins University, School of Hygiene and Public Health, Institute for International Programs, 103 East Mount Royal Avenue, Baltimore, MD 21202, USA.

**HIV/AIDS Project Planning Manual for NGOs.**

United Nations Development Programme. A manual presenting a planning framework for use by NGOs working in HIV/AIDS in developing countries. The framework examines each step of project development in detail, including raising funds, keeping records and monitoring activities. Includes six cases and their associated learning objectives, with a set of discussion questions to direct the analysis of each case. Available from the Regional Bureau for Asia and the Pacific, UNDP, 55 Lodi Estate, New Delhi 110003, India.

**AIDS: Images of the Epidemic.**

A new book published by the World Health Organization's Global Programme on AIDS (WHO/GPA) presents the many faces and facets of the global AIDS epidemic and aims to improve understanding of the deep-rooted factors - from prejudice to poverty - that fuel this "catastrophe in slow motion" and complicate efforts to protect people from HIV infection.

Drawing on eyewitness accounts and data from the WHO/GPA, the book goes beyond statistical forecasts to show how AIDS affects the lives of real people, why the infection continues to spread and what can be done to fight back.

The book is available in French, Arabic, Chinese, Russian, Spanish and English for US \$20.16 each, from WHO Publications, Distribution and Sales, 1217 Geneva 27, Switzerland.

**Learning to Teach: Training of Trainers for Community Development.**

Save the Children. A manual for training of trainers in community development that presents nonformal education and participatory learning methods. The approach builds on the experience of the learners to enable them to gain knowledge and technical

skills that are practical and relevant to the needs of their communities. Available for US \$10.50 from Save the Children, 54 Wilton Road, P.O. Box 950, Westport, CT 06881, USA, Attention: Josie Turnier

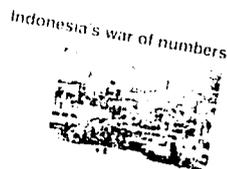
**Living with AIDS in the Community.**

World Health Organization, Document Number WHO/GPA/AIDS/HCS/92.1. Written in Uganda by the National AIDS Control Programme, the AIDS Support Organization, the United Nations Children's Fund and the World Health Organization, this booklet describes in simple terms how HIV is transmitted, how to prevent transmission, and how to cope if you or someone you know is infected with the virus. Available in English, Portuguese and French for Sfr 6.00 from WHO/GPA, 1211 Geneva 27, Switzerland.

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