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BOOK TWO

PN-ABT-194
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AIDSCOM

Lessons Learned

AIDS Prevention Counseling

Challenges In AIDS Counselling



Traditional Healers as Peer Educators



Technology Transfer



Condom Social Marketing

Mass Media Campaigns

Discuss **AIDS**
with your family



AIDS Prevention in Africa

CE N'EST PAS FACILE



CE N'EST PAS
FACILE

Produit par
The Federation of Uganda Employers
Experiment in International Living
Uganda Television

N-AB1-197

OVERVIEW

of

AIDSCOM Lessons Learned

AIDS PREVENTION IN AFRICA

The AIDSCOM Project

*The Support for Research and Analysis
in Africa Project*

*Operated by the
Academy for Educational Development
1255 23rd Street, N.W., Suite 400
Washington, D.C. 20037
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United States Agency for International Development

HIV/AIDS PREVENTION IN AFRICA

OVERVIEW

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

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

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

AIDSCOM Lessons Learned

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

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

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

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

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

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

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

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

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

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

I. RESEARCH LESSONS LEARNED

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

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

Skills

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

Social Norms

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

II. HIV/AIDS PREVENTION COUNSELING

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

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

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

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

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

III. LOCAL PARTNERSHIPS

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

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

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

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

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

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

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

IV. PERSONAL TESTIMONY TO MOTIVATE CHANGE

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

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

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

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

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

V. MASS MEDIA CAMPAIGNS

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

Philippines: *Barkada*

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

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

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

Eastern Caribbean: *Parents and Youth*

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

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

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

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

Ghana: *Get Protection*

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

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

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

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

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

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

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

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

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

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

VII. TRAINING OF TRAINERS

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

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

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

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

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

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

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

VIII. FAMILY PLANNING PROGRAMS

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

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

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

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

IX. WOMEN AND AIDS

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

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

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

to women. This means including men in the interventions.

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

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

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

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

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

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

X. SOCIAL MARKETING OF CONDOMS

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

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

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

XI. CONDOM BROCHURES

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

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

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

XII. *IT'S NOT EASY*

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

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

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