

TRADITION &

TRANSITION

NGOs RESPOND TO AIDS IN AFRICA

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Mary Anne Mercer
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Baltimore, May 1991

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Introduction

In October of 1990, representatives of a group of non-governmental organization (NGO) projects involved in AIDS prevention met in Zimbabwe for a week-long workshop entitled "NGOs United Against HIV and AIDS in Africa". Participants in the workshop were staff and local counterparts (local NGOs or Ministry of Health) of projects funded by the HIV/AIDS Prevention in Africa (HAPA) grants program of the Bureau for Africa of the United States Agency for International Development.

The goals of the workshop were to develop the skills of participants in key areas of project implementation, and to provide a forum for sharing lessons learned. World Vision Zimbabwe, with help from Save the Children Federation, coordinated local logistics and resources, while the HAPA Support Program of The Johns Hopkins University School of Hygiene and Public Health organized external travel and materials. Workshop sessions were led primarily by Zimbabwean nationals involved in HIV/AIDS prevention, counseling and care in that country.

As a result of the Zimbabwe workshop, participants developed a greater awareness of the growing body of experience being generated by programs that respond to HIV and AIDS. At the same time however there appears to be difficulty in getting access to that information, even for large international NGOs. Clear, program-focused written materials are needed to help guide projects through their early years of activity in HIV/AIDS prevention or care. This need, combined with the high caliber of workshop presentations, prompted the publication of selected papers from the workshop.

The nine chapters of this publication are based on papers presented in the workshop sessions and discussions that occurred during or after the presentations. The editors have tried to focus on key issues presented and discussed without losing the diverse perspectives of the presenters and participants. Although much rich and interesting material from the workshop could not be included in the publication, it is hoped that what is presented will illuminate certain critical issues faced by NGOs working in response to the HIV epidemic.

This publication is divided into three sections: the cultural context of HIV/AIDS prevention in Africa; specific intervention strategies; and programmatic issues.

Section I: The Cultural Context

Educational approaches to HIV/AIDS prevention imported from other settings have not always taken into account the complex relationship between HIV/AIDS and beliefs or practices specific to local cultures. Even when acknowledged, the cultural context may appear to be simply a stubborn obstacle to HIV prevention, a web of superstition and

taboo that hinders the adoption of sensible protective behavior. Yet aspects of this same culture, such as traditional beliefs discouraging adultery, may also support efforts to control or prevent HIV/AIDS. To help project staff better understand and uncover AIDS-related beliefs and practices embedded in local cultures, three workshop topics focused on HIV/AIDS in relation to Zimbabwean beliefs about religion and the family, particularly the role of women.

In the first paper, Jane Mutambirwa, an anthropologist at the University of Zimbabwe School of Medicine, discusses the links between ancestor worship in traditional religion and strongly-felt obligations to bear and raise children -- beliefs which can have a powerful impact on a couple's decision to use or not to use condoms. Dr. Mutambirwa also explores how moral interpretations of health and disease, particularly sexually transmitted diseases, can influence local understanding of HIV infection and AIDS.

Sunanda Ray, a physician with the Harare City Health Department, focuses on the dramatic impact of AIDS on women in Africa, where large numbers of women are infected by HIV and are also affected by the illness of family members. Dr. Ray draws on her clinical and counseling experience to describe how cultural pressures for a woman to bear children, and to accept her husband's having other sexual partners, can limit a woman's ability to protect herself from infection. In response, Dr. Ray and others concerned are helping women who are infected or affected by HIV/AIDS to create support networks for social and material assistance.

The evidence presented by Mutambirwa and Ray underscores the problems African women have insisting on "safe sex", especially within the context of marriage, and the need to change deep-rooted community norms that dramatically limit women's choices. For NGO project staff living outside the project impact area however, HIV/AIDS-related community norms are not always obvious, even if the staff share a common language and culture with the target population. For this reason the workshop included an introduction to focus group discussion methodology, and an exercise in which workshop participants moderated and recorded four focus group discussions with local residents. This brief exercise, described by Sally Scott, was a surprisingly fruitful probe into a shifting and emerging framework of beliefs and values surrounding HIV and AIDS in a Zimbabwean community.

Section II: Intervention Strategies

A clearer understanding of the local cultural context can lead to intervention strategies that draw on deeply-rooted local beliefs and values. Traditional healers are a group particularly well-situated to interpret and also influence local norms and beliefs. The first paper in this section is an interview with T.M. Musara, national AIDS coordinator for the Zimbabwe National Traditional Healers' Association (ZINATHA), which has organized a series of AIDS education and prevention workshops for traditional healers in

Zimbabwe. The interview with Mr. Musara indicates that traditional healers remain a powerful force in both rural and urban Zimbabwean life, a force with the potential to adapt and change when confronted with a terrible threat such as HIV/AIDS.

Another intervention strategy which links new ideas to a traditional format is AIDS education through drama. After a performance by the Batsiranai theater group, workshop facilitator Ben Zulu led a discussion, using the drama as an example, of working with artists to bring HIV/AIDS prevention messages into a community. In his paper Mr. Zulu points out that the artist and AIDS educator have very different areas of expertise to bring to the process of HIV/AIDS prevention. An understanding of their respective skills will enable educators and artists to both inform and entertain in helping people prevent HIV/AIDS, and in creating sympathy for people with AIDS.

AIDS-related counseling, unlike traditional healing and drama, is an intervention initially developed in the North. Christine Mutize, national health coordinator of the Catholic Development Commission in Zimbabwe, sees important connections between counseling and existing African family and community support networks. She believes that building on these connections will make counseling more familiar and appropriate to the African context. While the western model carefully spells out the characteristics and training needed for effective "professional" counseling, Ms. Mutize focuses on the need for counseling at the African community level, where people with special qualifications in counseling may not be available.

Section III: Programmatic Issues

The third section looks at two key programmatic issues for AIDS intervention programs, evaluation and sustainability, and at the lessons learned thus far from a project with vulnerable groups in southwest Zimbabwe. Mary Anne Mercer and co-authors stress the importance of timely and thorough evaluations to the work of NGOs in HIV/AIDS prevention. They present a model of organizational functioning that illuminates the relationship of objectives, targets and indicators to program activities and effects. Concrete approaches and steps to be taken in the monitoring and evaluation of HIV/AIDS projects are outlined, from planning through the sharing of results with collaborators and colleagues.

Sustainability, like evaluation, is an issue most effectively addressed when included in all phases of project planning and implementation. The presentations by Willy Salmond, Canisio Takundwa and Milton Amayun address sustainability from three different perspectives: NGO field office, district-level ministry of health, and NGO headquarters office. The different perspectives indicate the importance of communication about sustainability between donors and NGOs, NGOs and collaborators, and project staff and community leaders. Sustainability is examined not as a final result but as an ongoing negotiation over the transfer of responsibility for particular areas of activity, such as condom distribution or counseling training.

In the final chapter, David Wilson and his colleagues describe an HIV/AIDS prevention project among vulnerable groups in Bulawayo, Zimbabwe and discuss experiences learned from the project thus far. The Wilson paper and discussion incorporate several key concepts raised in the other workshop papers. The project uses anthropological methods to gain a deeper understanding of and respect for the groups to be reached by project interventions, and develops strategies that link existing social structures to HIV/AIDS prevention methods. Through careful monitoring and evaluation, project leaders are gaining a clearer notion of approaches that are most likely to succeed. They stress the importance of listening carefully to the community served by the project, and giving peer educators and community leaders real responsibility for planning and implementing activities.

Future possibilities

Recent projections by the U.S. Bureau of the Census¹ indicate that over 70 million people in sub-Saharan Africa will be infected with HIV by the year 2015, if present trends continue. This grim scenario, based on extensive epidemiological and demographic data, makes clear the threat that AIDS poses to African community, economic and political life. The projections include a measure of hope however, because even moderately effective interventions could affect the rate of infection substantially. For example, a 10% increase in urban condom use could result in an urban seroprevalence level about half the "no-intervention" level by 2015; a 15% reduction in the number of casual sexual contacts would result in declining infection levels. NGOs can play a critical role in a multisectoral effort to respond to and eventually to reduce the three interrelated epidemics of HIV infection, AIDS, and the stigma of both. As NGO efforts to respond to HIV/AIDS grow in scope and complexity, open sharing of lessons learned will be critical to the development of effective programs. It is hoped that this publication will contribute to this effort.

¹ 1991. Center for International Research, United States Bureau of the Census. *The Demographic Impact of AIDS in Sub-Saharan Africa*, *AIDS & Society*, Vol.2, No.3.

Section I

The Cultural Context

Aspects of Sexual Behavior in Local Cultures and The Transmission and Prevention of HIV/AIDS

Jane Mutambirwa

Dr. Mutambirwa is an anthropologist on the University of Zimbabwe Faculty of Medicine. Her paper draws on research undertaken in rural Zimbabwe.

Introduction

The objectives of this paper are to discuss marriage traditions and sexual behavior in the context of religious beliefs and moral values in Zimbabwe, and to suggest ways in which understanding those traditions and behaviors can be useful in addressing the HIV/AIDS epidemic. It is difficult to understand or respect community perceptions of sexually transmitted diseases, and particularly of HIV/AIDS, without having some knowledge of the religious and moral framework that shapes local responses to these problems. I believe that only through close collaboration with community members to identify the cultural norms and practices which affect the transmission of HIV/AIDS will we be able to work with them to develop effective strategies for combatting the rapid spread of infection.

This paper introduces the reader to the traditional religious context of community life in Zimbabwe, and the influence of this context on morality, spirituality, and sexuality. An overview of these core concepts leads into a discussion of local beliefs concerning reproduction and marriage practices, and the potential impact of these beliefs on HIV transmission and prevention. The concept of "bad airs" and disease causation is explored, particularly beliefs about sexually transmitted diseases (STDs) and the possible transfer of certain ideas about STDs to AIDS. Although my research draws exclusively on Zimbabwe sources, most of the cultures of Southern Africa have similar patterns of belief and tradition.

The Religious Context

What is the importance of religion, of spiritual beliefs, in the everyday life of Zimbabweans? We must understand the key features of the religious sphere to understand that in local cultures the aim of human development is to promote and sustain life so that the soul reaches eternal life through admission into ancestor spirithood. This is achieved through attainment of moral behavior, or behavior guided by the conscience. For a person's mind-soul to be accepted into the spirit world as an ancestor spirit requires that conscience be attached to the mind-soul before death of the physical body. Conscience restrains or inhibits the activities of the mind-soul, which is

believed in turn to influence the body to conduct just and moral actions. Conscience is thus viewed as the purifying arm of a person's character; while physical bodies were granted by the creator to all creatures, only man was given a conscience.

Conscience is believed to continuously influence a person's behavior only after spiritual or moral maturity, which follows the birth of the first child. In local Zimbabwean cultures, procreation and reproduction are viewed and interpreted in metaphysical terms. Every person is considered to be spiritually impure and is not permitted to participate in spiritual affairs until siring or issuing of offspring. This is clearly demonstrated by the burial procedures practiced. Those who die after puberty but before engendering offspring are buried with a corn husk placed on their back as a sign of their spiritual impurity. The purification ceremony which ensures admission into the spirit world as an ancestor spirit, who can then guard and mediate with the Creator for the health and welfare of the family, is not carried out. It is said that impure souls are isolated and end up as evil, aggrieved, or haunted spirits. **This has had a powerful influence on women and men deciding whether or not to modify their sexual practices so as to prevent pregnancy, as well as HIV infection. This would be particularly true for HIV-positive women who may want to bear a child before they are too weak to sustain pregnancy.**

Ancestor spirits are individuals who have gone up to the spirit world in more or less the same way that saints ascend to heaven and are closer to God in Christian religion. Ancestors intercede with the Creator, much as Christ is believed to mediate between the individual and the Christian God. They are thought to know the individual's circumstances and to work for his or her well being and health.

Spiritual morality is viewed as hygiene, and if one violates this morality, one is exposed to infection, just as someone who drinks polluted water would be exposed to disease-causing bacteria. The whole system, then, is based on moral hygiene, as opposed to the physical hygiene of western medicine. If one is not protected by spirituality, one will become as sick as a child not protected by immunizations. In the local culture, there are certain issues that cannot be addressed except through spiritual mediation.

Spirituality, Sexuality and the Life Cycle

The first marriage consummation is seen as cleansing the body of physiological impurities associated with immaturity, and the mind of unclean thought associated with sex and bodily desires. The bride is expected to conceive within the first year of marriage. This indicates the beginning of spiritual growth and development for the couple. In effect, their cognitive processes become guided by conscience as they learn to deny themselves physical comforts in order to promote the physical, social and spiritual well-being of their expected child. In other words, the couple begins to attain the spirit of self-sacrifice for others through the experiences of the first conception, childbirth and childrearing.

Based on the views and perceptions discussed above, local cultures view cohabitation, marriage and sexual activity as serving a physical, social and spiritual function. The physical function of sex is to serve the biological need for procreation in perpetuation of the seed. From conception to eternity, there are believed to be eight phases of growth and development in the human life cycle. In each of the eight phases there are five dimensions of growth and development: physical, mental, social, spiritual and behavioral. The degree of integration of these important mental processes determines the level of growth and development reached in each phase. Lack of integration of the above is viewed as abnormal and interpreted as a health problem. For example, promiscuous behavior is viewed as the lack of self control in basic impulses at the physical/psychobiological level. The person who contracts diseases through sexual promiscuity, just like persons who develop illnesses because of excessive drinking or overeating, are described as making herself or himself ill. Such behaviors are frowned upon and people who suffer from such illnesses are extended little sympathy.

The person who commits incest, like the murderer, is viewed as having an under or inappropriately developed social sense and control. His family, clan and community are blamed. It is for this reason that communities where murder or incest occur are expected to suffer from epidemics, endemic diseases, floods and droughts. These scourges are seen as punishment by ancestor spirits, who are guardians of health and life on behalf of the Creator, for the community's failure to instill in its members a sense of discipline. **People in rural communities may consider city dwellers struck by AIDS as lacking in discipline and deserving of punishment.**

Reproduction and Marriage Practices

How do people's beliefs about male and female sexual roles affect patterns of HIV transmission? It is understood that when the Creator delegated duties, the males were given the responsibility for the passing of life through the seed/sperm. Males are viewed as the procreators of life, and children are viewed as coming from the male and therefore belonging to the paternal line. Outstanding characteristics of the male or female child are attributed to his or her paternal ancestors: those who pass the seed. This male ability to pass the seed from generation to generation accords males higher status and a level of spiritual achievement than women, who are seen as receiving the seed. Women's reproductive functions are viewed more as practical responsibilities in support of life at the physical and social levels.

It is believed that women were given the role of receiving the seed and nurturing it, providing fertility. Anything to do with fertility and nurturing is associated with the female, as the soil is seen as nurturing the seed in the field. For example, if a couple can not produce a child, the first thought is that the woman is infertile, and the family will hunt for medicines to treat the wife. If eventually the family decides that the man is responsible, they will not examine his existence, but his mother's because women are

responsible for the nurturing of life; thus it must be the man's maternal line that has created the problem.

Our whole traditional marriage structure imposes these roles. For example, "roora" is supposed to consolidate the relationship between husband and wife. Each partner may demand sexual pleasures from the other. If a husband refuses to go to bed at his wife's request, she may take him to court and report to his aunts and his grandparents that "he doesn't comply with my requests". The husband may do the same. "Roora" also entitles the wife to support and provision of such basic physical needs as food, water or the means for their acquisition by her husband. **Because of this cultural tradition, the uninfected partner in a marriage is at risk for contracting HIV since neither spouse should refuse the other's requests for sexual relations.**

Tradition entitles a man to his wife's services and the children of the marriage, and thus a wife may not refuse to bear more children even after her husband is diagnosed HIV positive. During the 7th or 8th month of the first pregnancy, the two families brought together in the marriage perform a ceremony that symbolizes the spiritual binding of the two families. It unites and charges ancestors on both sides to become mediators with the Creator and spiritual guardians of health for the children born from the union. Virginity is associated with moral purity which indicates physical, social and spiritual hygiene; this purity assures disease-free offspring. It is for this reason that miscarriages and fetal malformations are associated with sexual immorality. Should a woman with ten children from her previous marriage remarry, she must give birth to a child for her new husband in order to cement family relationships; this again would put the uninfected partner in such a marriage at risk. If the woman was widowed because of AIDS, she would probably be HIV positive, and her new husband might become infected as well.

If a man dies, the practice is for the deceased man's brother to inherit the widow as his wife. Although the practice has declined because of changing values about wealth, the intention of the practice was to provide a surrogate father for the children left by the deceased. It was also intended to provide a moral marital relationship for the widow's familial and sexual needs. The widow does not have to be inherited by her brother-in-law, but can instead choose a favored sister-in-law to act as the spokesperson to the family on behalf of her children. The widow who chooses to be inherited by her husband's married brother becomes the second or third wife; as such, she cannot refuse to satisfy his sexual needs even after he is diagnosed as HIV positive. In addition, the first wife may not refuse to have sex with her husband after he inherits his brother's widow either, for fear of losing him and being labelled as a jealous wife.

Marriage and sexual intercourse are for the promotion of the clan by providing many male offspring to carry the family name. The woman who does not have male offspring often continues to have children in the hope that an heir will arrive. **Because of the strong desire to produce male children, people will continue to take risks, even after education and the diagnosis of HIV infection.** In addition to perpetuating the clan,

having a family is important because attainment of eternal life through admission into the spirit world as an ancestor spirit is possible only after experiencing childbearing and childrearing.

"Bad Airs" and Disease Causation

In our local cultures traditional health beliefs exist side by side with the western system of medicine. Even if highly educated people have a disease that has not responded to western medical treatment, they will go back to the traditional healer to find out what is going on. An outside observer might say that people should stop seeking traditional treatments, since they are not scientifically proven. But in a local cultural context, traditional methods have proven validity, just as western medicine makes sense from a scientific point of view. Each system has a distinct description of the causes of disease.

We somehow believe that traditional beliefs are haphazard, but in fact they are coordinated and coherent. That is critical to understand if one is attempting to develop education programs and change behavior, because if the programs do not "fit" with local thinking it is very difficult to successfully encourage behavior change. Many programs in health never succeed or become sustainable because as soon as program staff relax their efforts or move away, local people go back to what they know best, which is quite correct and scientific in their own perspective.

In terms of basic beliefs, diseases are viewed as arising from three sources: the body, the social environment, and the spiritual environment. There are two types of bad airs which cause disease: those attacking people lacking spiritual protection because of their immoral, unjust deeds, and those arising from the physical environment. The bad airs attacking people whose behavior is not controlled by their conscience are known as unnatural or abnormal bad airs because their origin is from evil powers which are unseen by the naked eye. They cause illnesses which are unnatural because they debilitate the person's physical, social and spiritual constitution. Illness caused by this category of bad airs require spiritual intercessions.

The bad airs arising from the physical environment affect only the body and do not require spiritual intercessions, for the airs have their origin in the physical or earthly environment. They are responsible for a turning over of the blood or body physiology. This includes coughs, flu, colds and transient diarrheas. These are viewed as challenging the body to become strong against future attacks (i.e., developing an immunity to future exposure). It is expected that the body returns to its normal state with minimum or no treatment.

Contagion or transmission of diseases is associated with coming into contact with bad airs through any one of the following ways: ingestion, insertion into an orifice, rubbing against the skin or bodily contact, and inhalation of polluted, jinxed, or hexed air, and

inhaling air from bad odors, body smells, halitosis, etc. The bad air is viewed as burning or overpowering the good air. This is said to cause disequilibrium which results in illness. Sexually transmitted diseases (STDs) such as gonorrhea, which cause a bad smell or "bad air" in an individual, are believed to be contagious by this mechanism.

Disease Transmission: STDs and AIDS

AIDS is widely known to be transmitted sexually. As such, many of the culturally determined beliefs about sexually transmitted diseases (STDs) are likely to influence beliefs about HIV and AIDS. Yet there are also clear differences between STDs and AIDS. STDs are described as diseases of men or women having symptoms such as dripping water, backache associated with problems of the sex organs, and stomachache associated with lower abdominal pains. HIV infection lacks such observable and describable physical symptoms, however, which may make it difficult for people to conceptualize HIV infection and AIDS as sexually transmitted disorders.

A number of misconceptions about HIV transmission are prevalent, many of which probably have a basis in culturally-determined beliefs about modes of transmission of illness. People are afraid of catching HIV/AIDS through shaking hands because they fear of contamination by sweat, which is thought to contain the disease. Using the infected person's drinking and eating utensils is believed to transmit the disease through the infected person's saliva. Some AIDS sufferers have had their property and utensils burned or buried by family members for this reason. Finally, because breathing the infected person's exhaled air is thought to transmit disease, community members may find sleeping in the same room unacceptable, or isolate a person with HIV or AIDS.

Diseases caused by normal or natural bad airs are viewed to be treatable by normal or natural remedies from the environment, from the earth -- from which the flesh came and must return after the mind-soul goes to the spirit world. The belief in developing immunity from a disease and the perceived appropriateness of herbal or earthly remedies for treating the body help explain why people usually delay coming to a clinic for the treatment of STDs. They will first try herbal remedies for a long period of time; those embarrassed to come for repeated treatments of STDs will sometimes alternate clinic consultations with visits to herbalists.

During discussions on developing appropriate support structures for HIV-infected women and children, respondents to the Behavioral Sciences Family Health Study (a longitudinal study in which first year medical students followed 86 pregnant women in a peri-urban area) talked about local beliefs of HIV transmission. AIDS was reported to be a disease which affects men who have several partners, women who are prostitutes, and women who "sleep around" or have sex with foreigners and diplomats (government officials who sleep with foreigners when abroad). **The faithful wife of a promiscuous husband is not believed by many to be susceptible to HIV infection, perhaps because in local**

communities it is said that the faithful wife of a husband with "runyoka" (which resembles Hepatitis B) cannot be infected by her husband. People in local communities report that "runyoka" is sexually transmitted by married women of a particular geographical area who are hexed or jinxed by their husbands. Any man having sexual intercourse with such a woman becomes very ill and dies. A scientific interpretation of this belief would refer to persons who have developed an immunity but are carriers of the disease.

Because of the conceptual links between AIDS and STDs, it may be critical to study local perceptions of known STDs as a part of educating people about HIV/AIDS. From such research, parallels between known STDs and HIV/AIDS may be drawn, and gaps in existing knowledge, views and practices identified. Building upon identified gaps, the community can be helped to specify and delegate tasks for appropriate prevention and management of HIV/AIDS. In Zimbabwe for example, the idea that faithful women are not susceptible to HIV infection needs to be corrected. However, the information and methods to achieve this must come primarily from the men and women themselves, and not from researchers and health care providers. The community's ideas must first be collected through qualitative data gathering tools, such as in-depth interviews and focus group discussions, in which both beliefs about illness and possible approaches to utilizing those beliefs as a part of a behavior change strategy can be identified.

Conclusion

Sexual interaction and behavior in local communities continues to be influenced by the religious and cultural value of sex for procreation and perpetuation of the seed. This is viewed as enabling the individual to reach moral or spiritual maturity by developing conscience-guided behavior through nurturing of offspring. The personal, social and spiritual importance of procreation may have a critical influence on the acceptance or rejection of programs designed to slow rates of HIV infection primarily through use of condoms. Certain sexual and marital practices which can put people at risk of infecting others or being infected with HIV, such as a man inheriting his deceased brother's wife, are best understood as part of a coherent framework linking sexuality, morality and spirituality. In the same vein, fear of casual transmission of HIV and lack of sympathy for PWAs are linked to existing ideas of moral hygiene and disease causation. How community members think about STDs, particularly how they think STDs are transmitted and prevented, may also have a strong influence on their beliefs about AIDS.

The cultural evidence indicates that to respond effectively to the threat of AIDs, health professionals need to respect and explore beliefs about spirituality, marriage, sexuality, disease causation and STDs, and to respond to beliefs patterns in AIDS prevention programs. Thus, strategies for education and combatting STDs and HIV, if they are to be effective, ultimately must come from the communities themselves. The role of the researcher should be to assist communities to identify their own problems for study, and

to develop strategies for appropriate modification of sexual behavior, in order to prevent HIV transmission.

Women and AIDS in Zimbabwe

Sunanda Ray

The opening workshop address was presented by Sunanda Ray, chair of the Zimbabwe Women and AIDS Support Network. Dr. Ray works as a medical officer for the Harare City Health Department.

Introduction

My own experience with AIDS and HIV has been chiefly through my work as a medical practitioner in primary health care. I am not an expert on the medical problems as one sees them in immunology or histopathology, or even the specialty of medicine; I am a specialist in community health care. I work with people at early stages in their illness, who have symptoms that may lead us to discuss testing. Later, at the point at which they become too ill to be looked after at the primary health care level, they are then handed over to the specialist in the hospital. My comments refer to the experience I and others in the Women and AIDS Support Network have had in helping women who are learning to cope with the knowledge that they have HIV infection or AIDS.

Prevention and caring: HIV and the community

I was asked to give an overview of women's roles in HIV and AIDS prevention. I'm not going to talk about prevention as a separate issue, however, because I think that this emphasis on prevention as an isolated activity has not always produced the most useful approaches to the problem. It leads to the idea that people need to choose between preventing HIV infection and working with people who have HIV infection. This reinforces the "us/them" attitude; the idea that there is a mass of people (us) who are not infected and can be protected from infection, and then there is another small group of people (them) who are infected and require separate programs. We prefer to see prevention and support as part of the same integral program. One of the reasons that we oppose this "us/them" approach is because we do not know, unless each of us has been tested, whether we are a part of the "us" or the "them". If one takes a moderate estimate of risk, such as 10% in the sexually active age group, we could estimate that at least 2 or 3 people in this room are infected. Unless all of us are tested, we do not know who is infected, so the distinction between "us" and "them" is not a useful one.

In self-help groups some of the people with AIDS or HIV are also beginning to adopt the "us/them" approach; they ask "how can others understand what we're going through?" I respond by saying that interacting daily with people with HIV and AIDS gives me some insight into what the problems are, whether or not I am infected with HIV. Building walls does not help us resolve the problems. This separation has also created problems with support and funding, because the donor agencies say "we'll fund those parts of your

work that have to do with AIDS education and preventive counseling, but not those parts that deal with providing material aid for families of HIV-infected persons --- those are recurrent expenditures, a bottomless pit." We see supporting solidarity programs as a route to prevention, since support helps people with HIV to come out in the open and be seen as human beings like anyone else, and this helps others to see that AIDS is here and now in society, and has to be addressed.

Many express dismay that people at risk of HIV infection have not changed their behavior. Now that there is more access to better information, my experience is that many are changing their behavior quite drastically. My contact with them is when they are referred for HIV testing. Many are very anxious and afraid when we discuss prevention and behavior change, but sadly for many, it is already too late to prevent infection. This is not to say that we should just give up, however, because there is an enormous amount of work to be done to benefit those in that situation; it is a very important part of the fight against AIDS. It is also through sympathetic and supportive counseling that the infection is not further spread to others.

Special Problems of Women and HIV

One issue frequently brought up when talking about women and AIDS is -- why women? Why do we need a separate program and groups for women? We can only argue that yes, men have problems, but an important difference is that they already have the facility to organize on their own. We are not excluding men or telling them that they do not have a problem or that they do not have to organize. We as a group, however, have chosen to focus particularly on the needs of women, on their problems and vulnerabilities. This has been taken up as a theme for World AIDS Day because people are beginning to recognize the ways in which women are particularly vulnerable, that women in many cultures and societies have less power than men to influence their interpersonal relationships. Men wishing to act in solidarity with us to meet our objectives are welcome to join us and many have done so.

At the same time, however, it is important to guard against the danger of overemphasizing women as victims. That reinforces the helpless, passive image of women, which we strongly oppose. The image that we prefer to encourage is the one we ourselves are using: women as active participants in this struggle, taking active roles in supporting each other and in fighting against HIV/AIDS. The use of that approach depends on women's ability to feel strong and confident. So long as a helpless, passive image continues, women feel unable to assert themselves in the ways that are necessary to make the effort to overcome their problems.

I would like to tell a story about someone I once cared for. She was a young woman dying of tuberculosis when I met her. Her baby had died of pneumonia a few months earlier, and as she herself became progressively sicker, she guessed that she had AIDS.

She had never been counselled about her condition. She was very angry. She accused her husband of infecting her, of killing their child. All the humiliation she had felt for all those years of silently watching her husband go from one affair to the next came tumbling out in that one big accusation--by your actions you have killed our child and now you are killing me, and I cannot forgive you for it. The husband was consumed by guilt and fear as he watched her in grief and pain, realizing that this is how someone who is dying of AIDS looks, and this was the path he had to prepare for in the next few months or years. The families looked on helplessly; her family blamed the man, but also knew secretly that all those times their daughter had complained about her husband's infidelity their response had always been that she had married him for better or for worse, that this is "how men are". They also worried about the remaining two children and wondered who was soon going to care for them, to pay their school fees, to assure that they had some kind of a future to look forward to.

I had, myself, my own grief and anger when I tried to help that family. Every time I am faced with this kind of human tragedy, I feel sad that I can do so little, angry that we somehow were unable for all sorts of reasons to stop these tragedies from being repeated over and over. I feel that if I had become involved with this family earlier and had been able to be frank with them, and if they had trusted me to guide them, I may have been able to help them come to terms with some of their distress, to perhaps make peace with each other. Instead of hurling accusations at each other in those last precious days and weeks, they could have had more love and support for each other. They may have been able to help each other through the misery of the loss of their child, and the fear of what lay ahead for both of them. We all know that stories such as these, full of tragedy and the pain of betrayal and anger, are now commonplace and affect us all very deeply.

AIDS and childbearing

Women with HIV or AIDS often are asked to make the decision to avoid childbearing. This idea has enormous repercussions for women in Africa, because the status of a woman depends on her ability to have children. A woman is a girl until she has her first child. Her reproductive capacity is often seen as the possession of the family of the man she marries. Even where women have increased status as professionals or workers, when they may have the choice over the number and spacing of their children, to only have one child or none at all makes them feel somehow inferior in our society. It is too important a need and desire. To tell an 18 or 19-old who has been diagnosed as HIV positive that if she gets pregnant, there is a high chance that her child will be HIV positive, and perhaps she should consider not having children, is totally unrealistic in our context.

Several times women have become pregnant after their HIV test, even between the pre- and post-counseling period. Sometimes testing positive for HIV seems to accelerate their plan to get pregnant. The reality of a baby's suffering and dying from AIDS may

be an unknown quantity to a young first-time mother. In the beginning I was astounded when this happened, and was concerned that I was not being an effective counselor. When I began to talk it through with other women it became clear that not having children was just not an option for them. So long as they felt healthy, they would go ahead and take their chances.

I don't believe that any clinician or health worker has the right to say to a woman that she cannot have a child, or to create such guilt in a woman that she feels terrorized. That woman will not come back to that clinic for the advice or support that could be provided. We try to encourage in our training that women be given information about the risks of childbearing, both to them and to their children, but that their choices be respected. It should be made clear that if an HIV positive woman chooses to get pregnant, that every support will be given to that woman and her child. Women need to support each other in the choices they make, and not condemn each other or lay blame for who passed on the infection. It is important to recognize that this disease is with us for the long term and to find the best ways of supporting each other. One way is for someone who has personal experience of a similar situation to give advice.

Women as caregivers

Women have many roles to play in society, and the HIV epidemic has not changed those roles in any important way. One area where women have a critical role in HIV and AIDS is in the traditional role of caregivers. The ones who nurse people with the disease are usually women: either professionally as health workers or in home care. We expect women to take the major emotional and physical burden of looking after people with AIDS. Often the mother or sister of a person dying of AIDS in a hospital is the one sitting beside them all night, providing care in their last hours.

It is important to recognize and not just expect this sort of care from women. We're trying to encourage AIDS support groups to also give support to caregivers. If they know of someone who is providing home care for a dying AIDS patient, they must organize to support her in her efforts. Who is going to feed that women, when will she have time to bathe herself, who will counsel her about her own grief as she watches someone die? She may feel the stigma of the person who is dying, and may not be able to go to her church group and say "I would really like to talk to someone about the fact that my son is dying of AIDS." She shouldn't be carrying that burden alone. There are already in existence community support systems which can be further developed and reinforced by women to provide material and psychological sustenance for each other. A critical issue related to women and AIDS, is that many programs involved in women's health view us primarily as mothers. We have our own personal health needs as well, separate from roles as mothers or caregivers, that deserve consideration.

Women will always be caregivers, but they should not have to take on alone the burdens

of the larger society. When we talk about orphans, for instance, they are not just a women's problem, but a community problem that must be dealt with by the whole community. No one wants orphans institutionalized, but in many cases that means that they must be cared for by the extended family. People often say, "look at that poor grandmother, see how many children she has to provide for." The grandfather is somehow in the background, even though he may be bringing money into the household and could be a more useful resource.

AIDS and children

We also need to ask what happens when AIDS orphans grow older. There are already teenagers who are becoming aware that their parents died of AIDS. Because of the association of AIDS with immorality and talk about the need for strengthening the moral fiber of communities, these children think that it means their parents were immoral; they themselves carry the shame and stigma. Often it seems that the stigma carried within a person is much greater than that placed by society, and we are concerned about these orphans unnecessarily carrying this heavy burden.

Preservation of the health of the 5-14 age group who are at present virtually uninfected is another priority. Adolescents must be specially targeted in preventive counseling strategies that emphasize the consequences of early sexual activity, including teenage pregnancies and sexually transmitted diseases. Schoolgirls are especially vulnerable, and sexual abuse of children becomes more grave in the light of HIV infection. Sex education in the schools should be improved; we would support sex education starting at a much earlier age, and programming it in a way that is suitable for each age.

Even 12 year-olds are quite aware of sex. Studies in rural and urban Zimbabwe, as in other countries in Africa, show that women are being infected 5-10 years earlier than men, often in the early childbearing stage of their lives. We are seeing cases even in 15, 16, and 17 year-olds which means they may have been infected a few years earlier. We should learn from the experience of other countries that to ignore teenage sexuality carries a severe penalty. In Zimbabwe, as all over the world, there is clear evidence that children are thinking about sex at much earlier ages than we or our parents did.

It is essential that children feel able to take their anxieties to those closest to them and that they have good role models to follow. The concept that sex is a means by which to acquire presents, new clothes and perfume is reinforced by urban culture and advertising, and is often a subtle influence in many homes, used by both men and women in their negotiations with each other.

Women must be encouraged to talk to their children about sex, although many people's reaction is to throw their arms up in horror and say that it is not "traditional" to do so. Mothers don't talk to daughters, although aunties do, and uncles talk to nephews--that is

the way it "should" be done. But then how do we cope with the fact that the auntie is often in the rural area or caring for her own family many miles away, and the problem we face with our children is here and now, and extremely urgent? Our approach is to emphasize that because this disease is new, and is causing a lot of new problems, we have to look for new solutions within our existing culture and traditions. It is important to emphasize that people may not be able to make dramatic changes right away. But if they can talk about it at church meetings, at school—from there they will begin to feel more comfortable about talking about sexuality. Women say that if their friends are discussing sex too, they themselves feel more comfortable about doing it. This indicates another important reason for the development of networks.

The stigma of AIDS

I believe that some of the stigma around AIDS was created unwittingly by health educators. They were initially so intent on frightening people about the danger of HIV and AIDS, that they neglected to emphasize the ways in which people don't get AIDS, particularly that it cannot be transmitted through social contact. There is therefore quite a bit of earlier damage to undo. This problem spills over into every arena. Even though people have the factual information about not getting the infection from putting an arm around someone or sharing a glass, people have internalized the fear of infection so much that they may avoid even breathing the air of someone they know is HIV-infected. It may even be true with nursing staff, who have asked for "danger money" for having to work with people who are HIV-infected.

We must make every effort to overcome the stigma of AIDS. One approach that has been useful is the involvement of people with AIDS or HIV in the counseling, support and education about AIDS. For this to happen, people must be able to come forward and say "yes, I am HIV positive," and know that their community will accept them as ordinary people. As long as "we" isolate "them," fear and shame will continue to be a major obstacle.

Most HIV-infected people are afraid to come out now, because they are afraid of being ostracized or fired from jobs. Discrimination in the workplace has become an area of concern because of women known to have lost their jobs when their HIV status became known. Even though the Zimbabwe Minister of Health has issued a directive that HIV infection is not a valid reason for discharging an employee, and has spelt out the modes of transmission to justify this policy, there is still a lot of anxiety. It is vital to get to the root cause of these anxieties. Often the problem is not so much due to ignorance of the facts, but because employers have not had to confront their feelings about people who are infected. As long as infected people continue to stay invisible, their problems can be ignored. It is only when they become visible that society is forced to come to terms with the reality of AIDS. By contrast, dealing with real individuals becomes much less threatening than trying to fend off a threat so terrible it can only be imagined.

At present, infected people are very concerned that no one else knows about their situation, for fear of victimization at the workplace or isolation by their friends. This means that after pre- and post-test counseling by health workers, people often keep their feelings to themselves, not even telling their families as they would traditionally with other life-threatening illnesses. They live in terror that someone will find out. This leads to emotional strain, which is intensified if they have not had the chance to sort out their family affairs. It is so important that people with HIV become accepted as ordinary people in society, that they get the emotional support that they need, and that they are seen as making a valuable contribution to society by their work.

Social welfare departments in many African countries were unable to provide for many of the underprivileged, destitute and abused even before this epidemic. Now the strain on existing services is becoming desperate, while the families of the HIV-infected are the most vulnerable. Young people are usually the economically most productive, producing not only for themselves but for their extended families and with a view to their children's futures. Now they are being struck down in their prime. Even for those well enough to continue working, their HIV status may become a barrier to finding employment or keeping a job, if it becomes known. The stigma of being infected is therefore enormous. Women are especially vulnerable because they may be rejected by their families, their partners and by their work colleagues, while having small children who also may be infected. The support needs of a woman in such a position cannot be overestimated.

Empowerment of women

Programs that empower women are urgently needed to arm them with the knowledge needed to fight against the spread of HIV infection, and to cope with the effects of the disease. This empowerment will only occur when we recognize the problems and work towards supporting each other. We must stop gossiping, after a man has died of AIDS, about who he has slept with, which woman gave him the infection, could it have been due to witchcraft out of jealousy? Many men refer to AIDS as a woman's disease -- something you get from women, that "dangerous" part of women. By thinking of women as "carriers" of the infection to men or to babies, we are undermining ourselves. The blaming, the victimization, has to stop and we won't move forward until we stop doing it.

Empowerment of women involves developing strategies whereby decisions are made for their own wellbeing and health, so that destructive relationships do not continue just because of economic dependence. Unfortunately, many income-generating projects planned for that purpose rarely generate much surplus, and the projects continue to be dependent on donor finance to survive. It is also preferable that people who are infected continue to work as fully integrated members of their communities, with sympathetic arrangements for sick leave, rather than being separated in 'HIV ghettos'.

Material aid is another area which can lead to donor dependency, with NGOs struggling to find resources for increasing numbers of people who are desperate for help with basic needs. Ministries of Health, Labour and Social Welfare need to develop strategies on how to cope with these demands, and to work closely with NGOs on provision of care. Community-based care is the ideal at every level. People who are dying of AIDS or looking after someone who is dying, adult or child, should be able to get basic training and supplies from their local clinic in home care, hygienic techniques and methods for disposal of soiled materials, with additional support from other community cadres, formal and informal.

I will conclude with a reminder that there are positive trends emerging from the tragedy that is AIDS. Women are looking for courage and compassion and finding it in all kinds of unexpected places. We are trying to enhance those features of culture and tradition that lead to better cohesion between people in communities. Rather than allowing the negative, destructive effects of the scourge of AIDS to dominate, setting families against each other and leaving the most vulnerable alone and uncared for, relationships and attitudes are being evaluated, sometimes challenged, and their strengths and weaknesses put into balance and perspective. These new perspectives are our best hope for the future.

Mosquitoes, Morals, and Misconceptions: Findings and Questions from Focus Group Discussions in Marondera

Sally J. Scott

During the workshop, four focus group discussions (FGDs) were held in the town of Marondera, the seat of the district in which World Vision Zimbabwe is implementing a HAPA grants project. This brief report will review preparations made for the FGDs, several patterns that emerged from the discussions, and some questions raised by the findings.

Background

The exercise was intended to provide an introduction to the methodology of focus group discussions, and to provide workshop participants with the opportunity to moderate, observe, or record an FGD session. The available time and resources did not permit a formal or complete training in focus group techniques. In preparation for the FGDs, the workshop facilitator, World Vision staff and local Ministry of Health staff developed criteria for selecting local participants for the discussions. World Vision and Ministry of Health staff then contacted English-speaking members of the community to take part in the discussions, comprised of two groups of married men and two groups of single women. In each focus group there were 7-10 local participants, and one moderator, one recorder and several observers drawn from the workshop participants. The workshop facilitator developed a discussion guide for the FGD sessions which touched on several major topic areas: AIDS transmission, personal risk assessment, condoms, communications about AIDS, testing and counseling, and behavioral change. The breadth of the questions prevented the groups from discussing any one topic in great depth.

In addition to introducing the workshop participants to FGD methodology, the exercise served as an initial probe into the maze of feelings and facts about AIDS circulating in the Marondera community. This chapter will describe three patterns that emerged during the discussions: differences between the ways women and men were able to talk about AIDS with others; the mixture of denial, fear, hopelessness and sympathy surrounding HIV infection and people with AIDS; and the range of beliefs and values concerning HIV transmission and condoms. NGOs and partner organizations that use, or want to use, qualitative data-gathering techniques to plan activities or assess projects, particularly in an African context, may find it useful to know what was learned and some questions that were raised in the Marondera FGDs.

Communicating about AIDS

In responses to questions about talking with other people about AIDS, denial and fear seemed to permeate the way female participants learn and think about AIDS. Several women were not able to discuss AIDS with their boyfriends, because the men denied the existence of the problem. Others reported that their boyfriends indicated that they "had to die of something", and that their fear of AIDS was not strong enough for them to give up sex. When one woman brought up the subject, her boyfriend replied "I'm not a fool!" and cut short the conversation. Some women however were able to discuss AIDS with friends, older people, and co-workers.

In contrast, male participants did not report the same resistance to talking about AIDS. They discuss the issue with workmates, friends, brothers, sisters, wives, and in-laws. One man did not think it necessary to bring up the subject with his wife because he did not "fool around" outside of marriage. In general, however, the relative freedom to talk about AIDS reported by the men, as compared to the difficulties the women faced, appears to parallel existing differences in sexual freedom between the sexes: the acceptability of multiple partners for men, and the expectation of fidelity for most women.

HIV testing and PWAs

Questions about HIV testing produced a range of fearful, angry, despairing and cautious responses. Some women felt strongly that they would commit suicide if they tested positive for the virus, and so would not elect to be tested. Usually participants did not make a clear distinction between HIV and AIDS. A few women indicated an inclination to seek revenge; in the words of one woman, "If I was HIV positive I wouldn't want to die alone; I'd take others with me." A different attitude was taken by others, who thought that they would cut back on the number of sexual partners if they tested positive. The men tended to believe that testing would be of no value: "Everyone [who tests positive] is going to die; why do you want to know early?". Some men thought that people who have tested positive do not disclose the results because their friends would avoid them.

Discussion of how to treat people with AIDS (PWAs) provoked apparent anger and fear among the participants, though some also said they felt pity and sympathy. One woman was convinced that pleasure-seeking PWAs spread the disease knowingly through their sexual practices and that they had no sympathy for their victims. Two women insisted that PWAs should live apart from the rest of society in an isolated camp. Other women felt sorry for PWAs, but also feared them, and said that they would separate from a boyfriend if he was HIV positive, though if married they would stay with an infected husband.

The men expressed both negative and sympathetic reactions to the idea of interacting with a PWA. Some said they would refuse to sit near -- or would even run away from -- anyone who was ill with AIDS, while others would contact or counsel a friend with AIDS only through letters or over the phone. One man thought that a person diagnosed with AIDS is already a "dead person". A few men did express sympathy, and indicated that they would treat a PWA like any other person with a serious illness. Others believed that no one would care for a PWA, because nothing could be done at home. They felt that the place for PWAs is in the hospital or with a traditional healer.

Transmission and condoms

In addition to the fear and anger expressed by the participants, a number of different opinions were voiced that seemed to reflect disagreement or uncertainty over several issues related to transmission of HIV. Participants disagreed whether in perinatal transmission an embryo is infected through a man's sperm, a woman's vaginal secretions, or in utero. Some women denied that HIV could be transmitted through casual contact, while others thought that the virus could spread by sharing a towel or a bed. The men came up with a longer list of possible routes of transmission, including swimming pools, mosquitoes, flies, dust, and stepping on sperm spilled from discarded condoms. One man expressed the fear that children would find condoms thrown on a road, think the condoms were balloons, and be infected by sperm leaking out into their mouths.

It was pointed out by one man that AIDS prevention programs had been sending a mixed message: use condoms with multiple partners, and stay faithful to one partner. Another saw condoms as a poor solution to the problem, because the real problem was the lapse of traditional morality, the adoption of western ways. For most men, condoms had multiple associations: AIDS, family planning, birth spacing, lack of pleasure, promiscuity, messiness. One man said that he would not use condoms because women did not like them, while another revealed that he would put on a condom for a few minutes, then take it off to enjoy skin-to-skin contact.

One woman admitted to having a partner who used condoms. While most women indicated that they would use condoms if men agreed, because condoms protect against sexually transmitted diseases and AIDS, they insisted that men do not accept condom use. They also expressed fears that condoms were not 100% safe, and might get stuck inside them. After the women discussed condoms for a while, an interesting exchange occurred: one woman asked "Are we allowed to keep condoms?" and another responded: "We should be allowed." The legality as well as the acceptability of condoms seemed to be in question.

Conclusion

The four FGDs held in Marondera introduced workshop participants to focus group techniques and probed the varied reactions of community members to current information (and misinformation) circulating about HIV infection and AIDS. While these FGDs can not take the place of a systematic qualitative investigation into AIDS-related beliefs, the exercise did raise useful if difficult questions: How can educational campaigns address the difficulties women encounter in discussing AIDS and safer sex with their partners? How can educators defuse the intense fear expressed by some in response to questions about HIV testing or relating to PWAs? What are the sources of common misconceptions about HIV transmission, particularly beliefs about casual transmission? Are there conceptual links which people are making between AIDS and other sexually transmitted diseases? Are people confused by the multiple associations -- casual sex, family planning, AIDS protection-- of condoms? Will it be possible to destigmatize and legitimize condoms for all types of sexual relationships, or only the more casual? Why do some people feel a deep concern about children being exposed to HIV through discarded condoms? Asking these kinds of questions in further qualitative studies will help NGOs to understand and more effectively address the complex community concerns raised by the HIV/AIDS pandemic.

Section II

Intervention Strategies

Interview With A Traditional Healer

Tarisayi Mark Musara

Mr. Musara, National AIDS Coordinator of the Zimbabwe National Traditional Healers Association (ZINATHA), was interviewed by the workshop facilitator and participants during a workshop session. Following are excerpts from the session.

Q: To begin with, what is traditional healing, as compared to other forms of healing?

A: It's like any kind of treatment given to patients, but this one is done at home by traditional healers. Certain illnesses can't be diagnosed except by traditional healers, and so these illnesses must be treated by them.

Q: Are there any female traditional healers?

A: I think there are more female than male traditional healers. Some are only traditional midwives and others have broader skills. Some men have other professions and prefer to be traditional healers only on weekends, but women have no other profession, so they stay with healing.

Q: How were you trained as a traditional healer?

A: In Zimbabwe we don't train traditional healers. To become a traditional healer in Zimbabwe you must have a talent. Instead of training a healer, this inborn talent is upgraded. After one has completed the rituals and so on, he is registered. In Zimbabwe we are making healers aware of AIDS as a part of upgrading their knowledge and abilities.

Treating AIDS

Q: How does a traditional healer work on HIV and AIDS?

A: First of all, HIV and AIDS are not traditional problems. If anyone thinks that a traditional healer would come up and describe AIDS like this, it's not true; it's a foreign disease. But through the Traditional Medical Practitioners organization, all the traditional healers have put their heads together for an AIDS awareness campaign. Why? Because at first there was a lot of resistance in our community, when people from Western cultures said AIDS has no cure. But now we know AIDS has no cure, except to change our behavior.

Q: How can you diagnose HIV infection in the traditional way?

A: Well, in Zimbabwe the doctors in Western hospitals don't diagnose HIV infection, nor do the traditional healers. Only the machine [ELISA and Western Blot tests] can tell if you are infected!

Q: We have been reading that maybe a treatment for AIDS will come from traditional healers. Do all the traditional healers follow the same treatment plan or does each one have their own method?

A: It's a bit difficult because now the patient only comes to the traditional healer when he is very ill, and there are too many illnesses for the traditional healer to attend. But there is not what you would call "uniformity" in traditional practices; one healer will use a certain substance for stomach trouble and another healer will use the same substance to cure a headache.

Q: What have you done when traditional healers try to use modern medicine in collaboration with their traditional medicine?

A: Here in Zimbabwe this is why there are two medical councils. The conventional practitioners and traditional healers each have their own methods, and they never directly exchange patients or ideas. It is taboo for the traditional healer to have tablets used by conventional practitioners.

Q: You encounter traditional healers who claim they can cure AIDS. What does the association do about this?

A: There have been three reported cases of healers claiming to cure AIDS, and we have punished them. The punishment is suspending them from taking any leadership and making any public statement while under scrutiny. A healer claiming to cure AIDS is not allowed to publicize anything about that. AIDS is a very serious issue for everyone, so any claims for a cure should be handled through the association, because people are trying to find a cure all over the world. The small man who is trying to gain lots of money easily by saying that he cures AIDS -- we punish him!

But we have also realized that this was done through ignorance and therefore we have intensified workshops on AIDS education whereby they themselves agree on explanations of AIDS. They accept that they cannot cure AIDS.

Q: What do you say when someone comes and asks, "You can't cure me -- is it because I am infected with AIDS?"

A: In Zimbabwe no one is allowed to point a finger and say "you have AIDS" -- it is like saying you are dying tomorrow. I think we need to train more traditional healers in signs and symptoms and counseling, so if they suspect someone of being infected, they refer this person to hospital.

Healers as counselors

Q: Are traditional healers involved in counseling people about AIDS?

A: In Zimbabwe two thirds of the healers' work is counseling; they are not only treating the physical problems of patients. So we're polishing their counseling skills. In the Western world, if a husband or wife is affected by AIDS, the doctors ask "Do you want us to tell your spouse?". Traditionally however, when a patient comes back to a healer in the home village, we like to see the whole family. The healer and family see this thing together, we take it as a problem for the whole family. We do not talk about a cure, because it's too early to talk about a cure.

Q: Would you call the whole family at this point?

A: Yes, we call the family and the problem is explained to them, because in our culture we have the extended family, through which we educate our sisters, our children, and our brothers. Confidentiality is kept by the family as a whole.

Q: Is your counseling practice different from more conventional counseling ?

A: In conventional counseling the healer asks for permission from the patient, and speaks to the patient alone. Traditional healers see the patient with their extended family; family members must help each other and be supportive.

Q: How about emotional support?

A: When you come to me as my patient, before I give you the cure, you must be cured. You see, you get cured because of the way you are thinking, because of the friendship created between counselor and patient.

Q: What difficulties did you have in getting traditional healers to advocate the use of condoms?

A: The problem is not with getting the traditional healers to use condoms, it is with getting the people to use them. We started our workshops with the view that we should break this resistance. Then we taught traditional healers how to use the condoms, and the next question that came was, "can you make a female condom?"

Q: I'm wondering if you and your colleagues can help in stopping the spread of AIDS just through counseling. If a couple comes and says they want to remain negative, but the wife suspects that the husband is going out anyway, is there some way that your counseling services can help stop the spread of the virus?

A: The traditional healers are keeping boxes of condoms, especially for those people

who are already infected. We cannot keep a husband and wife separate, but we advise them not to make any more children, otherwise they will keep on dying. If someone comes more than three times for treatment of STDs, we suggest that he should use a condom, especially a patient who is HIV positive. If they come to the traditional healer they have faith in us, maybe they will do as we advise.

AIDS prevention strategies and workshops

Q: What is your organization's role in the AIDS epidemic?

A: For us to survive in Zimbabwe you must have a private Western doctor, a lawyer, and a traditional healer! No matter what, you have to consult a traditional healer, which is why we thought we should assist the MOH. It is our job in the sense that we have patients that come to us for help, and it is our duty to enlighten our members, so that they know exactly what to do. It's a long term thing. Now we find that the headmen, the chiefs, and the counselors in the local areas are mobilizing their members; we find that when we plan a workshop for 50 people, 150 people come.

Q: Why do they respond in such numbers?

A: They're interested. Their relatives are dying. They want to learn. The chiefs are stressing to us, "you tell them what AIDS is, but to solve the problem we would like things to be the way they were yesterday and not today. Wives and husbands must respect each other as they used to do before". With such a response from the chiefs, we should eventually achieve results.

Q: There are certain traditional practices which may increase the spread of HIV/AIDS, like polygamy. Are traditional healers trying to discourage polygamy, and if so, how do communities react to that?

A: Yes, there are a good number of aspects on our culture that may cause the spread of AIDS, such as polygamy. This is why we have embarked on the campaign against the spread of AIDS where we cover the dangers caused by those activities, and we totally discourage them. As per adult education we don't say "don't do it", but we give suggestions and they choose what they should do.

Q: We've talked about people who are infected with HIV--what about those people who are not yet diagnosed? What have you done to protect yourselves and your clients?

A: This is why we are trying to get funding to do workshops all over the country.

Q: In your workshops do you cover all the modes of transmission?

A: We cover all that, but the first thing is to make the healers understand the importance of support for the patient with AIDS. Then we tell them the dangers of AIDS, the ways of transmission: not sex alone, but contaminated blood through open cuts, etc. The healers must have faith to believe and learn what we teach them.

Q: How do you deal with the misconceptions of traditional healers regarding AIDS?

A: Needs assessments in the workshops bring out the misconceptions. We start explaining bit by bit, and little by little they will get the answers. We don't say healers can't cure AIDS, because then they will never listen to us. We explain what "A", "I", "D", "S" stands for, and when they ask us if we can cure all the signs and symptoms with a single dose, we say no.

Q: What do you tell people about HIV infection through razor blades?

A: We advise the patient to bring his own blade, or the traditional healer will have many on hand that he will sell to the patient. Also, we have a new method of spreading the medicine first and then cutting with the razor blade.

Q: We hear that there is underreporting of HIV infection in Zimbabwe because many people with traditional beliefs believe in going to traditional healers.

A: At the moment, the project is to assist the government to increase the number of cases that are being treated. That is, the traditional healer is taught the signs and symptoms of AIDS. At the end of the workshop, the traditional healer is supplied with a diary, where he can record the symptoms. He should then refer suspected cases to the government clinics.

Q: How have you tried to evaluate your workshops?

A: Before we did the workshops, we conducted a KAP baseline survey, and then we designed a post-workshop questionnaire based on the baseline survey to evaluate the effectiveness of our workshops.

[Comment] You're challenging the participants' preconceptions of the traditional healers!

Q: There are a lot of AIDS educators trying to convince people to have monogamous relationships. Is this a waste of time, given our culture?

A: It is a long time before we can overcome polygamy, and I think that we should just try to use condoms, if exposed to a situation where we cannot control ourselves.

Q: When people are told that a person is HIV positive or has AIDS, there is a tendency to blame that person or to find somebody else to blame -- how do you overcome that

problem?

A: People say, why can't the government put people with AIDS into quarantine? This may be due to ignorance and therefore we recommend that workshops on AIDS should be intensified because in the long run you may find yourself suffering from AIDS also.

Q: Short of a cure, health education is our only salvation. What lessons can we draw from your experience?

A: Let's involve the community at large--we must be able to sit down and discuss the problem with the people and sell our message to them.

The Use of Theater for HIV/AIDS Education

Ben Zulu

The Batsiranai theater group, made up of professional Zimbabwean actors, presented a drama for workshop participants that portrayed some of the problems of AIDS in urban Zimbabwe. Following the drama, the actors engaged in a discussion with workshop participants on their experience with the drama. Workshop facilitator Ben Zulu later led a discussion of the drama that focused on the uses of theater and other arts as media for HIV/AIDS awareness and discussion. This chapter begins with a brief summary of the play, followed by excerpts from the discussion among workshop participants and Mr. Zulu.

Summary of play

The two main characters in the drama are a factory manager and his wife. The manager treats his workers, girlfriends, fellow drinkers and wife with arrogance and willfulness, though he is not without some charm. His recklessness with women is demonstrated in two scenes: first, he convinces his current girlfriend to make love at lunchtime in a warehouse storeroom; then, at a neighborhood bar he accuses a former girlfriend of having given him an STD, and drunkenly tries to seduce the young daughter of the bar owner. When his wife tells him that she has been diagnosed HIV positive, he angrily throws her out of the house and then stands weeping, in shock, beginning to understand that he may be infected as well.

The manager's wife, desperate and lonely, returns to her family compound in a rural village. There she is greeted warmly until she tells her relatives that she is infected with the AIDS virus. They are frightened by the news and force her to leave, and she sings a beautiful but haunting song of sorrow. The drama then jumps a few years ahead, and we see the manager staggering into the room with AIDS-related dementia. His wife remains by his side, but the factory workers (who have come to visit) jump to avoid touching him when he falls. The play ends with a funeral for the manager, followed by a rousing AIDS awareness song (sung, as were all the songs, in Shona).

Discussion: theater as education

Zulu: What did you think of the theater presentation as a method for education about HIV and AIDS?

Participant: We hope that our AIDS prevention projects are not just education, but are changing people's attitudes and behaviors. In the play, I don't think that issues related to behavior and attitude were clearly enough handled.

P: The director did say that the basic objective of their presentation was to create debate. He said that when the manager was very sick and falling down, and one of the workers did not even want to touch him, the worker's action was a reflection of the audience's attitude, and not intended to make the audience feel fear. The theater group wants to create debate and present the missing pieces in the discussion after the performance.

P: The group wanted to generate discussion in the community. I think that any time that you get people in the community talking openly about AIDS there is going to be some attitude change.

Z: If I understand you correctly, we need to make a distinction here between (1) promoting attitude change among the audience by using the play to stimulate discussion, and (2) promoting attitude change among the audience by showing the attitudes of the characters in the play change in a significant way. Another related question to ask is, if our intention is to stimulate discussion by using the play as is, how appropriate and accurate is the information provided?

P: The drama gave us little bits of information -- teasers -- which was a good idea. The actors are working with communities in a state of relative ignorance or misinformation about AIDS, and consequently they try to create interest in the topic, so that people in the community are able to overcome their fear of the disease. That in itself is already an attitude change. I think the theater group is successful if the play is not only entertaining, but presents a sensitive issue in a way that a community can understand.

P: I think that the drama raised many questions and problems, and a solution was suggested at the end. But how effective is this group at helping the audience find their own solutions to the problems raised in the drama? It was not clear whether the actors are able to answer all the questions raised. Does the drama group provide alternative information sources such that the audience will know where to go for additional information?

Z: Are you saying that there may not be enough information in the play to serve as a resource to discuss the issues raised? Perhaps the play should suggest where to go for additional information when needed.

P: Yes. For example, in that drama it was not clear how you can contract AIDS. If they had a set of questions to ask the audience after the performance, such as "was it proper for these people to run away from the manager when he had AIDS?", then the actors could hear the audience's opinions and they could give the audience proper information immediately.

Z: Remember, that live performances work differently at the community level than in some larger arena because the separation between performers and audience is a very

narrow one. The audience make comments as they go along and the performers interact with the audience. Drama speaks through action; I personally believe that the drama has to speak for itself. Once you add lecturing after the drama, you have changed the format. Some people will not even stay until the end, they just leave at different points depending on their commitments.

P: I think the role of humor in the piece shouldn't be underestimated in getting people to talk about the issue and diffusing the fear and stigma. Humor is very effective.

P: The drama might be more effective if the drama group didn't go around performing on their own. They should work with other people with more expert information to answer questions from the audience.

Z: I'm not sure about that either. When the actors go on tour, it is unlikely that a health educator will go with them. They are on their own most of the time. So the key role of the health educator is to make sure that they are able to present accurate information.

P: We must also remember that this is a drama -- we are trying to reach an audience that is probably anxious to see the latest film -- and if we put in too much information we might spoil the entertainment. So I think that at times it is not possible to put in as much information as we would like. It would make the play too long and not very entertaining.

Overview of working with artists

I want to summarize several main points we have made. When we try to fight AIDS with drama or some other creative approach, we use education through entertainment. We must clarify our own roles as health planners and educators. Our role is to emphasize what is going to be said. How it is done you must leave to the artist. After all, artists are good at what they do and they know what gets the audience involved, what makes the audience laugh. We must try not to control the artist too much. At the same time, we must be very specific in terms of the specific messages the artist should include.

We may be able to come up with entertaining dramas about AIDS, but the important issue is: how can we put across specific messages without interfering with the artistic presentation? In the Batsiranai group's drama, I think there were three points at which accurate information could have been conveyed more effectively without affecting the dramatic flow of the play. One was the scene where the wife is told by the doctor that she is HIV positive. Here, the doctor could give the audience some critical information about transmission and prevention. In the second scene the village aunt has the potential to play an important role as a counselor, but that potential is not realized. Last was the final scene; it could have shown much more about living positively with AIDS.

Artists may be defensive about any suggestions for modifying their work because they tend to be defensive about their works, be it a play or a poster. After all, it is their personal creation. For this reason, there always will be artists who want to maintain control and resist outside input. But, agreeing upon your respective roles with artist from the beginning should help to deal with any conflict in this area.

In sum, this is may checklist of four basic points to remember when working with artists:

- 1) When we work as health promoters with graphic artists and dramatists, it is important to be absolutely clear about what we want to be included in the artistic product. To not interfere with the creative process, we must say exactly what messages should be conveyed.
- 2) The information or message to be presented should be very straightforward, and supported by credible facts. It is important not to try to put across too many messages or the audience is likely to become confused. to determine how clearly the messages were transmitted and comprehended, it is always possible to conduct simple exit interviews as the audience leaves.
- 3) We also need to ask what we want people to do with this information, what actions we hope they will take as a result of watching the play. For example, we might hope that after watching this drama that people in the audience talk with their families about AIDS, or treat people with AIDS more kindly. Such objectives should be identified as clearly as possible and discussed with the artists early in the process.
- 4) Lastly, we should pay attention to the tone which frames the whole message. Think about your attitude as an educator, and explore the attitudes of the artist. You may have to educate the artists, or least give them access to very good information, before you can expect them to share and exhibit your attitude towards something as controversial as AIDS.

Community-Linked Counseling

by Christine Mutize

A day-long discussion on various issues related to counseling was lead by Christine Mutize, National Health Coordinator of the Catholic Development Commission in Zimbabwe. The following represents excerpts from Ms. Mutize's remarks, with significant contributions from Reverend Chad Gandiya of the AIDS Counseling Trust (ACT) and workshop participants.

Stigma of AIDS

The problem of HIV and AIDS represents many kinds of challenges to those who are working to reduce the toll of the epidemic. One key question for counselors is: how do we deal with the stigma of AIDS? When people see posters that say "AIDS Kills" or "Avoid Casual Sex" or "Don't Be Promiscuous" what are they learning? Perhaps that AIDS is only a problem for men who spend their money on prostitutes. All kinds of people are dying from AIDS, but the stigma is preventing us from seeing this clearly. I think the best way to break the stigma is to talk more about AIDS, to stop making excuses for AIDS, to accept that this disease is here, and now to plan together how to fight it. The only way we are going to convince people that AIDS is here is to make it clear that the main mode of transmission is a natural behavior, not some awful crime. The more we talk about AIDS, the less power the stigma will carry. I think that you don't owe anyone an explanation for having AIDS -- you don't even owe your family an explanation as to how you were infected.

Community-linked counseling

So what are the qualities of a good counselor? Experts in the field say that a counselor should be a respectable person, well-informed, welcoming, non-judgmental, empathetic, trustworthy, a good communicator, a good listener, etc. I have a different perspective. Previously, though I was a trained nurse, I tried to keep a distance from AIDS. I hadn't really interested myself in the problem; I knew about AIDS just as a bird in the sky knows about AIDS. All I had heard was from the newspapers and the radio, and sometimes I didn't listen very much. I took up counseling because people started to come, often uninvited, and ask me about AIDS. People came to me for counseling not because there was not another counselor in the area, but because they trusted me. I can help someone who trusts me. I began to see that anybody has the potential to be a counselor, because anyone can be chosen for that role.

When women meet after their husbands leave for work, and talk about their problems and advise each other, they are in a kind of counseling session with each other. In the streets, in the supermarkets, friends and neighbors counsel each other. **Their ability to**

counsel each other about AIDS depends first of all upon their being well-informed about the disease. We need to make sure that many people in the community --not just health specialists-- have accurate information on AIDS. Often a daughter will go to her mother to ask about AIDS testing; if the mother has accurate information, then she can counsel her daughter. Our aim is to enable everyone to counsel on AIDS, though certainly not everyone will have the same capacity. As a counselor, I have to know my own limits and refer to other people with more capabilities when necessary. Someone else can pick up where I leave off. Given the widespread nature of the problem, it is important to help people who are not specialists be able to help their family and friends, and also to understand their own limits, when and where to seek more help. We need to work much harder at reaching as many people as possible with accurate information.

Couples counseling

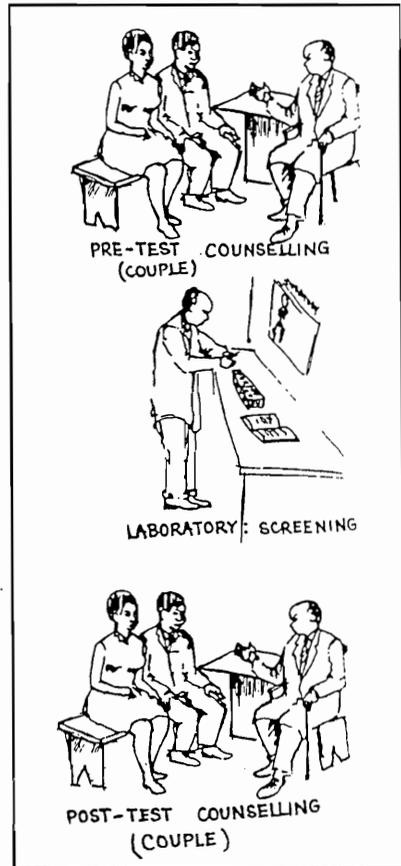
A counselor encourages clients to discuss their feelings and attitudes and to work toward behavior change. A counselor can also help people to communicate. Clearly if the counselor just tells someone what to do, they are unlikely to listen, and will resist behavior change. I have had women come and ask me for a doctor to write to their husbands suggesting they come for testing; the women want an authority figure to intervene, because it is difficult and frightening for them to talk directly with their husbands. They think that getting the test is the answer, that somehow it will solve their problems. But it is possible that their problems will be even more complicated and painful after the test, if they are not prepared for the process. **We need to remember that in counseling we are dealing with relationships, not just the AIDS virus.**

In pre-test counseling we give as much information about AIDS as we possibly can because the person is usually eager to learn and can absorb a great deal of information. Before the test is given, it is also important to understand the client's motivation for taking the test, and to obtain informed consent for the test. I want to tell a short story to illustrate this point. A close relative came to me asking to go to the AIDS clinic for testing. She thought she would convince this husband of hers that he was getting the AIDS virus from other women. To make things worse she was expecting a baby. She said, "If I have positive test results, I will show my husband the results of his promiscuous behavior!" Now, how does one counsel this woman? Her husband could turn the tables and say, "How do you know you got this virus from me?" Do you think she understood what taking an HIV test would mean for her, her baby, or her marriage? She may not have realized that a positive result would indicate that she would eventually develop a terminal disease. She thought that AIDS would give her some advantage, that AIDS would scare her husband out of his wits, out of his promiscuous behavior, and that then he would pay more attention to the home, and bring home more money for the children. Also, she was assuming that the results would be positive. What if the results came out negative?

The AIDS Information Center in Uganda has found that one way to prevent this kind of confrontational situation is to offer pre and post-test counseling for couples. The couple comes to counselling together, as they would to a marriage counselor, and they take the test and get the results together in the same room. Then with a counselor they discuss what the results mean. Many difficult issues come up for the couple -- marital tensions, their children's health, the husband's promiscuity -- but there is more chance for clarity and understanding when the couple is tested together. **There is greater honesty when both members of the couple hear the results at the same time, and one is not given the burden of telling the other.** A confrontational situation where the wife is accusing her husband may not work in couples counseling, until somebody has talked to the wife or at least told the husband that the two should come together for testing and counseling. In some cases, counseling as a couple seems to work better for couples who plan to get married than those already married. Some people want to get married but are afraid to go ahead because of AIDS. We hope that as the stigma decreases, more couples will come in for counseling before and after marriage.

In Zimbabwe, most of the counseling I do is not for PWAs in hospitals, but with the youth involved in church groups. They voluntarily come to me and we talk about their relationships and their intentions to marry. At this point, most of them are afraid even to get married. They want an HIV test. The question I try to ask them is whether they want themselves or their partners tested for HIV.

Similar questions arise when a child is diagnosed as possibly HIV positive. Do you counsel both parents before you test the child? Do you test the child and mother before involving the father? If you involve the father, at what stage do you get him involved? If the father is not included in initial meetings with medical personnel, it may be difficult to motivate him to come for counseling. He may realize the implications --that he too may be HIV positive-- and deny that any problem exists. Also, the wife may have a very hard time explaining the situation to her husband, and there may be negative consequences for her if she tries to persuade him to come. We need to help the mother, who is somehow expected to keep a cool head, to counsel and to support her husband, while also enduring her child's illness.



Source: The AIDS Information Center

Connections between counseling and education

One connection between counseling and education is the importance of understanding other people's points of view. When dealing with life styles, fears, and coping mechanisms, a counselor needs to recognize that HIV/AIDS is an issue when threatens the very being of a person. This effort may take us out of familiar groups and neighborhoods. I once went to talk to a group of male prostitutes. I thought they wouldn't want to talk with me if they knew I was an AIDS counselor and educator, so I pretended to be just a lady stopping in at their bar. When I came in several of them were happy to sit down and talk with me on social matters. I told them I was upset because a good friend of mine was sick with AIDS at the hospital. As we talked about my imaginary friend I began to hear what they thought about AIDS, their fears and misconceptions. Once I understood their point of view, I was in a better position to give them appropriate information and advice.

The counselor must take into account cultural, social and religious differences concerning what is acceptable as far as touching, greeting, and keeping physical distance between counselor and client. Leaning towards the person seeking counseling and maintaining eye contact usually will convey interest and help the client keep going. It may bring the two together in trust. In any case the counselor cannot simply ignore clients' feelings that are justified by what they are going through; those feelings are a kind of defense. To recognize these feelings, the counselor may break eye contact, or move away from or closer to the client.

Education has a preventive role in counseling. Issues a counselor may cover include: how HIV is transmitted and is not transmitted; any risk to the counselor; behavior change, particularly reinforcement of positive behavior; contraception and parenthood; general sexual wellbeing; care of the infected person, and affected relatives and friends; and, referral and resources. Counseling touches a great deal on especially sensitive issues. A counselor may help the client cope with everyday practical problems, including nursing care, as well as the deeper issues of loss, fear, pain, disability and death. A counselor may also counsel the relatives and friends of a person with AIDS, to help them accept and cope. Understanding that death is a mystery as well as a fact of life, a counselor may grow with a dying person into the fullness and completeness of life.

Conclusion

The problem of AIDS is growing each day in our country. We need to start by addressing the terrible stigma that makes people scared to think or talk about AIDS. If we discuss AIDS as we would discuss any other disease, and have the same sympathy for PWAs that we have for other ill people, then counseling will happen within our family and community networks. If people have accurate information about prevention, transmission, and treatment of AIDS, they will have the potential to be a first line of

counseling for family members and friends. For more persistent or complex problems, a second line of more experienced counselors is needed in the churches and health centers. An important complement to counseling is the option of blood testing, which should be as readily available everywhere as it is through the AIDS Information Center in Kampala. Counseling also is connected to education, because the process of listening to people in counseling can help uncover the misconceptions and fears which need to be addressed in AIDS education programs. At the community level, counseling and care should be closely linked to education and prevention.

Section III

Programmatic Issues

Monitoring and Evaluation of NGO AIDS Activities

Mary Anne Mercer, John Makina and Marshia Herring

Several workshop sessions focused on monitoring or evaluation of NGO projects for HIV/AIDS prevention. This chapter synthesizes key elements of presentations by the three authors. Dr. Mercer is director of the HAPA Support Program at the Johns Hopkins School of Hygiene and Public Health. Mr. Makina is a lecturer in the Department of Adult Education at the University of Zimbabwe, and Ms. Herring is serving as assistant chief of the AIDS Prevention Branch in the AIDS Office of the San Francisco Department of Public Health.

Introduction

Developing approaches to preventing the further spread of HIV infection and AIDS in Africa is the formidable task being undertaken by all of you attending this workshop. It is sometimes helpful to be reminded of the very important pioneering role you have taken on by accepting this challenge. We are living in a time when critical decisions must be made: decisions about how best to respond to the HIV epidemic in Africa and in the rest of the world, and how best to direct the limited resources that are available. The work you are doing will help assure that our future response reflects the most important "lessons learned" from our experience to date.

You have expressed concerns about limitations in your understanding of how best to proceed with your projects, and about what approaches and interventions are likely to be most successful. These concerns are realistic; at this stage there is much yet to be learned about "what works," and under what conditions. However, as staff and counterparts of voluntary non-governmental organizations (NGOs) you are in the best position possible to help find answers to these questions. There is increasing awareness worldwide of the important role that NGOs, working in partnerships with ministries of health, universities and others, can play in developing the most effective global response to the pandemic of HIV infection.

Recognition is growing that NGOs are well equipped in a number of ways to make a real contribution to the fight against AIDS. Your most important qualification for involvement in this effort is that you are already working at the community level to help people find answers to their many problems of health and development. Truly relevant and useful approaches to any of the persistent social problems of our time are unlikely to be developed outside the settings in which they exist. You have gained a lot of understanding about working with the community in other areas of health and development, and you are able to develop and test ways of applying that experience to the problem of HIV and AIDS more quickly than most governmental structures can. And, very importantly, you share a basic commitment to helping the most destitute and marginalized groups, a dedication that is sadly needed in the work to prevent or cope

with the devastation of HIV infection and AIDS.

However, the importance of NGOs in the fight against AIDS brings with it important responsibilities. Chief among those responsibilities is the need to do the best job possible with the resources available, and to do it quickly. Knowing that "things take time" is less than helpful when we consider that day by day, week by week, more and more people are unknowingly becoming infected with HIV. But experience also has shown the futility of attempting to do too much too quickly, and in the end having very little to show for our efforts. All of this leads to one inevitable conclusion: **the critical importance of monitoring and evaluating AIDS-related projects and activities.** The ultimate value of the contribution of NGOs may rest on how well they are able to track and assess the effectiveness of their approaches. The following sections will outline several key elements and issues for NGOs to consider in evaluating their HIV/AIDS activities and projects.

Objectives, indicators and targets for HIV/AIDS projects

The beginning point in program development is, of course, the assessment of need: analysis of what is considered desirable, in comparison to what is known to exist. The community in which the need exists should be involved in the process at this stage, and at every point thereafter.

The needs assessment leads to the development of specific **strategies** to meet the identified need. For example, the lack of pre- and post-test HIV counseling in a clinic might be addressed through the strategy of training clinic volunteers who have been recruited previously for another purpose (such as assisting persons with AIDS to be cared for at home). As the strategies are developed, specific **interventions**, or sets of program activities, evolve. In the above case, the intervention would be the provision of pre- and post-test counseling by trained community volunteers.

A key element in monitoring and evaluating the effectiveness of project interventions lies in the next step, the selection of appropriate **objectives** for what you hope to accomplish, and valid **indicators** to track those accomplishments. It is helpful to talk about project objectives and indicators in the context of a model of how an organization functions to bring about an effect in the population it serves. A simple version of this model is seen in Figure 1, along with examples for two kinds of project interventions, one for the training of counselors and one for the provision of prevention counseling services.

Models similar to that shown are used by many evaluators and others involved in program development. It is important to point out, however, that there are several schools of thought regarding the terminology appropriate for the model, and for other aspects of program evaluation. For example, some reverse the meaning of the terms "impact" and "outcome" as used here. Others consider the statements of specific

expected accomplishments to be "goals" rather than objectives. The term "target" has varying meanings. The diversity of commonly accepted terminology makes it important that, in any discussion of project or program processes, the terms used are clearly defined. The importance of a model such as that shown lies not in the terminology used, but rather in careful consideration of the various elements and relationships in the model in the development of programs.

The model in Figure 1 shows the steps and relationships that need to occur for an intervention, or a project, to succeed. In this model the starting point is a set of project **inputs**, the people and things that are used to carry out activities. Inputs usually represent what the project money directly purchases. The project inputs, through various **processes** and activities, produce **outputs**, the immediate goods and services that the project provides. Those outputs, which typically are things that can be easily counted, should directly lead to some immediate desired **outcomes**, or observable changes in the project population. In the case of training programs, an outcome can also refer to increased abilities of those trained, and can encompass changes in knowledge, attitudes, beliefs, and aspirations of the trainees. Outcomes are expected eventually to have one or more long-term **impacts** on the population (or on the activities of staff who have been trained).

Socio-cultural influences that are external to the project itself, indicated by the horizontal line at the top of the figure, may affect the likelihood that initial project inputs will result in the intended impact. A socio-cultural influence for the second example shown in the figure would be a setting in which those being counseled have very few options to change their behavior, such as sex workers with no alternative means of support other than their clients. Even though the counseling was well-conducted, the desired outcomes and impacts will not be observed unless the external influences are also addressed.

A well-designed project will try to take into account important external factors when interventions are planned. Typically, the external factors having the strongest influence are located in the right side of the model. So, for example, socio-cultural factors may not greatly affect the level of project **outputs**, but they may have a substantial effect on the level of **impact** (e.g., sustained behavioral change) that results from **outcomes** such as changes in knowledge.

How does this model relate to your carefully-developed project objectives and indicators? Objectives can be developed to reflect how well the project is working at each stage of the model:

- > **Process objectives** attempt to set standards for the quality of activities to be carried out, such as the appropriateness of the training curriculum.

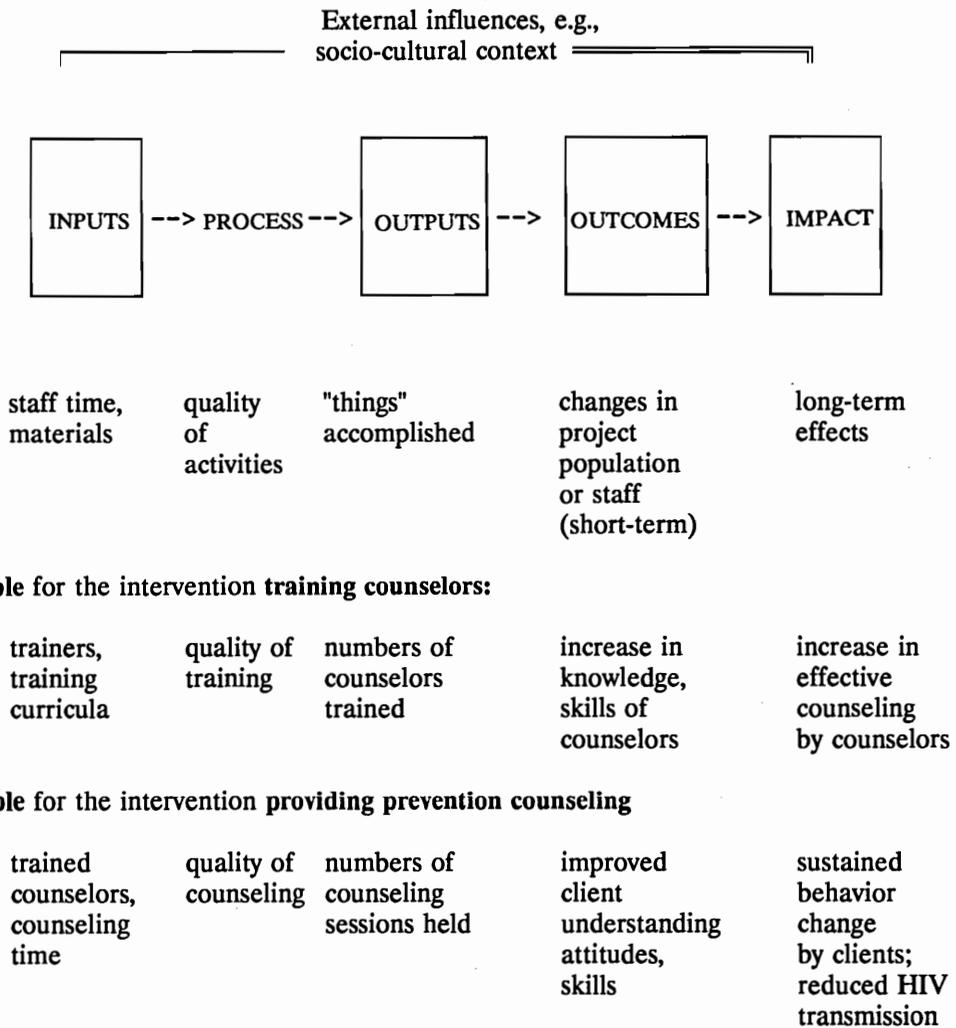


Fig 1. Model of Organizational Functioning

- > **Output** objectives state the expected "things" that the project plans to do, such as the numbers of trainees to be trained.
- > **Outcome** objectives state the main changes in the project population that are aimed for by a certain time (usually by the end of a given funding period), such as improved knowledge or attitudes.
- > **Impact** objectives state a long-term effect that the project aims to produce. The major impact hoped for in HIV/AIDS prevention projects is a reduction in transmission of the virus; however, a sustained change in behavior is an important anticipated long-term effect, or impact, that should relate directly to the rate of transmission. Realistically, however, short-term projects two or three years duration may be limited in the extent to which they can demonstrate long-term changes.

An indicator and a target level for that indicator should be included in every objective. For example, if the objective is "to train 20 prevention counselors," the **indicator** is "the number of counselors trained," and the **target** set for that indicator is 20, the number planned to be trained.

Objectives and indicators in monitoring

Project monitoring and evaluation relates directly to the key objectives and indicators that you have selected. Most often, the elements that you choose to **monitor**, or keep track of on a regular basis, are those further to the left in the model shown: the number and quality of activities being carried out. Providing feedback to project staff and, when appropriate, the community, is an important use of the monitoring system; be sure to build methods for accomplishing this into the monitoring system.

A wide range of methods and approaches can be used to monitor the effectiveness of activities, and in many cases to compare actual accomplishments with those projected in project objectives.

Some key sources of monitoring data are:

1. Staff activity reports, summarizing major activities for each week or month;
2. Monthly tallies of materials distributed, e.g., posters, brochures, condoms;
3. Summary reports and evaluations of training or educational sessions carried out by the project (which should reflect both numbers and quality of sessions);

4. Checks on progress in carrying out activities identified in timelines or work plans, as presented in the project proposal, detailed implementation plan, etc. This might be combined with a written narrative description of the progress of major activities during a given time period, e.g., quarterly reports;
5. "Spot checks" that solicit feedback from the community on the usefulness of specific project activities. For example, after a group educational session is completed, staff might approach a random selection of participants as they leave the meeting with a few key questions designed to solicit their reactions to the session, and/or assess the extent to which key messages were understood or accepted;
6. Open discussions with staff and community representatives on any problems or issues that have emerged during implementation of activities. This can be a good time to provide feedback as well.

It is important to identify approaches to monitoring each of the major activities of the project. Interventions that require involvement in new or complex areas of activity, such as counseling, need particularly careful monitoring in the early stages. Some of the important indicators to track for a counseling intervention, for example, might include:

1. Pre- and post-test training assessments, to determine whether the requisite improvements in basic knowledge, attitudes and counseling skills were acquired;
2. Direct observation of counseling sessions by newly trained counselors, with feedback provided immediately afterwards;
3. Detailed evaluation and/or self-evaluation of counselors' interaction skills, using a checklist of desired behaviors and skills (preferably one used during training);
4. Group update meetings with staff that include discussions of their progress in improving counseling skills and knowledge;
5. Oral or written tests of counselors' knowledge;
6. Evaluated role plays, which provide an opportunity for counselors to utilize a number of the skills they have learned, and for the evaluator to assess those skills.

Although there are many possible methods for monitoring project activities, the ultimate aim is to "keep your finger on the pulse" of the project, so that when difficulties arise a rapid and appropriate response can be initiated to correct the problem.

Objectives and indicators in evaluation

An important part of **evaluating** the project will be examining information provided by the monitoring system. You will also collect and analyze other types of information, including measures of the effects of project activities on the target population, indicated by project outcomes and impact (towards the right in the model). There has been a heavy emphasis in the past on assessing these project "end points" as the true measure of the "success" of the project. However, it is important to remember that the purpose of evaluation is to gain a better understanding of the functioning of the project as a whole, and not only to assess impact. A clear picture of how the project functions at the field level, the processes and the context of the project, is just as important, and in many cases may be more important, than measures of impact.

Why is it so important to look carefully at factors other than the end results of the project? Certainly it is important to know if the project is having its desired effect on the population. However, as was mentioned above, socio-cultural factors can influence the impact of a project, either positively or negatively. An evaluation may show that an appropriate intervention was carried out as planned, with high quality activities, but the desired outcomes were not observed. In such a case it would be important to look at other factors that may have influenced the effectiveness of the intervention. For example, the project may not have addressed the culturally-determined belief that AIDS is caused by witchcraft. Or, it could be that events quite external to the project have had a beneficial influence, such as a high level of favorable publicity for people with AIDS or a sudden change in government policy. Without a thorough evaluation the project might mistakenly take credit for a change in public knowledge or attitudes, and continue to carry out interventions that actually may be ineffective.

Another reason to focus on gaining a complete picture of the project is the long-term nature of social change. In a two- or three-year project it is unrealistic to expect profound changes in deep-seated behavioral norms or widely-held beliefs. However, it may be possible to gradually establish structures that will help assure that the process of change continues. For example, the project may aim to stimulate key community members to become involved in the ongoing development and dissemination of informational and motivational messages about HIV and AIDS. If this could be done, the long-term impact of the project would likely be far greater than one in which, for example, an expensive but unsustainable media campaign only temporarily increased peoples' awareness of the problem.

In all, it should be stressed that the function of evaluation is to gain a clearer understanding of how, and how well, a project is working at every stage in the program model. This will involve gathering several types of information from a number of different sources. The next section will discuss the steps in evaluating an HIV/AIDS prevention or care project.

Steps in evaluating an HIV/AIDS project

An evaluation involves, at a minimum, four distinct steps: planning and preparation, data collection, data analysis and report writing, and use of the results.

1. Planning the evaluation

The most important question to ask when planning an evaluation is: why? For what reasons, for what persons or groups, is the evaluation being conducted? A common response is that it is a requirement of the donor, but there usually are many other important reasons to evaluate. The most compelling reasons should form the basis for deciding where the evaluation will focus most heavily. For example, if it is the final evaluation of a project in which collaboration with the Ministry of Health has played an important part, the evaluation might focus on the collaboration process and outcomes. There may also be a focus on specific technical aspects of project interventions. A first step in planning is to spell out the overall goals of the evaluation.

The identification of an evaluation team is another important aspect of planning the activity. The evaluation team for an NGO project typically will consist of one or two key field staff members; a member of the home office staff, if such exists; an evaluation consultant external to the project and organization; a representative of any local collaborating group, such as the Ministry of Health or a local NGO; and/or a community representative, particularly when collaboration with the community has been an important approach of the project.

Why use a team, you may ask, why not simply hire one skilled evaluator to provide an "objective" critique of the project? Just as developing an HIV/AIDS prevention and care project requires more than one approach or one perspective, evaluating such a project will be most effective if multiple perspectives and skills are utilized. In addition, the best way to assure that those who have invested time and effort in developing the project feel committed to implementing the recommendations of an evaluation is to involve them in developing those recommendations. The concept of "ownership" is as important in enhancing the value of an evaluation as it is in assuring a community's commitment to a project.

Finally, preparation for an evaluation involves making tentative decisions about how the data will be collected and when, developing a tentative evaluation schedule, and making the necessary logistical arrangements. Just prior to data collection, the full evaluation team should finalize the data collection plan and schedule, making any modifications they feel important to assure that adequate information is available to the team.

2. Data collection

Much has been written about the importance of collecting the best data available for an

evaluation. The issue includes both concerns about **methods**, or how the data are obtained, and **content**, or what kinds of information are needed. There is no sure way to identify the "right" methods or data, as no two evaluations (or projects) will be identical. However, one useful approach is the concept of "triangulation" in gathering information. Triangulation means exploring the issues you are discussing from several different angles, getting information from several different sources and by several different methods. So, for example, if you wanted to know how a peer educator training intervention had affected the participants, you might try to get information:

- > from focus group discussions with the peer educators themselves about the personal impact of the program;
- > from individual interviews with the project's trainer/supervisors on the perceived effectiveness of the peer educators;
- > from co-workers, in written questionnaires about their contact with the peer educators; and
- > from project records, by examining training curricula, attendance and activity reports.

By combining all of these sources and types of information, you should be able to piece together a complete picture of how well the peer education intervention is functioning.

Another important issue in evaluation data collection is the use of quantitative and qualitative data:

- > Quantitative data refers to information that can best be represented **numerically**, such as percent of the population with a given level of knowledge or attitudes. Typical methods for gathering quantitative data include examination of project records and knowledge, attitudes and practices (KAP) or other surveys.
- > Qualitative data, on the other hand, refers to information that explores the **meaning** of what has been observed, that aims to improve one's understanding of a phenomenon. An example of qualitative data for an HIV/AIDS project would be a detailed description of differing local beliefs about the causes of AIDS. Commonly used methods for gathering qualitative data are individual or group interviews and anthropological approaches such as participant observation.

Both kinds of data require specialized training to carry out properly. Clearly, both kinds of information have a role in project evaluation and both should be included in the data collection plan.

3. Data analysis and report writing

Most of the data collection for an evaluation will take place in the field, as the team observes and interacts with project staff and community members. An important point to remember in data collection is that all team members must take careful written notes about their observations, so that the team later can share their impressions and come to a unified set of conclusions and recommendations about what was seen. Deriving meaning from this information, combined with other written data such as survey reports and other records, is what is meant by "analysis" of the data: **conclusions** about what was observed; **comparison** with what was needed or expected; and **recommendations**, based on as full as possible an understanding of the project and project setting. Since evaluation is meant to be a basis for future action, not simply an inspection of past accomplishments, the recommendations form the core of the evaluation report. They should define clearly the specific actions that are to be taken, as well as alternative strategies to be considered.

The evaluation report may be drafted by one or more of the team members, but must be cleared by all members before it is submitted as a final document.

4. Using evaluation results

Given the extensive time and effort that goes into conducting an evaluation, it is critical that the results be utilized as fully and as quickly as possible. To be most useful, results must be shared with all those who have a stake in the project: staff at all levels, funders, collaborating groups, other organizations doing similar work, and the community served by the project. The evaluation plan should include a strategy for disseminating the results to these groups and any others that are appropriate for a given project. Dissemination of evaluation findings should include a presentation of how the action recommendations of the team are to be implemented.

It may be necessary to present evaluation results in a different way to different "audiences," depending on their technical abilities and interests. For example, sharing the results with the community may mean selecting a few key findings that would be of most interest to them and presenting that information verbally and visually, in simple charts or graphs. When presenting the results to management staff of the project, however, greater attention should be given to providing details about what was found and the recommendations for the future.

Conclusion

We have reviewed the importance of monitoring and evaluation for NGO projects that address the problem of HIV and AIDS; the use of objectives and indicators in HIV/AIDS projects, referring to a model of organizational functioning; the role of

objectives and indicators in developing monitoring and evaluation approaches; and the main steps to be taken in evaluating an NGO HIV/AIDS project.

Although the technical issues involved are many and, at times, complex, the driving force behind the need for better evaluation is a simple idea; to do the best job possible with limited resources, we must be able to recognize what works, what doesn't, and why. Just as NGOs have become deeply involved in finding the best approaches to preventing and coping with HIV and AIDS, they must now become fully engaged in the task of evaluating their efforts.

Three Perspectives on Sustainability

A panel of workshop participants spoke on the sustainability of NGO projects addressing HIV/AIDS awareness and prevention. What follows are excerpts from the remarks of three panelists.

Establishment of a local NGO

Willy Salmond, field director
Experiment in International Living in Uganda

I want to focus on the AIDS Information Center. In January 1990, Experiment in International Living (EIL) used some seed money from the HAPA grant to rent office space, and to buy a car and a video machine for use in the AIDS Information Center (AIC). InterAid also contributed funding for salaries. Local currency funding was given by USAID, and the AIC was then started. One key to the sustainability of that center is that it is a local NGO trying to become registered under the NGO bureau in Uganda. That means that the center can have duty free status and vehicles registered in the center's name. This is a key issue because an international PVO like ourselves cannot take on any more vehicles; a PVO is only allowed so many vehicles.

The AIC was started by a consortium of 10 groups, which is essential to sustainability. Local NGOs form part of this large, all-encompassing consortium: WHO, Experiment in International Living, The AIDS Support Organization, the main blood bank in Kampala, InterAid, USAID, Red Cross, etc. Not all of us turn up for the management meetings. We've found that a smaller group has really kept the consortium going, but that's fine. All of us sign a letter of intent specifying what we would contribute, whether funding, or time, or --in the case of WHO and the AIDS control program-- testing kits coming from Geneva. All of those commitments are on paper and all of these different groups are committed to doing their bit to make the AIC work. Another aspect of sustainability is the selection of personnel for the center, and we've been extremely lucky to steal Lydia Baraguhare away from a family planning program where she was a very senior person. As we continue to establish staff, we need the best people available and we've got to pay as well as possible to keep the best people in place.

The AIC is comprised of pre-testing for HIV, taking blood within the center, and then post-test counseling. The blood is sent out to the blood bank every night, tested, and the results are sent back to us. Our counselors were trained by TASO; we didn't train them ourselves because we were able to give the job of training and selecting counselors out to a member of the consortium. The counselors are not full-time. They come from other jobs, and we have asked their employers to release them as their contribution to the fight against AIDS. We pay them a fair amount in addition to their salaries for the counseling they do during the week. Then every Saturday we have the "positive living" post-test club

for people who have gone through the test, with either positive or negative results. Our counselors come in to the post-test club; when clients recognize their counselors, they feel much more at home in the club, and discuss safer sex, watch videos or talk individually with a doctor about symptoms of the disease.

In the initial concept, when we designed the HAPA grant, we also had a line item for condom distribution, but we realized after about a year that we were doing nothing about that because we were too busy with other things. We were very happy when SOMARC, the social marketing group, started a commercial condom promotion program on their own, and we have been able to use our funds for other things like the AIC. In terms of research, we also just farm it out; I think it is essential to say what we can't do, and get someone else to do it. Case Western Reserve University is starting a major piece of research in the AIC, tracking people who have been tested to see if we are changing sexual behavior in a radical way. The results of this will be out in about a year and will be very important for us as we consider expanding our activities. One of the lessons learned is that we can't do everything, and it is great when someone else comes in and helps out. It is wonderful to set a difficult and important task aside when someone else is doing it much better than we can because we lack the time.

In sum, the key to this in terms of sustainability is the local NGO status and the commitment from this large, broadly-based consortium. Sometimes the AIDS control project will say to us, "we're not sure about this couple counseling, it's not been done before; we're not sure if it's ethical to give results to two people." We give them the letter of intent and say to them, "You signed this, you're part of this, you ARE the AIC. You're sometimes dragged along unwillingly, but you're still part of our work." That is very helpful, to not get stuck out on a limb doing something all alone without having the support of a broad-based group. It's also important in terms of funding. After getting the local NGO status, AIC can start to run on its own and look for funding from a wide base of donors. Our current plans are to open another four centers throughout the country within the next three years.

Issues in MOH collaboration with an NGO

Dr. Canisio Takundwa
District Medical Officer, Marondera District, Zimbabwe

The World Vision HIV/AIDS prevention project started only last year (1989). Initially World Vision wanted to take this project to a different district altogether, but that district MOH office did not have adequate senior staff, and that's how the project ended up in the Marondera district. So the first lesson we learned is that we must identify a district that is appropriately staffed, with fairly senior staff to complement the younger staff. The next matter was to discover if the proposal goals were within the health priorities of the Marondera district. We accomplished this through meetings with the

World Vision director and through consultations with the regional AIDS program. Everyone that was going to be involved understood that the project would address the problems that were within the district.

The implementation plan was designed using the grassroots health staff plus NGO staff. Our planning system starts right off from the grassroots. We consulted our rural health center staff on how they thought we should implement the program to address the problem. We're trying to foster the health staff's feeling that this project is theirs. In the plan we attempted as much as possible to define the methods that we are going to use. However, we still failed to define project ownership, what we mean by project partnership: who is actually in control of the project. We think now that it is important that we work out some way to define all these things.

We tried not to restrict the project to AIDS activities alone; we are trying to cover other problems as well. The health workers were already complaining of being overworked. We worried that with the addition of an AIDS program, the health worker would either ignore it completely, or feel it was an extra burden for which they need better remuneration. We have tried to use the existing health structures to implement what is required by the project. We also tried to set up a monitoring system. The donors contributed some ideas on how to monitor the progress of the project. Some of these ideas were actually in conflict with government policy, such as declaring how many AIDS patients the MOH sees. The lesson we learned is that if we are to have a monitoring system, it should be in agreement with the host government policy. The only way to do that is to integrate the NGO system with the one used by the MOH. We still need to work out exactly who is in charge of that monitoring system within our own program--is it World Vision or the MOH? We have to identify the individuals in charge and give them total responsibility.

We have trained both MOH and World Vision staff in health education, and we have been training counselors in the MOH staff. The counselor training system in the MOH allows us to tap existing talent. It is critical to ensure adequate support for the ministry staff, or they may block the progress of the project. In addition, NGO staff must have proper credentials because the MOH staff will look carefully at their backgrounds. If the MOH staff feel that they are much better qualified than the NGO staff, then the NGO may be in trouble. NGOs need to give their staff adequate preparation and training, to enhance staff skills, as World Vision has done.

The HIV/AIDS prevention project in Marondera is pooling resources with the Ministry. We have tried to incorporate the AIDS project into some of the existing administrative structures within the community, because we did not want to create a new category of health worker called "AIDS motivator". For example, we tried to incorporate AIDS education into the existing training for community health workers. We hope that when World Vision moves out, the supervisors will continue to impress on the CHWs the importance of the AIDS education. We have meetings at all levels where the MOH and

World Vision staff can share information and everyone can know where we are.

By generating interest, we can get more ideas about how best to go forward. I'm hoping that this year we can identify those activities which require more intensive intervention and then sit down either with the MOH or other donors and see how best these activities can be funded. One of the main problems is time; it is difficult for a project to run only for a two-year stint, and then to be told "no more funds". Just understanding the local people and why they think the way they do takes a lot of time. The time that we spend understanding why they think this way is time away from the project, so I think that we need an extension of the project.

A response to concerns raised by Dr. Takundwa

Dr. Milton Amayun
World Vision International, Monrovia, California

There are many countries like Mauritania or Senegal where an additional hand is welcome, no matter how simple the contribution. In countries where the level of institutional sophistication is high, there are local personnel to fill a variety of positions within the MOH; the entry of an NGO that has a health program with professional staff may create tension. Zimbabwe has a sophisticated system and substantial numbers of trained personnel. Here, the MOH demands a higher quality contribution from an outside NGO coming to work at the local level.

The other area of tension is the control of material resources. The unfortunate reality is that USAID will pay for some items and not for others, and one thing they don't provide is vehicles. If World Vision imports a vehicle and pays 60-100 percent tax, the World Vision people in that country will not easily give up that vehicle. This reality is repeated in many countries around the world. When we have to pay double the cost of a piece of equipment, it is not fair to our private donors to leave that piece of equipment behind. We would be open to donating project equipment to the MOH equipment if the government of Zimbabwe gave us tax-free status for imported equipment and capital items.

We have been working with USAID grants since the early 1980s, and we have five years' experience with a child survival projects funded in roughly the same way as HAPA projects. HAPA projects are slightly different in approach because AIDS is a new disease that has not been as vigorously addressed by governments around the world, unlike immunizations which have been running since the 1970s. World Vision is still grappling with how HIV/AIDS projects should be implemented. Who should be the primary partner: the community, the government, another NGO or hospitals in the private sector?

The first factor to sustainability that we are concentrating on is finding a niche for our NGO efforts. There are inherent tensions between government and NGOs, so if they must partner, the two entities have to work side by side; there has to be mutual tolerance in order to achieve our objectives. For World Vision, relationships are key, and we have to find our niche which we can offer to the government at national, local and regional levels. Governments and NGOs must respect and work with, not against, each other.

The second factor to sustainability that we need to address is technical capacity. AIDS prevention and control brings the expertise of social scientists to the medical field. Most Ministries of Health do not have such professionals, They must bring on staff persons with the expertise or train medical staff already hired. World Vision will collaborate with the MOH to decide the most crucial technical areas to the current HAPA program and ensure that the expertise is in place in Marondera over the long term.

Thirdly, how do we insure financial sustainability? We at World Vision do not yet have the model for HAPA, but we are exploring the applicability of the model for child survival. For example, oral rehydration therapy (ORT) doesn't require much technology so a community may be able to continue ORT on its own. Immunizations however involve the cold chain and thus require government support. Maybe we can look at the HAPA projects, define the financial requirements of the different components, and decide where responsibility for each component should be assigned when the project ends. For example, in some countries community-based condom distribution systems are already in place. Those who are best placed to do condom distribution should be given this responsibility. If counseling should be done by an NGO, then that NGO should be either ready with or acquire the capability to do counseling. In Marondera, World Vision Zimbabwe will collaborate with the MOH to determine who has the capability to continue each component of the HAPA program.

Program to Reduce HIV Transmission Among Vulnerable Groups in Bulawayo, Zimbabwe: Experiences and Lessons

David Wilson, Barnet Nyathi, Miriam Nhariwa, Nancy Lamson, Sharon Weir

David Wilson, acting chairman of the department of psychology at the University of Zimbabwe, presented the key points of the following paper. His presentation was followed by a discussion with workshop participants.

Introduction

I would like to discuss the lessons learned from a program to prevent HIV-transmission among vulnerable groups in Bulawayo, Zimbabwe's second largest city (population 700 000). These groups include prostitutes, their clients, STD patients, truckers, the uniformed services and other vulnerable occupational groups. The project began informally in January, 1989 and formally in October, 1989. It is a Bulawayo City council program, led by Dr. B. Nyathi, Director of Health Services, with funding and technical assistance from AIDSTECH.

Components

The program has ten interdigitated components, each of which I will briefly summarize below to provide background for subsequent discussion of programmatic lessons.

1. Baseline research

This element, encompassing sex workers, clients, STD patients, transportation workers and the general population, seeks to provide logistic, ethnographic and psychosocial data for our program. Findings with policy implications include:

- o Economic need, the major reason cited for the existence of paid sex, is central to commercial sex in Zimbabwe. Only 17% of those in formal employment in Zimbabwe are women and the only jobs sex workers ever held were as domestic servants or informal vendors.
- o Commercial sex in Zimbabwe is largely bar-based.
- o Vaginal intercourse is standard and condom use is reported in only a third of paid sex acts.

- o The clients of prostitutes largely hold formal employment.
- o Clients have more negative attitudes to condoms than do sex workers and client refusal is the major reason cited for not using condoms. Sex workers repeatedly request client education.
- o Sex workers must act in concert to enforce condom use. However, Zimbabwean sex workers are not organized, so interventions must foster tightly knit, cohesive, sex worker groups.
- o Clients averaged 7 visits a month to sex workers; nearly 70% had visited sex workers for over five years; over two-thirds of sex workers said their last client was a repeat. Many clients were known to several sex workers and reported non-paying partners, thus providing a conduit for HIV transmission between sex workers and beyond. Clients were a cross-section of society, with widely varying education and occupations and little in common beside involvement in commercial sex. Interestingly, a disproportionate number were formally employed.
- o Alcohol use, which is central to the culture of commercial sex, may discourage planfulness and lead to disruption of health meetings.
- o Door security personnel for the bars, who are trusted by many sex workers and clients, may play a role in the initiation of interventions, acting as mailboxes, publicizing meetings and distributing literature and condoms. However, their role may diminish as projects mature and as direct links with interventionists grow.

2. Training of Professional and Community Workers

Training is held for nursing and health education professionals and for community personnel, including peer educators, hotel security, reception and barmen, barmaids, municipal security guards, taxi drivers, the uniformed services, long distance transportation staff and industrial workers. Training covers biomedical facts, condom use, and health education and counseling techniques, and emphasizes collective development of specific community action plans.

3. Peer Education

Peer education is the cornerstone of the program. Peer educators encompass prostitutes, their clients, STD patients, persons with HIV/AIDS, cultural performers, including dramatists and musicians, school-leavers, bar security personnel, members of the uniformed services and other concerned community members. There are currently 60 peer educators, all of whom are paid travel expenses and an honorarium. They meet weekly for two hours for further training and re-training, to review accomplishments, to

develop plans and to prepare activities.

The selection of peer educators can be delicate. In large sex worker residences, women elected their own peer educators, but in bars and elsewhere, they do not know each other well enough to do this and among clients, STD patients and other groups, this approach is impossible. In general, we ask individuals interested in becoming peer educators to informally attend training sessions and to organize their own AIDS education meetings before they are enrolled as peer educators. This enables potential peer educators to understand clearly what is involved and allows individuals who are insufficiently interested to leave.

To date, 17 peer educators have left the program for full-time employment. Their workplaces are noted and every effort has been made to maintain contact with them and to encourage them to initiate workplace programs. They are proving excellent points of entry to workplaces.

4. Community Outreach

AIDS meetings are held for prostitutes, clients and the general public, involving video tapes, some literature distribution, lectures, discussion, role plays, condom distribution, demonstration and practice. They take place at prostitutes' residences, hotels, bars, nightclubs, workplaces and public arenas. About 50 public meetings and 100 door-to-door visits occur each month. Bar and workplace meetings are typically attended by 50-100 people, the majority male, and home-based meetings usually involve 10-20 individuals, most of whom are female. Peer educators conduct outreach activities in their networks. They carry letters of authorization and wear distinctive t-shirts identifying them as AIDS educators. They are readily identified and are frequently called upon by the public to provide literature and condoms and to organize meetings.

5. Condom Distribution

Zimbabwe has Africa's best family planning condom service. However, the amounts used are inadequate for STD control, as the number distributed would supply about four condoms per male of sexually active age per year. We supplement existing services with vigorous condom dissemination in sex worker residences and hotels/bars using security, reception and bar personnel, in STD and other clinics, and through peer educators, who have condoms carrier bags emblazoned with the name of the project. Approximately half a million condoms were distributed by the program in the first year, and it is envisioned that one million condoms will be distributed in the second year.

6. Strengthening STD Services

This component involves improved biomedical diagnosis and treatment and training STD staff in HIV prevention counseling. It also included the development of a streamlined

AIDS education package, involving video tapes, pictorial displays and leaflets. Discussion groups, punctuated by musical and dramatic presentations to maintain impact and interest, were developed for use at STD centers.

7. Drama and Music Groups

Drama, music and other cultural activities are an integral part of the program. The project has invested in musical instruments and in simple, inexpensive, materials to produce costumes and stage props. Peer educators have created their own songs, dances, poems and dramatic productions. Individuals from drama cooperatives have been recruited as peer educators to help other peer educators refine their scripts and stage production. Drama groups perform in hotels and bars, at workplaces, at uniformed services bases and in drama competitions. Peer educators transportation costs for rehearsals and performances are provided by the program, but it is expected that companies can meet transportation costs for performances at their workplaces.

8. Support for People with HIV/AIDS

Several forms of support have been given to people with HIV/AIDS. People with HIV/AIDS are recruited as peer educators (They do **NOT** have to disclose their HIV-status). The intervention coordinator, who has been trained to counsel people with HIV/AIDS, offers counseling. The project refers people to the Matabeleland AIDS Committee, who offer support groups for people with HIV/AIDS. A study of the problems encountered by people with HIV/AIDS in Bulawayo has been conducted. The project assisted in the formation of a society for people with HIV/AIDS, providing seed money and the use of its premises and helping to draft a constitution that gives people with HIV/AIDS a majority on the executive committee. The program coordinator initially belonged to the executive committee of the society.

9. Income Generating Activities

Program funds have been set aside to assist participants develop self-help activities for program participants. A small proportion of these funds is being used to conduct feasibility studies and to prepare a report requesting a donation of land within the city for market gardening. Another small proportion is devoted to small enterprise consultancy, while most of the funds go to provide start-up capital and credit for activities.

10. Evaluation

Information about Elizabeth Ngugi's work with commercial sex workers in Nairobi, presented at the 1988 Stockholm AIDS conference, inspired a great deal of interest in sex worker interventions. However, her colleague Plummer's later study of sex workers in the same city, showing converging seroprevalence rates in intervention and non-

intervention conditions, tempered expectations of such projects and reaffirmed the cardinal importance of evaluation. In the Bulawayo program a carefully developed report-form permits accurate monitoring of health education activities and distribution of condoms. Naturalistic, ethnographic methods, including participant observation, depth interviews with key informants and other participants and focus groups are used for process evaluation.

Pre- and post-intervention sex worker and client reports of condom use in the last paid sex act is our first summative evaluation indicator. Our research shows that client and sex worker reports closely agree with respect to the last paid sex act, but, unsurprisingly, diverge over longer recall periods. Male report of STDs, using the QUIST index as a point of departure, is our second outcome indicator. Abstraction of participants' medical cards and time series analysis of STD data for Bulawayo and other cities is the third, and principal, summative approach used. We are emphasizing process evaluation, with a long-term, naturalistic, orientation. One cannot understand or improve outcomes without considering precisely what happened. To genuinely understand an audience, one must be willing to spend a long time studying it, without, it need scarcely be said, delaying an intervention.

Experiences

Our chief purpose here, however, is to distill, for debate, the key programmatic lessons learned in the Bulawayo project. Our tentative do's and don'ts, subdivided into different aspects of the program, are as follows:

1. Inception

It is essential to begin with baseline research, because we must know how participants live and interpret their world. This research should be at least partly qualitative, as quantitative approaches have profound limitations. Quantitative research, which imposes the investigator's framework, omits key program information. It is imposing, insistent yet incurious and may make interviewees feel exploited. It saps energy and is analytically so demanding that it either delays intervention or is completed a year or so after program inception. The baseline research must never delay program implementation and if necessary, should run concurrently with project initiation.

One must train and sensitize everyone even remotely involved in a program as to its approaches and philosophy. In our program, for example, clinic staff initially threw away prostitutes' free treatment cards, asked them intrusive questions and behaved rudely to them. Security guards in beer gardens were abusive to peer educators involved in AIDS lectures, drama or music. Secretarial staff adjacent to rooms where peer educators meet claimed they dirtied the toilets. I could have forestalled these problems, had they been foreseen, through training.

As family planners know, it is vital to start small, lest one overextend a project, and to suspend judgment for at least six months, as project start-up time is typically underestimated.

2. Scope

Programs must not be limited to prostitutes, for two important reasons. First, to do so may implicitly scapegoat them, and encompassing a spectrum of men and women lets one deny it is a prostitute program. We tell the press our program embraces anyone and everyone public-spirited enough to educate their peers, which, of course, it does. Secondly, clients have more say over condom use than anyone else. Their attitudes must be addressed everywhere, including STD clinics, bars, work places, and in the streets.

3. Staffing

At least one full-time coordinator is vital. It is no use sharing duties among those already holding responsibilities, since those responsibilities will not wither away. Without a full-time coordinator no one is truly responsible for project outcome.

Whenever possible, the bulk of salaries should go to full-time staff and peer educators, which, apart from condoms, are the most effective investments possible. Paying peer educators should not be contentious. Tragically, few AIDS resources ever seem to reach communities directly. Lip-service is ritually paid to community work, yet, for example, it remains easier to hire and transport one international consultant than, for a similar amount, to pay and transport 50 peer educators for a year.

4. Relations With Participants

While peer educators should be paid, money must never be the focus of interactions. It should be given respectfully, apologetically, recognizing its inadequacy as a gratuity, and coordinators must emphasize peer educators' self-sacrifice and public-spiritness.

The language we use is important. As Sabatier notes, if we call people reservoirs or pools of infection, can we seriously expect them to change their behavior or to trust us? Similarly, the phrase "vulnerable" may be preferable to "high risk" groups and "focused" interventions may sound less hostile than "targetted" ones.

Among prostitutes inured to exploitation, respectful treatment repays itself several-fold. Two examples suffice. We hesitated at buying tea-cups and offering tea and biscuits at peer educator meetings, but it became clear that the decision to do so subtly bespoke respect. Similarly, Bulawayo's highly respected Medical Director attends home-based meetings, interacting respectfully with women customarily harassed by authorities.

It is vital to promote a sense of self-worth among participants, particularly prostitutes, who often have poor self images. After all, how can we expect people to protect themselves if they don't think they're worth anything? Encouraging individuals to become peer educators, incorporating them in successful dramatic and cultural activities, entrusting them with responsibilities, emphasizing their contribution to society and constantly treating them respectfully will, it is hoped, increase self-worth.

Projects must discourage dependency on interventionists for advice and motivation and instead help participants organize themselves into cohesive, motivated, self-sustaining groups.

Coordinators can enhance individual confidence and group cohesion by progressively devolving responsibility to participants. Our peer educators develop their own T-shirts, condom carrier bags, drama and music scripts, organize tea and cleaning rosters and elect their own disciplinary committee (no "kangaroo court", incidentally).

We must use participative, not prescriptive, approaches. Most prostitutes know the risks, but they also know how limited their choices are and how easy it is for middle-class professionals to tell them the obvious. People and communities must help frame and execute plans. We are all more likely to adopt ideas we develop. Meetings must use participative small group, face-to-face approaches. Health educators require training, constant support and frequent re-training, so they do not lapse into didactic approaches in the face of unremitting pressure.

Interventionists must respond to participants' broadest needs to maintain credibility. Free STD treatment must be provided, as it is a major motivation for participation. Support for people with HIV/AIDS is a major expressed need, but our experience, reflecting my own mistakes, is that interventionists lack the skills to mount PWA programs and should cooperate with NGOs who do. Income generating activities are frequently requested and require the participation of organizations with the requisite skills.

5. IEC Materials

We must use suitable IEC materials. I support T-shirts, which give peer educators identity and make them recognizable, and videos, whose rarity enhances their impact. No one needs to be convinced about drama or music. Personally, however, I execrate posters, leaflets and brochures. I view as tragic the spectacle of the many ministries, municipalities and NGOs in African countries that are slavishly designing mediocre, often essentially identical, written materials. The money spent on those materials could pay 20 or more peer educators for a year.

6. Maturing and Expanding Programs

If we have learned anything, it is the need to be flexible. Programs change and so must we. We initially used bar and security personnel as peer educators, but their role diminished as our links with prostitutes and clients grew. Moreover, we must keep moving just to maintain motivation. If we just keep having weekly peer educator and public meetings, participants will lose interest. To maintain that interest, we are developing drama, music troupes and income generating activities.

We must keep outreaching -- it is tempting to stay in touch with an accessible nucleus, but we must remind ourselves constantly that we have not yet reached everyone.

We must expand projects, but there may be no blueprint to take a local community-based initiative and embed it nationally in a ministry. Instead, there may be emerging principles, do's and don'ts we can use to put the right ingredients together, using very different coalitions in different places. Above all, when considering replicating programs, we must be mindful of the minimum criteria for success.

7. Afterword

First and last, we must, above all, LISTEN, LISTEN, constantly and carefully to participants.

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A Discussion with David Wilson on Program Evaluation

Q: We have been talking in this workshop about gathering qualitative baseline data. Do you think that quantitative baseline data has any importance in an AIDS program?

W: There are two types of baseline data. The first type is used to plan an intervention, and the second type contributes to evaluating an intervention. Clearly the baseline would include a few quantitative components. We now advocate focusing on specific self-reported male sexually transmitted diseases (STDs) of acute duration as probably the best quantifiable measure for baseline data.

I'm incredibly skeptical, I think with some justification, about self-reported sexual behavior as a way of evaluating an intensive intervention. **When there is an intensive intervention and people are asked about changes in sexual behavior after the intervention, you are guaranteed to show behavior change, you almost can't miss.** And in fact some studies of large groups in Africa have got both a serological and behavioral component, and I've seen conferences where, at the same meeting, the KAP component reports incredible increases in condom use and a co-presenter in another hall will

present terrifying data about increases in seroprevalence. I'm not criticizing the people concerned, but it underscores an important point.

Q: Has the approach of looking at self-reported STDs among men been field tested yet, and how are they evaluating it?

W: Yes, David Sokal of AIDSTECH is working on it in several countries. They are validating it against clinical data, as well as against other data indicating attitudes, behavior and practices. The validation is serological where possible, and also looks at the internal consistency of self-reported STD rates in relation to other self-reported indices.

Q: You feel that this approach is ready to be used more broadly?

W: I think we should be trying it more.

Q: How are you trying to build community participation into the Bulawayo AIDS prevention program?

W: I think that at first as a coordinator you can come along with a big splash, lots of condoms, an exciting program, and lots of energy, and can easily center the program around yourself. You'll be saying, "I'll give you the condoms tomorrow, I'll call the next meeting, this is what we should be talking about, concentrating on." **But I think the best way of coordinating a project is to let responsibility shift from the coordinator to the participants**, so that instead of designing t-shirts, carry bag, and IEC materials for participants, they design their own and have the final say over it. Instead of providing all the services, women themselves will set their own agendas, determine when to have tea and when to schedule meeting times, and decide whether or not condoms are to be distributed and where. If they are totally involved through the responsibility of doing the program, the coordinator becomes increasingly a coordinator and not the manager.

It's very easy to be didactic and prescriptive. Especially when you're as busy and pressured as our coordinator frequently is, it's much harder to draw out people's own feelings. At the outset of our program, our peer educators would never have volunteered to go into bars and address potentially hostile groups of men, but now they do that quite frequently, and never under compulsion--they choose to do it. We see marked increases in their assertiveness and in their willingness to confront these issues, and I think also in their own sense of worth because we tried to stress that what they are doing is an immense contribution. That is something we don't have to lie about. **Our experience is that prostitutes are among the most responsible people where sexuality is concerned anywhere in society, immeasurably more so than men.**

Q: In your talk you suggested using key informant interviews -- what about focus groups discussions as a means of getting qualitative information?

W: I think focus groups have a place, but I also think they've been oversold. There's a very good recent study by Dooley Worth done primarily among New York Puerto Rican prostitutes who are also involved with IV drug use. They did focus group as well as KAP studies at the outset of their program, and found reasonably high levels of reported condom use. But after the team worked intensively with these women over the next nine months and gained their trust, the rates of reported condom use started to go down. Then, one by one the women all repudiated their initial statements -- initially they had been saying what they thought the program people wanted to hear. **I think that we only get to know honestly what a person thinks and does through long-term, naturalistic participant observation.**

Focus groups have a place as one of several quick, rough techniques that can be useful but should be regarded with healthy skepticism as well. Another reason I have misgivings is that the very term "focus group" can be incredibly abused. What it sometimes means is that the project staff talked with six or eight people, and decided upon certain conclusions. Also each person has preconceptions, and may be quite domineering in one way or another. It's hard to be so objective that you don't influence a focus group, especially given the power and educational differentials that usually exist.

My own view is that the older anthropological techniques should have greater weight than the focus group technique. It's a slight bias, in all fairness, because of the fact that focus group techniques originated in marketing as a "quick fix" technical type approach. **I don't want to knock focus groups totally -- I think people have used them successfully, but I think that their status along with KAP studies is too hallowed.** I think they should be regarded with much greater skepticism.

Q: One problem of the project staff at this workshop is finding a method that is really available to them -- could a project use the approach of the New York study, and get that kind of information, given that they do not have a full-time anthropologist on the staff as the study did?

W: Well, perhaps, to be controversial, I've overstated my case. What I have said, as you've pointed out, is short on concrete guidelines. I think that focus groups do have a place and one of the virtues is that the methodology has been quite well described and documented. You are using, I believe, the book produced for the Academy for Educational Development on focus group techniques that describes the process very well. And WHO has very good guidelines for qualitative research.

One of the recommendations I would make, regardless of what "research" techniques you use, is that you really get to know whoever you're working with as well as possible. The relationship of growing trust through daily interactions, based on observing and working with them in every possible setting, and on being accepted without reservation, is probably the best way of planning and fine-tuning a program.

Authors/Presenters

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Dr. Amayun was trained in medicine at the University of the Phillipines and in public health at Harvard University. In the course of working at refugee camps and for World Vision Relief and Development, Dr. Amayun has lived in Thailand, Costa Rica, Kampuchea, Ethiopia, and Senegal, and travelled to over 50 countries. He currently is manager of the international health programs for World Vision, in Monrovia, California.

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David Wilson

Mr. Wilson is acting chairman of Psychology Department at the University of Zimbabwe in Harare. He holds degrees in psychology from the University of Zimbabwe and York University (Canada), and has published and presented widely on HIV/AIDS-related knowledge, attitudes, beliefs and practices in Zimbabwe. Mr. Wilson has a book in press entitled *Rapid assessment procedures to design interventions for prostitutes in Sub-saharan Africa*, to be published in Nairobi, Kenya by NARESA .

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NOTES

AIDS poses an unprecedented threat to African families, communities, and society at large. In response to the epidemic, nongovernmental organizations (NGOs) are finding innovative ways to educate and care for affected communities, and to prevent further spread of the infection. Alone and in partnership with government and private industry, NGOs are emerging as critical players in a multisectoral effort to contain the epidemic and to cope with the existing devastation.

Under the HAPA (HIV/AIDS Prevention in Africa) Project, a group of U.S.-based NGOs has been funded by the Bureau for Africa of USAID to integrate HIV/AIDS prevention into existing health and development activities. In October 1990, after one year of implementation, staff and counterparts from the HAPA grants projects met in Harare, Zimbabwe, to share experiences and sharpen their technical skills. The workshop sessions drew heavily on the experience of committed individuals from the nongovernmental, governmental and academic sectors in Zimbabwe who are responding to AIDS in that country.

Tradition and Transition features papers from the Zimbabwe workshop, edited to enhance their usefulness for other groups. The early chapters focus on the cultural context of AIDS prevention and care: religious and social traditions which influence HIV/AIDS-related behaviors, and cultural barriers facing women infected with HIV or caring for sick family members. Subsequent chapters discuss specific interventions and broad programmatic issues facing NGOs and others responding to the AIDS epidemic: working with special groups, such as traditional healers and artists; the role of counseling in AIDS prevention and care; sustainability of program efforts; and key issues in AIDS program evaluation. The volume ends with a summary of widely applicable lessons learned from an AIDS prevention project for vulnerable groups in Bulawayo, Zimbabwe.

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