

AIDSMARK

REGIONAL LESSONS LEARNED

East Africa

With neither vaccine nor cure, several East African countries have made progress in responding to HIV, creating optimism that the epidemic can be reversed. While Uganda's experience is the best known, Kenya and Tanzania have also recently recorded some success in reducing HIV prevalence (1). Despite these promising results, much work remains to be done. In most East African countries, HIV prevalence remains unchanged or has decreased only slightly, and Uganda's rising incidence rate is provoking fears that a second wave of the epidemic is underway (2).

AIDSMark responded with funding and technical assistance to HIV epidemics in seven East African countries: **Angola,^a Eritrea, Kenya, Malawi, Mozambique, Sudan and Uganda.** Adult HIV prevalence rates in these countries ranges from 1.6 percent in Sudan to 16.1 percent in Mozambique (1). The HIV epidemics in most East African countries are high-prevalence, generalized epidemics driven primarily by heterosexual sex and exacerbated by low rates of consistent condom use, concurrent sexual partnerships and cross-generational sex, where young women enter sexual relationships with older men in exchange for gifts and/or financial support.

Lessons Learned

Advanced market segmentation and branding techniques that encourage target groups to identify with health products can enhance health impact.

When Population Services International (PSI) first began work in East Africa, the majority of consumers in many countries did not have access to high-quality condoms. At the time, because of the virtually "untapped" nature of the East African market, sophisticated marketing techniques were not necessary to achieve health impact. Over the years, however, marketing strategies such as segmentation and brand positioning became necessary to enhance health impact. Market segmentation involves dividing a large, heterogeneous market into smaller, homogenous markets on the basis of common consumer characteristics. Segmentation allows for better brand positioning, whereby highly tailored promotions can demonstrate more effectively how a product is consistent with a particular target group's needs, desires and lifestyle, in order to boost both uptake and healthy behaviors.

When PSI/Kenya's initial advertising campaign for *Trust* condoms was launched in 1993, it targeted all Kenyans of reproductive age with messages focused on HIV and sexually transmitted infection risk reduction, as well as minimizing consumers' embarrassment in purchasing condoms. In response to high HIV rates among young people,^b PSI/Kenya decided to target youth ages 15–24 as



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^a Angola is included in the East Africa region as a Lusophone country.

^b According to UNAIDS, the 2001 HIV prevalence rates for young men and women between the ages of 15 and 24 ranged from 4 to 7 percent and 12 to 18 percent, respectively.



a high-risk group to increase health impact. Trust advertisements on radio and television positioned it as a cool product used by young Kenyans who enjoy life. The brand was developed to evoke the image of a young, confident and affluent man who would appeal to peers not currently using Trust condoms. Moreover, the campaign normalized the idea of condom use among the target group. A 2004 survey found that young men who identified with the Trust brand were more than four times as likely to have used a condom at last sex with a regular partner than those who did not identify with the brand (3).^c

In Angola, research showed that young men believe condoms diminish sexual pleasure and young women fear that suggesting condom use will diminish their partners' sexual pleasure (4). In an effort to appeal to Angolan youth and increase condom use among this target population, PSI/Angola positioned the *Legal* condom brand as "hip and pleasurable." The program used posters, radio and television to promote both non-product-focused HIV prevention messages and branded condom use messages to young men and women. During the program's implementation period, surveys showed that condom use among sexually active Angolan female youth significantly increased from 53 percent in 2003 to 75.5 percent in 2005 (4).

Intense, sustained and multichannel communication programs are required to have an impact on behavioral determinants; however, more operations research is needed to establish the level of exposure required to achieve behavior change.



"Nimechill" (I have chilled/I am abstaining), an AIDSMARK-supported multimedia program in Kenya, conveyed positive messages regarding abstinence to foster youth's self-efficacy to refuse sex and delay sexual debut. The program ran for seven months between 2004 and 2005. High exposure to the campaign through multiple channels was associated with increased self-efficacy and intention to abstain from sex – two important determinants of delayed sexual debut (5). However, no significant change in high-risk behavior attributable to the campaign was observed (5). These findings suggest that future behavior change campaigns should aim to achieve high or multichannel

exposure, and that campaigns longer than seven months are required to affect behavior (6). To this end, Nimechill received follow-on funding from the U.S. Agency for International Development (USAID) to create "Chill Clubs" that employed interpersonal communication (IPC) techniques to increase primary school students' exposure to the campaign, and continued to reach them with basic reproductive health and HIV education (7).

In 2004, PSI/Uganda implemented a program to decrease cross-generational sex between girls or young women and older men. Working closely with the government of Uganda, the program utilized mass media to highlight the problem of cross-generational sex. Formative research revealed that young women believed parental guidance and support was one way to prevent this practice (8). As a result, PSI/Uganda worked closely with faith-based organizations in training religious leaders to address the issue with their congregations. Religious leaders, in turn, trained parents

^c Brand appeal was measured by the statement "Trust condoms are for people like me."

to talk to their adolescent children about reproductive health and related issues – including the dangers of cross-generational sex – and worked to develop their IPC skills to address sex, HIV and other taboo issues with their children. More than 600 parents were trained in churches and mosques across Kampala (8). The program also created a network of peer educators, called “Go Getters,” across university campuses who facilitated life skills education classes and internship placements in an effort to cultivate confidence and self-esteem among young women and equip them with the skills to plan for their careers and provide for themselves. By the end of the program, 687 girls had been taken through the life skills curriculum and 47 had received internships (8). The program was implemented for nine months and, while no significant change in high-risk behavior was reported during this short time (8), the evaluation did find that the proportion of 19- to 24-year-old unmarried women who believe that the benefits of rejecting cross-generational sex outweigh the costs of practicing it rose significantly from 70.8 percent to 88 percent (8).

What is common in both these programmatic experiences is that communication programs managed to have a positive effect on behavioral determinants, but fell short of affecting behaviors themselves. More operations research is needed to determine thresholds for how much exposure (or “dose”) to a communication campaign is required to realize behavior change (or “response”).



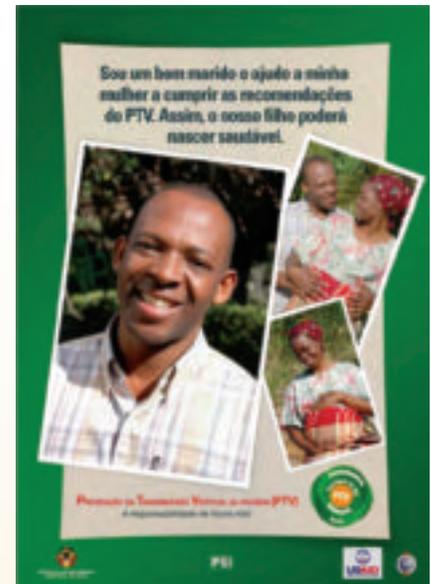
When social marketing health services, it is important to monitor the quality of promoted services – regardless of whether they are provided by the public or private sector.

In 2002, PSI/Uganda developed a private sector social franchise branded *ProFam*, which integrated HIV counseling and testing (CT) and prevention of mother-to-child transmission (PMTCT) services into antenatal care services at 20 private clinics across the country. PSI trained health care providers in delivering the integrated services. AIDSMark supported the development of accompanying information, education and communication materials, as well as



community-based and mass media promotional campaigns using the “edutainment” format (9). An evaluation of the program found that, while client satisfaction with franchised services was as high as 92 percent by 2004, lack of direct control over service delivery and high staff turnover led to 11 percent of franchise staff failing to consistently meet established quality standards that year (10). Given PSI’s success in developing high-quality social franchises for CT using public and private sector partners, this finding indicates that it might be better to integrate more complicated medical interventions, such as PMTCT, into existing public sector health facilities to ensure that the services PSI promotes meet the highest possible standards of quality.

However, public sector health service delivery also has its weaknesses. In Mozambique, AIDSMark supported the Ministry of Health’s CT program, operating in 24 fixed sites and 18 satellite sites. This highly effective HIV CT program has grown steadily since inception and maintains high demand with minimal marketing by integrating high-quality CT and PMTCT services into public health facilities where demand for CT is already high (11). PSI/Mozambique



hires and trains staff to provide CT services in public facilities and refer HIV-positive pregnant women to public sector nurses for PMTCT services and follow-up. However, the severe nursing shortage in Mozambique often results in poor follow-up. Thus, even when complex medical interventions, such as PMTCT, are delivered by the public sector, it is important for PSI to continue to monitor the quality of services to ensure that clients that are referred there will get the best possible care. This is critical to maintaining the credibility of PSI's CT franchises.

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This report was made possible through support provided by the Global Bureau of Health/HIV-AIDS, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-97-00021-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

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