



IMPACT PROJECT EXPERIENCE AND LESSONS LEARNED

From Behavior Change Communication to Strategic Behavioral Communication on HIV in Kenya, 1999–2006

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Family Health International

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The Implementing AIDS Prevention and Care (IMPACT) Project, managed by FHI, has been the flagship project of USAID for HIV prevention, care, and support worldwide. In Kenya, the project has helped to reduce HIV prevalence and encouraged patients to begin antiretroviral therapy.

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Acronyms

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
ART	Antiretroviral therapy
BCC	Behavior change communication
FHI	Family Health International
HIV	Human immunodeficiency virus
IMPACT	Implementing AIDS Prevention and Care Project
KAP	Knowledge, attitudes, and practices
KGGA	Kenya Girl Guide Association
NGO	Nongovernmental organization
NOPE	National Organization of Peer Educators
PATH	Program for Appropriate Technology in Health
PEPFAR	US Presidents' Emergency Plan for AIDS Relief
PLHA	People living with HIV/AIDS
SBC	Strategic behavioral communication
STI	Sexually transmitted infection
TB	Tuberculosis
USAID	US Agency for International Development
VCT	Voluntary counseling and testing

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Acknowledgments

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Deepest gratitude also goes to implementation partners and community volunteers who patiently executed the strategy over the eight-year period. We hope the experiences documented and lessons shared will go a long way toward improving communication programming on HIV/AIDS.

Introduction

Since 1999, communication-related interventions have been key components of FHI's Implementing AIDS Prevention and Care (IMPACT) Project in Kenya. Behavior change communication (BCC) was an essential part of these interventions, which aim to help people increase their knowledge of HIV and AIDS, change their attitudes and beliefs, modify their perception of risks, and build their skills in adopting and maintaining healthy behaviors. As IMPACT expanded expertise in strengthening risk reduction, care, and treatment, its communication program adapted to the changing landscape.

Over time, BCC became associated with prevention-oriented programs, and a strategic behavioral communication (SBC) approach to HIV and AIDS communications evolved. This approach resulted from overcoming challenges, learning lessons, and recognizing that young people need to be empowered to acquire new behaviors that minimize the risk of contracting HIV.

SBC is an interactive process, both with individuals and within communities. It develops tailored communication strategies, messages, and approaches, using a mix of communication channels and interventions to promote healthier behaviors and support individual, community, and societal behavior change. SBC supports the entire continuum of HIV/AIDS prevention, care, treatment, and support interventions, and lends communication expertise to advocacy and social and community mobilization. SBC also supports other interventions to deliver consistent messages through multilayered approaches and channels for maximum effectiveness. IMPACT's communication interventions thus embraced new developments in AIDS treatment and care, including adherence to antiretroviral therapy (ART), counseling on nutrition needs, prevention of transmission of HIV to partners, changes in lifestyle to avoid opportunistic infection, and the adoption of new behaviors.

IMPACT has been a major player in the implementation of HIV-related behavior change programs in Kenya, working in four of the country's eight provinces. Its BCC interventions have the main—and sometimes the only—such program in these communities, and have contributed to the behavior change achievements recorded by the 2003 Kenya Demographic and Health Survey. These included increased age of sexual debut between 1998 and 2003 (from 16.8 to 17.8 for women and 16.8 and 17.1 for men), increased condom use for last reported high-risk sex (from 15.1 to 23.9 percent for women and 42.5 to 46.5 percent for men) and a reduction in the proportion of women reporting more than one partner (from 4.2 to 1.8 percent).

This document describes the design and implementation of IMPACT's BCC interventions and the evolution to comprehensive SBC. Chapter one delineates steps followed in designing the communication strategy, including the formative assessments and creative workshops employed and the communication strategy's evolution and expansion. Chapter two outlines the implementation process, including the role of peer education and youth campaigns, and describes how HIV/AIDS education and behavior change have been communicated in interactive ways through theatre presentations, murals, and a museum exhibition. Chapter three details the campaign to promote voluntary counseling and testing. Chapter four shares results of evaluations of the strategy, and chapter five synthesizes lessons learned that may assist those designing or managing HIV communication programs in resource-poor settings.

1. Communication Strategy Design

IMPACT initially selected five primary priority community sites in three provinces in Kenya for intensive prevention programming, based on HIV-prevalence rates, intervention needs, and gaps. The prevention programming included intensive BCC and community outreach for men at worksites, female sex workers, women, and youth, as well as promotion of voluntary counseling and testing (VCT) services and healthcare-sector upgrading relating to sexually transmitted infections (STIs) and maternal health. The project design included national-level supportive and exploratory activities, including mobilizing private and parastatal businesses to initiate HIV interventions; supporting nongovernmental organizations (NGOs) and other networks to expand coverage of HIV/AIDS interventions; improving blood safety; strengthening serosurveillance and behavioral surveillance; and supporting innovative prevention and care initiatives.

Several programming expansions and amendments followed. With USAID's Kenya Life Initiative funding in 2000, IMPACT's geographic coverage was expanded to 10 community sites in the three provinces, and the strategic focus was broadened to include activities linking prevention, care, and psychosocial support. In 2003, Nairobi was added as a region, and priorities set by the US Presidents' Emergency Plan for AIDS Relief (PEPFAR) came into play, including care and treatment as major focus areas linked to the prevention, care, and support program.

Because an effective communication program requires a blend of reinforcing strategies commonly known as media mix, the IMPACT communication strategy combined mass media, print materials, interpersonal communication, a museum exhibit, theatre, and murals.

Formative Assessments

In October and November 1999, IMPACT teams in Mombasa, Nakuru, and Kakamega carried out formative assessments at priority sites, the first such collaborative efforts of all local implementing partners. As partners worked together to gather community data and share findings, their trust and respect for each other grew. The teamwork that became a hallmark of IMPACT's work in Kenya began with this exercise.

Formative assessments such as these are a crucial step in the design of any communication intervention. They permit planners to

- identify opportunities, resources, and potential barriers to BCC interventions
- specify behaviors and current knowledge and attitudes about HIV and AIDS of different target populations, their likes and dislikes, and their hopes and fears for the future
- identify specific interests and concerns about HIV/AIDS of different target populations and the type of programming and support they need
- define the social networks of target populations and their risk settings
- identify ways to increase health-seeking behavior with respect to HIV and AIDS

The IMPACT team used focus group discussions, in-depth interviews, and key informant interviews with members of different target groups to determine their knowledge and attitudes toward HIV and AIDS, their perceptions of risks and how to prevent HIV infection, and related health-seeking behaviors. Information was also gathered about daily life in the communities, including how people earn their living and spend their leisure time, as well as their living conditions, relationships, and sexual networking. Informants also answered questions about the availability of medical services, their religious affiliations, and their fears and aspirations for themselves and their communities.

The team also employed mapping and zoning. Mapping involved identifying and plotting "hot spots" where at-risk populations are likely to be found, including bars, brothels, and truck stops. Mapping exercises also identified community resources (such as churches, mosques, community halls, and clinics) that could be used to support prevention interventions. The plotting and mapping of hot spots and community resources allowed easy identification and targeting during implementation. Zoning entailed

Excerpts from Formative Assessments

Rumors and misconceptions

"Condoms are not at all that good. My sister died because of a condom. She became sick for a long time. When she was taken to Russia, it was said that a condom slipped and got into her uterus."
—low-income woman, Mombasa

Abstinence

"These young people have hormones they cannot control. And because of that they find it hard to abstain."
—man in workplace, Nzoia

People living with AIDS

"They are treated like outcasts; nobody wants to associate with them, and subsequently they have no friends."
—community leader, Webuye

Media influence

"Though some adverts may be trying to campaign against AIDS, they are actually encouraging the youth to have sex. For instance, there are advertisements on the television that have young girls scantily dressed and promoting condoms."
—youth, Mombasa

Peer pressure

"The problem of delayed sex is the intimidation one is exposed to, especially from boys who laugh at you when you delay sex and look at you as stupid."
—primary school girl, Nakuru

"Girls who abstain from sex are always subjected to abusive language from the boys, especially when they turn them down."
—secondary school girl, Mombasa

dividing priority community areas into manageable operational zones with clear boundaries, and responsibilities for each zone were assigned to implementing agencies and peer educators.

The findings of the formative assessments were rich and plentiful. Along with the creative workshops facilitated by IMPACT partner Program for Appropriate Technology in Health (PATH), these assessments provided the basis for the development of the IMPACT communication strategy. In addition, the assessment process introduced partners to communities.

Assessment findings directly relevant to HIV included the following:

- Though wives said they believed their husbands were unfaithful, they felt helpless to protect themselves from HIV and other STIs.
- Attitudes toward condoms were mixed; some people felt they promoted immorality and others questioned their effectiveness.
- Many people, especially sex workers, considered themselves at risk for HIV and AIDS, but they had fatalistic attitudes.
- Young people who reported that they were sexually active did not discuss sexuality issues with their partners or other adults.
- People expressed interest in VCT but feared learning their HIV status.

Creative Workshops

The IMPACT communication strategy was also based on research gathered in creative workshops held in Mombasa, Nakuru, and Webuye in February 2000 that brought together key stakeholders for three days of simulation games, role-play, and open-ended dialogue on important issues in the era of HIV and AIDS. Participants included IMPACT partners, representatives of local government health services, stakeholders from affected communities, journalists, theatre performers, artists, and others. In the workshops, they explored their own experiences, attitudes, feelings, and needs, and they examined existing communication resources and strategies, experimented with creative expressions, and arrived at consensus on communication requirements.

The goal of this informal, participatory approach was to probe more deeply than is usually feasible in standard focus group discussions. The method elucidated barriers to effective behavior change—for example, issues of stigma revolving around HIV and AIDS—and opportunities for intervention. In addition, the approach offered a clear understanding of the communities' priorities and the emphasis that needed to be placed on various issues.

Communication Strategy Components

IMPACT's initial communication strategy for HIV focused on prevention. But the formative assessments and creative workshops made it clear that awareness about HIV was not sufficient to change behavior for most people. They needed information, but they also needed to own that information or they would not act on it. They would own the information they asked for and

received through a dialogue, especially if their questions sprung from heartfelt reflection.

The assessment and workshops also posited that AIDS was the consequence of fractured, flawed, and distorted personal relationships—between husband and wife, adolescent boys and girls, older men and younger women, widows and their inheritors, teachers and their students, workers and their colleagues, and people at risk and those close to them. These flawed relationships, rather than AIDS, were the root of the problem. Poor relationships were considered the proximate causes of the risky sexual behavior that fueled the vast majority of HIV transmission in priority communities. Relationships marked by miscommunication, power and financial imbalances, or predetermined and entrenched cultural beliefs set the stage for the kind of behavior that spreads HIV. With better-quality relationships, people would be better equipped to reduce their HIV risk, and they would have a foundation for optimism, hope, greater self-respect, and more positive attitudes toward life.

In the prevailing atmosphere of despair and fatalism, changing people's mood and perception was seen as a prerequisite for greater acceptance and involvement with life-saving messages about HIV and AIDS. The challenge of developing what was to be called the "Question Your Relationships" strategy was discovering how to encourage community members to ask the questions that were important to them and their relationships and act on the answers. The premise was that misguided trust often leads to unprotected sex and HIV infection, since monogamous people who trust their partners often do not see the need to use condoms. The campaign thus encouraged individuals to reflect on their relationships with sexual partners as a way of assessing their self-risk.

Peer Education and Diffusion of Behavior Change

IMPACT's communication strategy involved highly focused and targeted interactions with relatively small groups of people, then reaching out to the rest of the community (and, indeed, the nation) through a process of diffusion. Those chosen to be in small groups were selected, in part, because they were connectors—or people with wide social networks.

Small-group interactions were carefully designed. Peer educators were given in-depth training to help them master detailed information and give them skills to facilitate a variety of discussions within fixed groups, with the objective of stimulating behavior change among group members (see appendix 1). Peer educators were also trained to recognize when participants may be changing their behavior.

The quality of the questions emerging from the community at different stages of the dialogue became an important indicator of progress. In the strategy, the delivery of information was designed to respond to questions emerging from communities as they deepened their ability to reflect on their predicaments through peer education.

One objective of peer educators was to provoke more and better questions from the community. Behavior change was then to be monitored by observing how questions changed as risk perceptions were altered. The risk continuum ranged from feeling far

from the epidemic and at virtually no personal risk to living with AIDS. In between were people who were practicing multipartner sex or had contracted an STI, along with others who were contemplating an HIV test. Along this continuum, increased risk perception prompted more detailed, heartfelt, and personal questions. The closer an individual felt to the epidemic, the more likely was the possibility of behavior change.

Once participants demonstrated sustained behavior change that could be linked to any of the program's communication objectives, those individuals would be encouraged to bring first-person testimony to the IMPACT weekly radio show, *Kati Yetu (Between Us)*, and to become an exemplar of behavior change within the community. For example, a group of young men from Western Province spoke about their VCT experiences in one episode with the goal of creating a climate of hope that behavior change was already happening. By demonstrating behavior that works positively and showing that change is possible—and, in fact, is already happening—community members may begin to speak passionately for change and growth. This process redefined the role of mass media from a simple means of disseminating messages to an instrument that reflects to the community what is already taking place. Radio thus becomes the magnifying mirror of behavior change.

Objectives and Target Groups

The objectives of the communication strategy were to

- increase the perceived distance between exposure, HIV infection, and AIDS
- encourage young people to delay sexual debut and to develop long-term, trusting relationships
- improve negotiation skills, particularly for women and girls
- disseminate better understanding of and confidence in condoms
- create greater comprehension of the risks of unprotected sex with multiple partners
- promote greater interest and confidence in VCT

These objectives were carefully chosen, as were the target groups to receive the messages. Those targeted were identified in the formative assessments as persons engaging in or associated with high-risk behavior, whose behavior must be changed to stop the HIV epidemic. They thus included men at worksites, female sex workers, women in low-income communities, and in-school and out-of-school youth.



Male sugar-factory workers in Western Kenya attend a peer education session.

Men at Worksites

Men at worksites were selected as having a higher than average risk for HIV because they generally have a relatively large amount of disposable income that may be used to purchase sex. They may seek sex partners because they have migrated away from their spouses and families in pursuit of employment. Other men may live with their families, but may travel for extended or short periods to perform work-related duties. In 2005, the worksite target group was expanded to include the police.

Female Sex Workers

Female sex workers are a high-risk group for HIV, and they are also considered a “core transmitter” group. They may have many clients, and those who do not use condoms expose themselves regularly to possible HIV infection.

Women in Low-Income Communities

Women in low-income communities were considered a risk group, and those considered at highest risk were divorced, widowed, or had been abandoned by their husbands or partners. Such women may have a number of children but little education or means of providing their support. Low-income communities near large worksites were incorporated into BCC activities because women living in them may seek occasional or long-term sexual relations with male workers in exchange for money.



In-School and Out-of School Youth

The communication strategy included youth, since AIDS has a long incubation period and many infected adults may have acquired HIV during adolescence. It was also widely acknowledged that youth were the “window of opportunity”—the generation through which society hopes to achieve an AIDS-free population. In addition, a 1999 Population Council study in Kisumu (part of a multicountry study of three cities in Africa) showed that girls ages 15–19 had up to a four-fold higher chance of contracting HIV than boys the same age.

School leavers were considered to be at risk for HIV; many drop out due to poverty and lack of school fees, and their need for income may expose them to HIV. In addition, formative assessments indicated that those who dropped out due to low educational aspiration had less parental support, lower self-esteem, or a combination of these and other psychosocial factors that put them at greater risk for HIV. Furthermore, most out-of-school youth were unemployed or idle, and they may expose themselves to sexual risk out of boredom or hopelessness.

Revision and Expansion of the Strategy

Decentralization

In 2002, a midterm IMPACT strategy review observed that the national BCC strategy was still useful for creating synergy and uniformity across the provinces, but there was need to create local ownership and relevance by decentralizing planning to constituency AIDS control committees, nongovernmental organizations (NGOs), and businesses at district and community levels. Each involvement would facilitate participatory, comprehensive, and site-level BCC plans.

As a result, IMPACT established and built capacity of district teams in the three regions to develop site-specific HIV communication action plans. These plans needed to ensure that messages going out to the community were harmonized, and that communication on HIV addressed local root causes of risk behavior. The teams were assisted to develop these local messages. For example, the HIV communication committee in Naivasha developed a communication strategy that focused on life and associated HIV risk around the Naivasha truck stop and flower farms.

The ABC Approach

In 2003, with the availability of funds from the US Presidents' Emergency Plan for AIDS Relief (PEPFAR), the communication program was expanded to more sites, including Naivasha, Malindi, Kwale, Voi, Narok, and Nairobi. At these sites, the community mobilization process was similar to the one used in 1999.

PEPFAR funds strengthened the "ABC" approach already initiated for in-school youth programs. This approach emphasized abstinence for youth and other unmarried persons, including delay of sexual debut; mutual faithfulness and a reduction in the number of partners for sexually active adults; and correct and consistent use of condoms by those whose behavior placed them at risk for transmitting or becoming infected with HIV.

Interventions targeting in-school and out-of-school youth emphasized abstinence until marriage as well as "secondary abstinence"—a return to abstinence—for sexually experienced youth. Those targeting in-school youth promoted abstaining from sexual activity as the most effective and only certain way to avoid HIV and other STIs and eliminate the risk of HIV transmission. The program sought to develop skills for practicing abstinence and promoted social and community norms that support delaying sex until marriage and denounce cross-generational sex and transactional sex, as well as rape, incest, and other forced sexual activity.

Be faithful programs encouraged individuals to practice fidelity in marriage and within other sexual relationships as a critical way to reduce risk of exposure to HIV. The main target groups were men and women in workplaces and women in low-income neighborhoods.

These programs promoted

- the elimination of casual sexual partnerships
- the development of skills for sustaining marital fidelity
- the importance of mutual faithfulness with an uninfected partner in reducing the transmission of HIV among individuals in long-term sexual relationships

- joint HIV counseling and testing for couples unaware of their HIV status
- endorsement of and respect for social and community norms that support marital fidelity, avoidance of sex outside of marriage, and a reduction in the number of sexual partners
- adoption of social and community norms that denounce cross-generational sex and transactional sex, as well as rape, incest, and other forced sexual activity

Correct and consistent condom use continued to be promoted by the program, which supported the provision of full and accurate information among highly vulnerable populations. These include sex workers, truckers, and migrant workers, as well as uniformed servicemen, who exhibited high rates of partner change during formative assessments. The program also promoted correct and consistent condom use among discordant couples.



Material developed by the TB communication campaign.

TB Communications

IMPACT's formative study on tuberculosis (TB) in priority communities revealed that most people did not know or recognize the critical early symptoms of TB. Most delayed seeking care and relied on self-medication, using cough syrups and herbs. In response, the program initiated a communication intervention for TB whose main objectives were to

- increase general knowledge about the critical early symptoms of TB
- discourage overuse or substitution of over-the-counter products
- promote adherence to TB medication
- encourage people to seek proper diagnosis and care at recognized TB centers and promote good health facilities as places to obtain TB care
- provide education about proper TB diagnostic procedures—sputum tests and x-rays—as a way to promote a patient's right to request or seek such services

The program embarked on developing messages and materials to address these objectives, and all peer educators received training on TB messages.

Antiretroviral Therapy

At the same time, the HIV/AIDS arena was rapidly changing. Treatment, initially expensive and out of reach for most Kenyans, had become affordable, and the government and donors were exploring ways to make antiretroviral drugs (ARV) available.

In 2003, with funding from USAID and FHI, IMPACT started an ART program at the Coast Provincial General Hospital in Mombasa. As part of this intervention, IMPACT carried out a formative assessment that revealed varying levels of knowledge about HIV/AIDS and ART. Some people in target communities



An example of printed materials on antiretroviral therapy.

had never heard of HIV treatment, while others had heard about it but had inaccurate information. Many believed incorrectly that all people living with AIDS (PLHA) would be eligible for treatment. Others were skeptical about imported ARVs, concerned about patient confidentiality, and unaware of existing testing and counseling services. Research also revealed high levels of stigma and discrimination, even among health workers, which inhibited people from seeking or continuing services. Education and communication were also needed to foster a climate in which clinically eligible PLHA could meet social criteria (such as disclosure), initiate treatment, and adhere to medications.

With a grant from Pfizer, FHI developed ART literacy materials for the Mombasa program. These included brochures and flip

charts with local images and analogies (appendix 2). USAID and Kenya's National AIDS and STI Control Program and the UK Department for International Development provided additional funding to create the materials, which were geared to both literate and low-literate audiences. Coast People Living with HIV and AIDS (COPE), the largest PLHA association in the province, provided technical input at each stage to ensure that materials were on target and resonated with the intended audiences.

A flip chart to enable health workers to communicate HIV/AIDS and ART in lay terms was developed, along with booklets and brochures on ART basics and how to manage side effects and avoid opportunistic infections. These were developed, printed, and distributed to all IMPACT project sites, and have since been adapted for use in Eritrea, Ghana, Malawi, Zambia, South Africa, and other countries.

In addition to broadening the communication strategy by incorporating care, treatment, and support, IMPACT provided print materials to support interpersonal communication. A series of workshops were held for stakeholders and target audiences that produced support materials in a participatory manner, which were pretested by target audiences and produced and distributed within IMPACT priority sites.

2. Communication Strategy Implementation: Peer Education, Youth Campaigns, and Interactive Programs



Community leaders attend a sensitization meeting in Mombasa.

Community Mobilization

To ensure that priority communities fully supported the implementation of the communication strategy, IMPACT held a series of advocacy meetings with key stakeholders in the communities. In Mombasa, IMPACT brought together political, church, and administrative leaders for an orientation meeting on the proposed communication strategy and their involvement in the program. A meeting with imams of various mosques in Mombasa was also held, and similar stakeholder meetings were held with community, administrative, and political leaders in Western Province and Nakuru. A total of 42 imams and 230 other community stakeholders participated in the sensitization meetings. One challenge was meeting their expectations. “Some community members expected IMPACT to pay them for their participation in meetings,” said Gordon Nyanjom, project manager in Western Province. However, constant dialogue overcame this difficulty.

The meetings illuminated leaders’ level of ignorance about HIV, moralistic views of religious leaders toward people living with HIV, and negative attitudes toward condoms. “By promoting condoms, we are condoning and promoting immorality among our people, and this is unacceptable” one leader stated at the start of the workshops for religious leaders in Mombasa.

But the meetings also proved very useful in changing the community leaders’ attitudes and creating the necessary supportive environment. The Council of Imams, as well as political and Christian leaders, became great supporters of the communication intervention. “We want you to help us reach out to madrasa teachers and students; they need this information now,” said Sheikh Mohamed Dor, the chairman of the Council of Imams in Mombasa at the end of sensitization meeting. In addition, the Reverend Joseph Kashuru of the Anglican Church of Kenya in Mombasa enrolled in peer education and community counselor training and became a major IMPACT supporter in Coast Province.

Achievements and Lessons Learned

Sensitization meetings not only helped to bring down barriers of suspicion and stigma, they unlocked the potential for stakeholder participation in HIV communication interventions in the commu-

Support for Community Mobilization Interventions

“You can count on my support, and I will ensure that I personally participate in the community mobilization efforts in my constituency.”

—late Member of Parliament Emauel Karisa, Kisauni Constituency, Mombasa

“After the sensitization meetings, it was easy to work with highly stigmatized groups, such as the female sex workers in the predominantly Muslim neighborhoods in Mombasa.”

—Ruth Odindo, IMPACT manager in Coast Province

nity. The active engagement of politicians in the process helped galvanize community involvement and its receptivity to the program.

Through the decentralized BCC planning process, a critical team was built of individuals who internalized the SBC process on HIV at the provincial level and, for Naivasha and Malindi, at the sub-district level. A total of 60 people worked closely with the FHI and PATH technical team on developing the communication strategy, and they acquired skills to move the process forward beyond the IMPACT Project.

The IMPACT communication strategy was sound, from a communication theory point of view. Several lessons emerged from its implementation.

- Having a uniform communication strategy across IMPACT priority sites enabled the program to have uniform standards across three regions. The program used a uniform curriculum for training peer educators and a quality assurance system.
- The communication program was flexible; it adapted to emerging needs for communication about HIV.
- Having PATH as the single source of technical assistance enabled transfer of lessons from one region to another and a consistent message across implementing partners.
- Decentralizing the planning and review process of BCC activities reenergized and empowered teams in the regions. After the USAID midterm review in 2003, IMPACT reorganized the program to establish local HIV communications committees. These met to review priorities and plan joint activities to address local issues, including the development of local communication materials. Local partners thus began to own the process and identified with the outcomes.
- Whereas information for the development of the strategy was assembled in a participatory way, the community-based organizations that implemented the program had not been involved in all of the design process, including determining the objectives, developing a monitoring and evaluation plan,

and determining methods of delivery. As a result, they did not own the final Question Your Relationships strategy. In addition, the need to jumpstart the program caused IMPACT to start up activities (such as the theatre and the peer education program) before developing a communication strategy. Attempts to change activities mid-stream to fit into the finalized communication strategy were resisted by some members of field implementation teams, since they were already used to implementing activities in a particular way.

- The advent of treatment and the need for comprehensive care meant the scope of the communication strategy needed to expand. Instead of being purely about HIV/AIDS, it needed to address health and development in general. People not only required information about HIV-prevention, they needed to know how to stay healthy and get information about life-saving drugs, nutrition, lifestyles, and how to access psychosocial support services.

Peer Education for Adults

Peer education, the centerpiece of IMPACT's communication program, was one of the first activities implemented. In March 2002, 24 peer coordinators representing IMPACT partners from all three regions attended a week-long training-of-trainers workshop in Nakuru. This training focused on adult education theory and participatory education techniques, with little emphasis on HIV and AIDS technical information. These trainers returned to their regions and trained over 1,000 peer educators over the next few months.

The peer education groups were known as radio groups because their feedback informed the national radio show *Kati Yetu*. The groups were fixed in size, and the same people were expected to meet each week for intensive discussions. The goal was to facilitate a process in which participants considered their experiences, attitudes, emotions, and behavior as four interlinked factors whose interplay could lead to sustainable changes in behavior.

The peer educators were selected because they were seen as connectors within the community.¹ In turn, they were encouraged to form peer groups that included other connectors. Once they began to change attitudes and behavior, those selected were expected to carry ideas to the greater community and become advocates for change among their many contacts. In addition, peer educators were trained to recognize and nurture community members who were adopting new attitudes and behaviors. Where possible, those who changed behavior were invited to share their experiences on *Kati Yetu*, magnifying their behavior change and exerting a motivating influence on the rest of the community. By working intensively with these connectors, the program could reach many more people than just those who participated directly in peer education groups.

However, observations were made in the field in the first six to eight months about the lack of accord between peer education activities and the Question Your Relationships strategy. This was partly the result of peer education skills being imparted in advance



Low-income women in Mumias attend a radio group session.

of the formulation of the communication strategy. It was also observed that peer educators did not receive the depth of knowledge on HIV to enable them to respond to questions. Given that the communication strategy was based on high-quality interaction, questioning, and dialogue, a new approach was clearly needed.

The Splash! Methodology

The new development was the Splash! methodology, a thrust toward increasing peer educators' technical mastery and improving the quality of their interactions with the community. Splash! focused on intensively training peer educators and guiding them meticulously in conducting discussions with selected groups from each priority community. Splash! also featured detailed guides that steered peer educators, step-by-step, to questions to ask that would nurture healthy and vigorous community discussion. The discussion guide for the peer educator included procedures, questions to be asked during a particular discussion, and detailed technical content needed for that discussion.

The term Splash! emerged from a simple analogy. If someone in a crowd started sprinkling water from a bottle in hand, at first only those in the immediate vicinity would get wet. If the splashing continued steadily and patiently, eventually everyone within reach of the drops would be equally drenched, even if all individuals were not specifically targeted.

This idea operated both within the peer education groups and in the wider community. The Splash! peer educator used a gradual yet persistent approach, meeting with the same people week after week and "sprinkling" them with a manageable amount of content and discussion each time. Participants were offered a chance for dialogue, reflection, enquiry, and greater ownership of that information—and hence, behavior change. The radio show was the ultimate diffuser, disseminating stories of individuals who had changed their behavior.

The Splash! approach to BCC was based on the following assumptions:

- An intensive, educational engagement process is more appropriate for early adopters.
- Early adopters will help set a community agenda for behavior change through demonstrations and endorsements, thus exerting a motivational emphasis on the rest of the community.

¹ As suggested in diffusion theory and described in Malcolm Gladwell's *The Tipping Point* (Boston: Little Brown, 2000), connectors are people who have many contacts, through work, leisure, church, sports, or other activities.

- Early adopters are linkage agents between the resource system (the IMPACT Project) and the user system (identified priority communities in Mombasa, Rift Valley, and Western regions).
- The mass media and folk media magnify and amplify behavior change among early adopters and thus exert a motivational influence on rest of the community.

These four assumptions are rooted in some of the precepts of the diffusion of innovations theory of Everett Rodgers,² and they assume a behavior-change process where four interlinked and causative factors— experience, attitude, emotional response, and behavior—operate within the audience selected.

Peer Education Achievements

One of the notable achievements of the peer education program was the establishment of the National Organization of Peer Educators (NOPE), one of the fastest growing organizations providing peer education training in Kenya. NOPE was established in 2000, with the participation of the coordinators and peer educators within the three priority regions, to spread the IMPACT peer education methodology to as many groups as possible for HIV/AIDS behavior change. In April 2001, the organization launched its Coast chapter, which was soon followed by launches in the Western and Rift Valley regions. In December 2001, NOPE was officially registered as an NGO.

To date, NOPE has trained over 3,000 peer educators and trainers, about 1,000 of whom are workplace peer educators. About 600 company managers have also received sensitization on workplace HIV/AIDS policies and programs. NOPE is now a leading technical assistance provider in peer education in Kenya, and is working with 24 companies at different stages of program development and implementation. The quality of its services has attracted some of the biggest business enterprises in Kenya, including Unilever Tea, the Kenya Ports Authority, British American Tobacco, East African Breweries, Serena Hotels, D.T. Dobie, Coca-Cola, and Hotel Intercontinental.



A peer education session in Kwale.

Measurable Results of IMPACT's Peer Education Program

Peer educators trained	10,239
Individuals reached, one-on-one	1,054,418
Individuals reached by group or community outreach	2,585,274
Total	3,639,692
Condoms distributed by peer educators	49,350,728
STI referrals made	90,220
VCT referrals made	158,388
Workplace managers and/or supervisors of peer educators trained	587
Workplaces with peer education programs	116

Lessons Learned

- Retaining the interest of peer educators was a challenge, but the program experienced a 70 percent retention rate—a higher rate than other peer education programs.³ This was largely attributed to the rigorous selection criteria for peer educators and the close monitoring and supervision system in place, along with incentives that were built into the program. Peer educators received uniforms (mainly T-shirts) and a monthly transport allowance of 400 Kenyan shillings (US\$5)
- Starting the peer education program before the finalization of the overall communication strategy proved to be costly in the long run. The program had to invest in retraining trainers, supervisors, and peer educators after the strategy was in place.
- Changing the peer education approach mid-stream, without a proper transition plan, caused discontent among peer educators. Those who could not be accommodated in early workshops for revised Splash! training program felt let down. This was overcome several years later, when all the peer educators and supervisors received Splash! training.
- Discussion guides were developed to help facilitate meaningful, structured discussions, but peer educators hardly used them, despite several pre-tests, orientations, and training.

Kati Yetu Radio Show

The *Kati Yetu* radio show featured a soap opera, *Maisha ya Nuru*, which was developed by listeners in Mombasa, Nakuru, and Western region during a series of creative workshops in February 2000. *Kati Yetu* also featured talk sessions, interviews, panel discussions, and songs, and the moderated segment had

² Everett M Rogers, *Diffusion of Innovations*, 5th ed. (New York: Free Press, 2003).

³ Population Council, *Peer Education and HIV/AIDS: Past Experience, Future Directions* (Washington DC: Population Council, 1999) www.popcouncil.org/pdfs/peer_ed.pdf

interviews with audience members who had demonstrated changed behavior or become advocates of attitudes that can reduce the risk of HIV and AIDS.

Both the drama and talk show segments were shaped by feedback from peer education groups in IMPACT priority areas. These groups listened to the show live or on cassette tapes. The moderated talk show component responded to issues and questions raised by listeners' letters, as well as feedback received from peer education groups. The topic of each week's show was often expressed in the form of a question, in keeping with the communication strategy.

Kati Yetu also served a key function within the Question Your Relationships strategy: magnification of behavior change. When individuals adopted a new behavior as a result of their participation in IMPACT activities, they were asked to appear on the show to share their stories. For example, after a young man from Mumias who had been a regular in Magnet Theatre activity told of his decision to go for VCT, a number of other youths from the same group also went for VCT.

Community members participated in the radio show in other ways. For example, early in the series, a group of women in the Changamwe section of Mombasa responded to the rape scene in *Maisha ya Nuru* by composing a song that urged Nuru, the victim, to be strong and resolute. The song was woven into the story and became part of a later episode.

Achievements and Lessons Learned

During the project period, 123 radio shows were produced and aired twice a week. They reached over 2 million Kenyans,⁴ and more than 5,000 letters were received from listeners.

Though a 2002 evaluation study established the reach and impressive effect of *Maisha ya Nuru*, it never became the talk of Kenyans. This is partly because radio listenership culture was changing with the advent of FM stations in Kenya. The FM stations introduced formats such as live call-ins and competitions that engaged listeners, while *Maisha ya Nuru* relied on letters from listeners for feedback. In addition, the cost of production and broadcasting was very high. Efforts were made to negotiate preferential rates with stations, but the best IMPACT could get was a free repeat of the broadcast at 3 pm, not the most convenient time for listeners.



Young people on a bus read Nuru comic books.

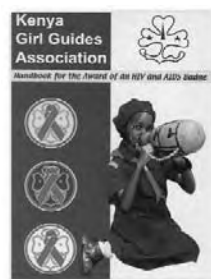
Youth-Focused Peer Education

Nuru Comic Books

Nuru comic books produced by IMPACT centered on Nuru, the teenaged girl and protagonist in the *Kati Yetu* radio soap, and the challenges and choices she and her friends face concerning friendships, dating, and sexuality. The comics used bright colors, youthful language, a gripping story, and characters to whom young people can relate, creating an entertaining read for young people that also encouraged them to think about relationships and behavior.

The three-volume book series, produced in both English and Kiswahili, was field-tested with in-school and out-of-school youth. The series was designed to help young people consider the everyday pressures and challenges they experience, since they are bombarded with conflicting messages about how to succeed. The decisions they make and how they behave—in terms of relationships, love, sex, and peer dynamics—are often linked to their perceptions of themselves and others and their visions of the future. The series fostered positive attitudes and perspectives to help youth consider quality relationships and encourage sexual behavior choices that can save their lives.

The goal was to be thought-provoking: Did Nuru do the right thing? Should Oscar emulate Leon's ways? Will Angel's relationship with the sugar daddy be her undoing? The problems were real, and so were the characters' struggles. Some made irresponsible choices and faced the consequences. Others reacted to the challenges with growing self-esteem and the courage to do what they knew was right.



The cover of the Kenya Girl Guides Association handbook on HIV and AIDS badges.

Life Skills for Girls in School

IMPACT worked with the Kenya Girl Guides Association (KGGA) to implement a youth-focused peer education intervention in schools in the three regions. The Girl Guide program is the largest program for girls in Kenya (and Africa), and it could use its existing patrol structure for HIV education. By funding KGGA for HIV and AIDS education, IMPACT allowed the association to increase the number of schools with a Girl Guide program.

The IMPACT program began in October 1999 with orientation and sensitization on HIV and AIDS for adult leaders of the Girl Guides (active or retired teachers who volunteer in the Girl Guide movement) and the KGGA national leadership. The first Girl Guide leaders were trained in November 1999 with the manual *Training of Guide Leaders on Participatory Peer Education for HIV and AIDS Prevention: A Life Skills Manual for the Kenya Girl Guides Association*. Before it could be used, the manual had to be approved by various stakeholders, including the Ministry of Education, parents, and some key representatives of religious and community organizations.

Adapted for the project, the manual drew on or borrowed elements from several behavior change models (such as the health belief model, the theory of reasoned action, and the social cognitive theory), and it aimed to incorporate individual, social, and environmental influences on behavior change. It covered topics such as personal, community, and family values; gender roles and equality; sexuality, adolescent development, and relationships; pregnancy prevention; HIV/AIDS and other STIs; and communication and self esteem. The 39 weeks of training sessions could be adapted to various age groupings. The manual was also highly interactive, incorporating discussions, role-play, brainstorming, case studies, guest speakers, and games and exercises.

The key elements of the manual were condensed into *Talking Points*, a small, user-friendly booklet that became the main reference document for peer educators. The booklet was laminated to withstand frequent use, and each section covering a specific subject was color-coded for easy access. Each of these sections was divided into three broad components: factual information; a “did you know?” component that highlighted key aspects; and questions and answers to test knowledge acquired. Sessions led by Girl Guide leaders or peer educators were held at least once a week (although some schools held them daily), usually during lunch or immediately after school.

The KGGGA integrated a new HIV/AIDS badge into its elaborate badge system used to recognize achievement, and the association has developed a special booklet to guide the young people through the acquisition process. There are three levels of HIV/AIDS badge, corresponding to the three cadres within the Girl Guide system, and members of each cadre has to accomplish different sets of activities to earn the badge. Brownies (the youngest cadre) are required to undertake simple activities, such as making drawings about HIV/AIDS, writing a poem, or learning how HIV is transmitted. Older Girl Guides might need to make a 10–15 minute presentation about HIV/AIDS to their peers, visit someone with AIDS, or write an essay about self-esteem and negotiation skills. Rangers and Cadets undertake more difficult tasks, such as interviewing a VCT counselor, writing letters to a newspaper about HIV/AIDS, organizing discussion groups with peers, developing HIV/AIDS risk-assessment questionnaires, and regularly assisting a child orphaned by HIV/AIDS. The emphasis on care and support

in the HIV/AIDS badge system is designed to counter stigma and discrimination against PLHA.

Once trained, the Girl Guide leaders returned to their schools to educate patrol leaders, who then became peer educators. Each school had about 10 peer educators, and each was the head of a Girl Guide patrol. The trained peer educators embarked on information dissemination activities for their patrols, schoolmates, communities, church groups, and any other audiences they could access. Each peer educator was required to reach at least 10 other individuals. Thus, eventually, a peer educator’s audience included boys, parents, community leaders, religious groups, and others in the community.

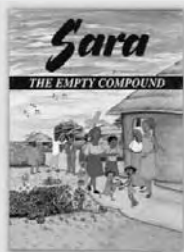
Sara Comic Book Series

The KGGGA program integrated the Sara Communication Initiative, a multimedia project that has produced to date seven comic books and five animated films, in collaboration with UNICEF and PEPFAR. The animated films have elements of realism and drama, blended with serious messages, and imparts educational content in unique and entertaining ways.

The Sara character was designed to capture the concept of a “positive deviant” and be a promising behavior model for young girls in Africa. The charismatic heroine is an adolescent girl living in peri-urban Africa. Like many girls her age, Sara faces nearly insurmountable sociocultural and economic obstacles. But her aspiration to improve herself and her community and her quest for alternative solutions to problems inspire anyone who encounters her. Sara’s ability to negotiate and persuade and her determination never to give up, even in desperate situations, make her a dynamic role model for girls; she inspires self-esteem and models the lifeskills essential for empowerment. Rather than being presented as a victim, evoking pity and sympathy, Sara emphasizes girls’ potential. The stories expose the issues that hinder girls’ development and illustrate the supportive environment that they need to flourish.

The Special Gift, the first *Sara* story, was a communication tool for HIV/AIDS prevention. All subsequent stories were built around themes with a direct relation to HIV/AIDS and its impact on adolescent girls. However, AIDS messages do not dominate the stories because audience fatigue might result.

The reality of HIV/AIDS in Africa has been woven integrally and subtly through *Sara* stories:.



The Empty Compound

Sara’s cousin has died, leaving his young wife, Sofia, and their baby son. Although Uncle says his son died of cancer, everyone knows he died of AIDS. Then Uncle starts blaming Sofia for his son’s death and banishes her from his compound. Sara is delighted when Sofia comes to stay with her family, but people whisper and point at them whenever Sara and Sofia go out together. Some even call Sofia a witch. Sara and her family show how and why it is necessary to confront prejudice and the reality of AIDS.



The Trap

Mr. Mbuta, the shopkeeper and local sugar daddy, tries to trick Sara into becoming yet another of his “girlfriends.” Sara cannot turn to her mother, who is away. Then Sara’s grandmother tells a story about men who turn into monsters. Sara realizes she has to take decisive action against Mr. Mbuta and the diseases he might be spreading. With some quick thinking and help from friends, Sara turns Mr. Mbuta’s trick around.



A Straight Talk editorial meeting at school.

Straight Talk and Straight Talk Clubs

In collaboration with the Kenya Association of Professional Counselors, IMPACT supported *Straight Talk*, a newspaper addressing adolescent sexual and reproductive health and dedicated to educating young people on HIV/AIDS and helping them develop and maintain behavior that supports eradication of the risk of infection through abstinence. A continuous abstinence campaign appeared in a regular column called “behavior change alphabet.”

The content was determined by an editorial board of youths, who were guided by questions and requests received from young readers ages 13–19. *Straight Talk* was distributed as an insert in the *Daily Nation*, a Kenyan newspaper, on the last Friday of every month. Other copies were directly mailed to schools and youth-serving organizations, including Straight Talk Clubs.

The clubs were established in secondary schools, and their main activities were group discussions, health talks, debates, quizzes, exchange visits, conferences, and community services. Straight Talk clubs, managed by adolescents elected as officials and guided by teachers trained in facilitation and group management, allowed discussion of many issues relating to HIV prevention and offered a forum to explore issues appearing in the newspaper. Members also generated their own topics, based on their reproductive health concerns. The clubs met once a week when schools were in session.

Program support needed during school holidays to maintain the focus on prevention was achieved by working with commercial- and faith-based organizations in communities. Youth-friendly and youth-developed supporting materials (such as posters, brochure, T-shirts, and badges) motivated participation and promoted program ownership. Inclusion of additional relevant information, such as youth-friendly counseling and VCT services, made the program relevant to youth, some of whom were taking care of family members with AIDS-related illnesses.

Achievements and Lessons Learned

Comic books provide a very useful means of communicating health messages to youth in a language they can understand. In an entertaining way, the comic characters in the *Nuru* series depicted the challenges that youth face and reinforced the fact that their lives depend on choices they make. The comic characters effectively communicated health messages and provoked lively, informal discussion among young people.

A small number of comic books can reach many youth: a single copy was read by more 20 young people. In addition, *Nuru* was serialized in local newspapers, and a short story was published in youth-focused magazines each month, dramatically increasing the number of readers. The number of youth reading *Nuru* was estimated in the hundreds of thousands.

In 1999, the KGGA program broke new ground in reaching in-school youth—particularly young girls—with information on HIV in Kenya. Until then, the Ministry of Education and faith-based groups could not allow education about sexuality in primary schools in Kenya, save for subtle mention of HIV within the subject of social ethics. Through the KGGA program, 900 teachers received orientation, and 50 leader coordinators and 875 Girl Guide leaders were trained. About 5,000 Girl Guides have earned the HIV/AIDS badge.

The Sara Communication Initiative reached 80,000 pupils in 800 schools, where 43,200 copies of *Sara* communications were distributed and 1,500 girls earned Sara badges. There were no development costs, as materials are already printed and available. They are adapted to the African context, and supplement existing peer education and classroom reading in schools. One comic is read by many pupils, and videos serve whole classes.

Some 980,000 copies of *Straight Talk* were produced and distributed, and 180 Straight Talk clubs were established in secondary schools, increasing openness and dialogue on reproductive health issues. The dialogues generated created ownership of information. Such ownership is seen as the precondition for behavior change, which starts with individual appreciation of the magnitude of risk, being in control of the new behavior, and cues to action to help maintain the new behavior.

Youths are a strong influence on other youths, and can reach them with HIV/AIDS prevention information if provided with the right support. However, messages sent out to youth on condom use need to be harmonized. Glorifying the condom through celebrity advertisements sends confusing signals to young people when the key message is abstinence.

Theatre Outreach

In 1997, a group of young people approached FHI with an idea of holding an annual youth theatre festival with an HIV/AIDS theme to coincide with World AIDS Day, observed every December 1. FHI supported the concept through its small grants program known as Rapid Response Fund, and about 8,000 young people turned out to watch 43 groups compete for trophies in the first two-day festival. However, most performances had negative messages and depicted the prevailing hopelessness of people with HIV.

IMPACT provided funding to Artnet Waves, the group that organized the festival, to establish theatre outreach in Mombasa, Nakuru, Nzoia, Webuye, and Busia. In each region, coordinators trained youth theatre leaders in organizing outreach events. “The entire outreach process was carried out on young people’s own terms; this allows them to interpret the meaning of HIV/AIDS for themselves



Theatrical performances by and for youth.

and, through dramatic arts, to explore associated values, conflicts, and solutions pertinent to their own generation,” said Hamisi Salim, an Artnet Waves theatre coordinator in Mombasa.

A group typically began by identifying a problem related to HIV affecting youth in the community. The artists prepared a performance to address that problem, using poems, oral narratives, song, dance, and drama. The theatre group would then organize an outreach event for the community and invite young people.

After each performance, a facilitator stimulated debate on the issues raised or invited comments from the audience. Very often, audience members themselves came up with solutions. Audiences clearly enjoyed such exchanges. “It’s about the youth and by the youth; it has to be fun,” said Crispine Mwakideo, a member of St. Luke’s theatre group in Mombasa.

Challenges and Redesign

Scaling up the theatre program from a fixed World AIDS Day activity to a regular community outreach reaching more people brought major challenges. Artnet Waves—essentially an organi-

zation of young people—had excellent theatre skills, but lacked program and institutional management experience, such as financial accounting. They could not set up systems for program management and concurrently plan and assure quality performances. FHI started noticing that financial reports and records were inaccurate and arriving late; the quality of facilitation, message conceptualization, and delivery also waned. The theatre troupes were too large (16–20 people), making it difficult to control quality of performances. The performances also moved from place to place in the community, making in-depth engagement of the audience to elicit a behavior change response impossible.

FHI asked PATH to provide technical assistance that would revitalize the theatre program and make it respond to IMPACT’s communication objectives. FHI decided that PATH should take over management of the staff of Artnet Waves and put them through an induction program to enable them to internalize behavior change program design and processes.

PATH immediately did a SWOT (strengths, weaknesses, opportunities, and threats) analysis of the existing approach. Among issues to be addressed were the cost of outreach and the number of people in a theatre troupe. The limit was set at 8–9 members, instead of 16–20, and the cost per outreach was similarly negotiated downward. Regional theatre coordinators who joined PATH finally came to appreciate the need for these reductions, but they had to get buy-in from the theatre troupes, which was a definite challenge.



A Magnet Theatre performance attracts a crowd.

A Theatre Outreach Story

A taxi driver drives different makes of cars. “One day he drove this big BMW (Be My Wife), with a big bum and lovely curves,” says the storyteller, sending the audience into gales of laughter. “The next day, he squeezes into a tiny Japanese model. He was the envy of the taxi drivers in his neighborhood.”

The narrator continues, “All this time, he never used to buckle up. One day, he had this terrible accident, which left him with scars all over his face and a broken leg, putting to an end his exploits with different models of cars. His experience made him become an advocate of safety-belt use.”

The facilitator then turns to the audience, seeking interpretations of the story. An audience member identifies the parallel with safe sex, leading to a lively discussion on condom use.

Magnet Theatre

Magnet Theatre evolved as a response. IMPACT used it to reach out-of-school youth, and aimed to increase their HIV and AIDS knowledge, confidence in condoms, and interest in VCT, as well as encourage delay in sexual initiation, abstinence before marriage, and reductions in the number of sexual partners.

The idea for the project happened organically, with self-expression, analysis, dissent, and consensus at every step. The buy-in of the regional coordinators was a huge advantage, since they already enjoyed the respect of the communities. There was ownership of outcome from the start, and this helped the coordinators speak with conviction.

Magnet Theatre drew performers from local theatre groups, and they performed at fixed venues within communities, including under trees in open spaces. Rather than performances moving to different places on different days, the audiences were “pulled” to attend Magnet Theatre.

Performances were pre-scripted, based on issues and situations relevant to youth. Each performance had several “dilemma points,” where actors freeze in a dramatic moment and face multiple behavior options. The audience was asked to choose the best decision, and the story proceeded on the basis of that behavior option.

Each performance was followed by a post-show discussion, when audience members sat with the theatre facilitator and shared their experiences and feelings. These became emotional sessions; participants often said they had shared issues they would not have raised in larger groups. After each show, individuals who changed behavior and consented to talk about it shared their experiences with the community.

Achievements and Lessons Learned

To implement Magnet Theatre, 362 youth received both AIDS competency and Magnet Theatre facilitation training. Over 800,000 youth were reached in priority communities.

Magnet Theatre was a very successful program that engaged youth through edutainment. The intervention engaged youth to do what they like to do, but structured in a way that helps them assess their personal risks and make choices that enhance their survival and that of their generation.

Fixed venues allowed a sharper focus on the specific target audience because sites could be chosen near youth hangouts and performances timed when out-of-school youth were more likely to be present. They also allowed for repeat audiences and the possibility of some continuity in discussions from show to show.

By introducing incomplete stories and “freeze” points when audiences could intervene and challenging the crowd to think through how the story should or could end, the level of participation was boosted enormously. Simultaneously, detailed human resource and financial accounting was implemented, and the cost of the shows was dramatically reduced by reductions in troupe size.



Magnet Theatre performers convey education about HIV and AIDS.



One of the youth murals that resulted from a day of drama and discussion.

The Mural Initiative

The mural initiative began in Western and Coast Provinces in May 2000 with sensitization by Sanaa Art Promotions that raised muralists’ awareness and knowledge about HIV and AIDS; design and painting of the murals begun in June. In 2002, Global Fund funding expanded the initiative into a national program, which was implemented in several parts of the country between 2003 and 2005.

Youth Murals

To begin the youth mural project, students were selected from 35 clusters of schools in the Western, Rift Valley, and Coast regions. Students from three to five schools in each cluster gathered on a Saturday for a day of drama and discussion. Performers enacted skits on a relationship-focused dilemma that required a response. (One example: a boy is insisting on sex with a girl within a few days after meeting her. How should she respond?) The students then reenacted the skits, role-playing behavior change options and expressing different behavioral responses. Based on the behavior change options being acted out by the students, graphic artists began sketching proposed scenes for the murals. The students then selected the scenes that would be used.

After the discussion, a topic was chosen for an essay contest organized for students. A week later, they submitted essays (with titles such as “Mary finds a way to say no,” and “John solves a tricky problem”). Students who wrote the best essays received awards, as did the schools submitting the most essays. The 7,641 essays submitted were evaluated not so much for literary merit as for their use of certain key phrases and expressions used as “tracers” during the mural discussions, since the appearance of these phrases and expressions provides clues on the extent to which discussions have been internalized and disseminated to other youth.

Community Murals

As with the youth murals, community murals were developed with a participatory approach and interactive discussions within communities. The main objective was to provoke discussion about relationships, health, coping with HIV and AIDS, behavior options, and life choices. The intervention provided an informal and non-threatening forum for a semi-structured discussion of health issues affecting the community. The discussion provoked new and deeper questions among participants, a key feature of

Discussion Topics for Community Murals

The most practical way to protect yourself and your loved ones from HIV is by using condoms.

HIV is not AIDS. Learn the difference and start living.

It is a long way from liking someone to feeling faithful to that person.

Till you are sure you trust each other, stay happy by staying safe.

A faithful, loving relationship with one person can keep HIV out of your life.

IMPACT's Question Your Relationships communication strategy. The mural process also engaged participants in the creative activity of mural painting.

After sites were selected, themes for the murals were chosen, discussions facilitated, and behavior options explored. Artists then drew up comprehensive lists of appropriate and inappropriate behavior options and sketched basic illustration templates for each option on separate sheets.

The day of the mural session, facilitators guided participants through discussions of themes and options that had emerged. The template corresponding to behavior options was colored over rapidly and shown to the group. While drawing was in progress, facilitators moved discussions forward. The process was brisk and energetic, but also allowed time for participants to ponder and come up with their contributions. Eventually, the whole mural was sketched using this technique, and artists started painting after the crowd dispersed.

Achievements and Lessons Learned

In all, 93,140 students from 152 schools participated in the youth mural project, and over 200,000 people were reached through the youth and community mural program. Of the 20 community murals, 10 were in Western Province, 6 in Nakuru, and 4 in Mombasa.

With youth participation, 35 murals were designed for schools. Another set of 20 murals were designed with adult and community participation for other buildings. Both sets of murals were developed in a participatory manner, enabling youth and the larger community to identify with their messages.

The mural paintings depicted real-life experiences and behavior options, and they had both visual and emotional impact. They communicated health messages to a large number of people without incurring the cost of billboards, and they remain on view over a long period. Because mural images are derived from local discussions undertaken, they can reveal responses and behavior options appropriate to a given cultural setting.

National Museum HIV/AIDS Exhibition

Among opportunities used to expose individuals to information on HIV/AIDS was an exhibition IMPACT organized with the theme "Take a Positive Step" at the Kenya National Museum in Nairobi, a location popular with members of public, including school children. Over 105,305 students and teachers and 10,530 adults went through the exhibition at the museum between 18 August and 30 October 2005.

The exhibition included poster displays on what HIV is, how the virus is transmitted and how its transmission can be prevented, the benefits of VCT, and basic facts on prevention of mother-to-child transmission. It also included information on what a person living with HIV and AIDS should do for care and treatment, such as use of ART, better nutrition, and treatment of TB and other opportunistic infections. For school children, the exhibition also included a large screen that aired the shortened episode of UNICEF's Sara communication video.

The exhibition's messages and more in-depth topics were also provided interactively for teachers and other people with access to computers. The museum's website brought these into people's homes and offices and provided links to major HIV/AIDS websites. A video clip on the importance of home-based care for PLHA was also part of the interactive program.



A section of the gallery walk in the HIV/AIDS exhibition at the museum.

3. Communication for Voluntary Counseling and Testing

As part of IMPACT's effort to increase uptake of VCT in Kenya, a national communication strategy was designed and implemented by Population Services International (PSI), in collaboration with other stakeholders. The formative research that informed the design of the strategy included a national KAP (knowledge, attitudes, and practices) survey in 2000, focus-group discussions with non-VCT users, and in-depth interviews with current VCT users and those currently and potentially making referrals to the centers—teachers, healthcare providers, counselors, and religious and business leaders.

Formative Research and Findings

Of those surveyed by the KAP, 78 percent had a strong interest in getting an HIV test. Interest was strongest among those ages 20–24 and 25–29 (82 percent and 80 percent, respectively), and weakest for those ages 30–34 (72 percent). However, only 14 percent of those surveyed had actually been tested. This rate was lowest among those ages 15–19 (6 percent) and higher among those ages 25–29 and 30–34 (19 percent and 18 percent, respectively). Although awareness of HIV testing was high, the level of knowledge about the range of VCT services was low, especially with respect to counseling and voluntarism. Only 4 percent cited a VCT center when asked where they could go to get a HIV test; 93 percent stated a hospital or clinic.

Among those who reported that they were not interested in having a HIV test, the most common reason given was fear of the outcome (53 percent), which affected more women than men (56 versus 49 percent). Others—42 percent—said they did not need the test. Within this grouping were more men than women (47 versus 38 percent) and more single than married people (48 versus 38 percent). Adolescents 15–19 (53 percent) were most likely to believe they did not need to be tested.

Focus group discussions and in-depth interviews indicated considerable potential interest in knowing one's serostatus. Youth and young adults were thought to be at particular risk, since they were more likely to have more than one sexual partner. Sexually active youth and adults who thought they had engaged in risky behavior also indicated an interest in knowing whether they had contracted HIV. Married people felt they were at risk if they did not trust their spouses' sexual fidelity.

Notwithstanding, fear of an HIV-positive outcome constituted the greatest barrier to being tested for many. Many Kenyans assumed or greatly feared that they would test HIV-positive, which would result in severe personal trauma, societal stigma and discrimination, and the equivalent of a death sentence. Many Kenyans said they would commit suicide if they tested HIV-positive. For many, these fears far overshadowed the benefits of knowing one's status, including preventing the infection of one's own family members.

Another barrier was the belief that the test was not needed because there had been no risk of HIV-infection. Focus group discussions with non-VCT users indicated that this belief was particularly prevalent among youth. Being a virgin, married, not "promiscuous," and using condoms were seen as reasons for

being in this category, although partners' sexual pasts do not seem to have been taken into account.

One perceived benefit of knowing one's serostatus was the chance to take control of one's future. For youth, this meant achieving aims and goals; for those in their 30s, it meant planning for children and family. Adolescents tended to perceive taking control as a way to maintain their negative serostatus, while adults tended to perceive taking control as learning how to manage a positive serostatus. People in their 20s demonstrated characteristics of both cohorts. Another reason for wanting to know one's serostatus was a change in lifestyle, including courtship, marriage, having children, or separation and divorce. VCT users overcame fears of testing HIV-positive when they needed to plan for the future or were about to make a lifestyle change. Others would go for VCT because they assumed their test results would be HIV-negative.

Counseling offered helped to motivate individuals to access VCT services. It encouraged people to go to the centers, and focus group discussions with non-users indicated that many saw counseling as an important tool in decreasing fear associated with HIV testing. VCT clients perceived counseling as the way to take control of their HIV serostatus (when they were ready to) and learn how to manage it, whether it was positive or negative. They could learn to take the steps needed to protect a negative serostatus or, if HIV-positive, learn how to have a healthy lifestyle and not infect others. Counseling was also seen as helping prepare clients to counsel others, within and outside of their own peer groups.

The focus groups and interviews also illuminated barriers affecting access to VCT centers. One such barrier was the general lack of awareness about VCT services and their benefits. Many people associated VCT with diagnostic HIV-testing, and they were unclear about what counseling entailed. Those who knew more about VCT had serious concerns about the quality of service, including the confidentiality of counseling discussions and test results; safe, accurate testing; and professional, courteous, and friendly counseling. Another barrier was accessibility, including the locations of centers and their operating hours before and after work or school. Affordability was yet another barrier, since many were concerned about the cost of services and related transportation. This was a particular concern for youth, rural respondents, and some married women. Youth were particularly affected by peer pressure and, for some, lack of parental support. Some married women reported their husbands would not allow them the time or money to go to a VCT center or would force them to disclose their status.

Societal barriers have also affected access to VCT services. Many Kenyans expressed concern about the stigma associated with HIV/AIDS; they feared being branded HIV-positive if seen going to a VCT center, and they feared being treated differently if they tested HIV-positive. VCT users tended to have more open attitudes toward people affected by HIV/AIDS than non-users. For example, men from Kakamega who had used VCT services were those most likely to report that they had discussed HIV/AIDS-related issues with their wives. VCT users obviously

overcame the stigma of being seen going to a VCT center, and several returned for repeat VCT services.

Most focus group respondents were enthusiastic about the use of multiple media channels to promote VCT services. Suggestions included electronic media, public announcements, and folk media such as drama and puppetry. Most non-users supported using “HIV/AIDS” in promotional efforts, but they were hesitant about using the acronyms on billboards because of the related stigma.

Individuals who make referrals were an important channel for linking potential clients to VCT centers. Such people feel a high sense of duty toward preventing the spread of HIV/AIDS, and they are excellent resources who are already connected to communities. Several VCT users reported having gone to the centers because of such referrals.

The VCT Communication Strategy

Research findings greatly influenced the way the VCT communication strategy was designed. It was decided that VCT messages needed to address manageable barriers to VCT use, and that initial campaigns should create awareness of VCT as a new service. In particular, they needed to draw attention to the attributes and benefits of the counseling offered, build consumer confidence in the quality of services, and address issues of accessibility and affordability.

VCT messages needed to reinforce the idea that individuals are vulnerable to HIV infection, that sexually active people are most at risk for contracting HIV/AIDS, and that getting infected will affect their future plans and ability to provide for their families. These self-risk perception messages needed to include the implications of the sexual past of one’s partners, since this concept was not well understood.

The communication strategy also sought to help manage the fear of an HIV-positive test result, the most serious barrier to VCT use. Though the campaign needed to convey that most Kenyans will test HIV-negative, it was important to uphold the need to know one’s serostatus and to communicate that VCT is an excellent tool that allows a client to protect a negative serostatus, take control of his or her future, and embark on long-term lifestyle and behavioral changes. The campaign also needed to convey to those testing HIV-positive that VCT provides a chance for a “fresh start,” and that VCT services help them to learn how to live healthily and avoid infecting others. The tone of campaigns needed to be positive and upbeat, since fear is a paralyzing factor in proactive decision-making.

VCT messages also needed to highlight the confidential counseling and related support services that help clients manage their fears and issues on their own terms. Communicating the supportive care aspect of VCT, both psychological and medical, was geared to help potential clients reduce their fears of testing HIV-positive and their dread of the rejection and isolation that might ensue.

A corollary campaign strategy needed to address the societal issues of stigma and discrimination against PLHA, since many

Kenyans preferred ignorance of their serostatus to the rampant stigma and discrimination they face if they test HIV-positive. Since this stigma is partly rooted in the fear of accidental HIV infection by being around someone HIV-positive, it was important that messages stress that fear is irrational, and that stigma and discrimination against PLWA are unjustifiable.

A mix of electronic and interpersonal channels was deemed appropriate for communication-related messages, since both approaches could deliver VCT messages in an effective, synergistic manner. Each medium has its strengths, and a well-considered mix can maximize VCT message delivery. The electronic media would be used to increase consumer awareness of VCT benefits and attributes, while interpersonal communications, including the use of referral makers, reinforce these messages and provide a link between clients and services.

Because many people fear being branded as HIV-positive if they are seen using VCT services, “HIV/AIDS” was not used on logos, slogans, or signboards. However, associating VCT with HIV/AIDS was appropriate during promotional activities, since potential clients believe it is the best way to create awareness of VCT services.

Goal, Objectives, and Target Audience

The goal of the strategy was to decrease HIV incidence in Kenya by increasing safer sexual behaviors. The growth of individual commitment to manage one’s serostatus—whether HIV-positive or negative—is believed to increase these safer sexual practices.

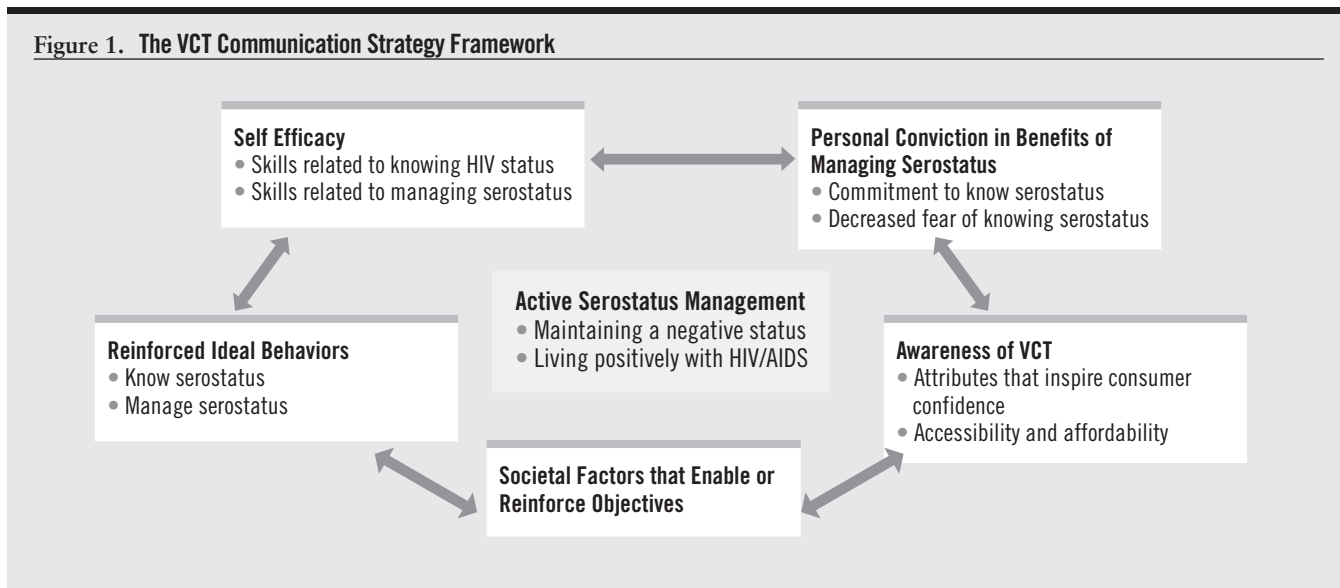
The strategic objectives of the communication strategy were to

- create awareness of VCT as a new service
- reinforce behavior related to serostatus management
- increase personal conviction in the benefits of managing one’s serostatus and self-efficacy
- build societal elements that encourage knowing and managing one’s serostatus

The strategy targeted sexually active men and women ages 25–39, with a focus on couples making lifestyle decisions (such as getting married and having children) or planning their and their children’s futures. The primary target audience included couples worried about past risky behavior and wanting to strengthen a current relationship. Youths ages 15–24 were also targeted, particularly those making lifestyle decisions and planning their futures.

A quantity of materials—including radio and television spots, print publications, road signs, and billboards—were produced to promote VCT and reach youths and young and established couples (appendix 3). Communications messages and creative approaches were significantly different for youth and adult audiences because of their differing perceptions of the benefits of knowing their serostatus. For youths, the prime benefit was the ability to achieve aims and goals, while adults saw the prime benefit as being able to plan for their children and families. The differing market profiles and motivations of the two groups meant that separate campaigns were needed to promote VCT services.

Figure 1. The VCT Communication Strategy Framework



Phase One

Phase one of the VCT communication campaign had three waves, each of which ran for six months. The first wave sought to brand VCT services for ease of recognition. After pre-testing several versions, the VCT logo design shown was adopted. It was placed on signposts in strategic places, along with directions.

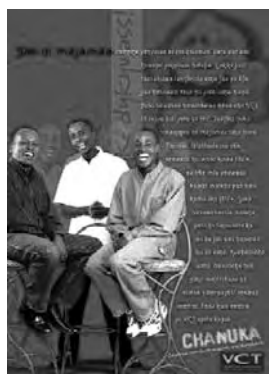


The branded VCT logo design.

Wave one activities aimed to create general awareness of VCT as a new service in Kenya. The activities promoted existing VCT centers and responded to typical consumers' questions about what, where, why, and how much. Questions posed about

HIV by participants in focus group discussions and in-depth interviews were cited in the campaign, with VCT centers stated as the places to go to obtain answers. For wave one and wave two, radio was the main communications channel, supplemented by TV, billboards, and the print press.

Wave two focused on youth and their perception that VCT provided a way to take control of their future and achieve their plans and goals. The youth-oriented "Take Control of Your Serostatus" campaign promoted knowing one's serostatus and adopting the appropriate behavior to actively conserve a negative serostatus or proactively manage a positive serostatus. The youth campaign used a generic Swahili word, *Chanuka* (be informed), which soon became a popular slogan. The campaign also employed popular young celebrities, including musicians, disk jockeys, and comedians. In addition, youth who actively managed their serostatus became trendsetters for other youth.



A poster used in the youth campaign.

The third wave of the youth campaign, targeted to ages 15–24, aimed at establishing the context of a youth culture that supported proactive serostatus management by reinforcing positive deviant

(or early adopter) behaviors. This wave, designed to create demand, centered on increasing personal conviction about the benefits of managing one's serostatus, in particular within the context of dating, considering marriage, or conserving a seronegative status. The campaign aimed at increasing the desire to know one's serostatus and decreasing the fear associated with taking a HIV test.

Phase Two

Phase two focused on creating demand for VCT services by couples and adults. Formative research had established that adults had considerable general interest in knowing their serostatus, although this varied by age, sex, and marital status. However, barriers to knowing one's serostatus included the widespread fear of testing HIV-positive and losing marital support. Nonetheless, many adults perceived VCT to be a useful tool that enabled them to plan for the future and take care of their families and children. Although studies demonstrated the epidemiological and economic benefits of couples receiving VCT services, few Kenyan couples were accessing VCT together.

This demand-creation campaign targeting adults and couples centered on increasing personal conviction about the benefits of managing one's serostatus, in particular within the context of a relationship. This was to be achieved by increasing the desire to know one's serostatus and one's self-efficacy and decreasing and managing fears associated with taking an HIV test.

The last wave of the national VCT mass media campaigns, from January to April 2005, focused on the importance of HIV testing as a lifestyle strategy for those who feel perfectly healthy and promoted the message of positive living and treatment options



A poster used in the couples campaign.

for people who test HIV-positive. The focus was on couples was retained: the campaign targeted established couples ages 18–35 as well as male family decisionmakers.

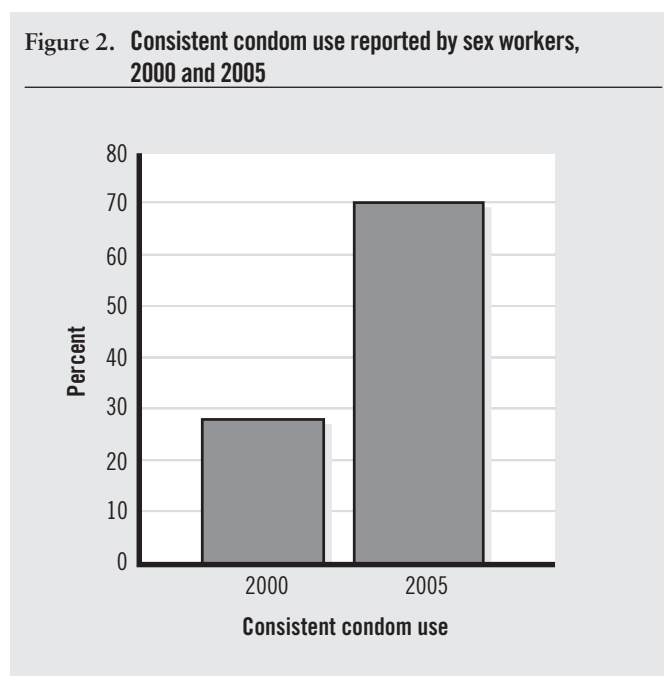
Lessons Learned

- For a communication strategy promoting services to succeed, planners should work closely with those delivering services, ensuring that services, supplies, and consumables are available. The VCT communication campaigns went alongside a rapid expansion of services in Kenya, and the coordinator of the communication campaign was on the national VCT planning committee.
- Communication campaigns promoting uptake of services can be rendered ineffective by interruption of services. During the VCT campaigns, test kit outages sometimes occurred, and the launch of some phases had to be postponed until test kits were available at VCT sites. There were also occasions when the few urban centers could not meet the demand for VCT services.
- The rapid expansion of VCT provided to be a challenge to the VCT communication planners. IMPACT could not meet the growing need for VCT materials for all the government and private sites.
- Not all communication campaign waves and phases were equally successful. Whereas the initial campaigns (questions on HIV and youth VCT) created interest in VCT, the young couples' campaign was not as successful, and not many young couples visited VCT centers.
- Mass media campaigns are very expensive. Those chosen from the media mix should have maximum reach, but be cost-effective.
- Monitoring the effectiveness of the VCT campaigns by utilizing data from outside the IMPACT sites was not possible; there was no routine system of channeling VCT data from areas outside the IMPACT program focus regions.
- Development of the logo ensured a brand identity, but not service quality. During the campaign, the National AIDS and STD Control Program developed a national quality assurance strategy, which involved registration of sites and annual assessments to ensure adherence to set standards. However, there was no punitive measure for those who failed to meet standards yet continued to display the VCT logo. With the rapid expansion of VCT in Kenya, there is need to enforce annual accreditation and deregister sites that do not meet minimum standards.
- Toward the end of the project, there was push for diagnostic testing and counseling (as opposed to voluntary counseling and testing) to initiate ART for as many people as possible. This push required a different communication strategy and affected the VCT campaign, since it emphasized the voluntary part of counseling and testing and made it the selling point for VCT.
- A public relations strategy should be part and parcel of future communication campaigns to mitigate any negative reaction. A quick public relation campaign was needed after the Association of Kenya Medical Laboratory Scientific Officers issued statements to discredit VCT services because non-laboratory personnel were engaged in the testing, though this practice had been recommended in national guidelines.
- Future challenges for national VCT campaigns include reaching sexually active young people ages 15–19 whose risk perceptions are very low, along with married people with low levels of education and those less exposed to mass media, particularly those in rural areas in Nyanza, Coast, and Rift Valley. This calls for a greater synergy and coordination between mass media campaigns and ongoing interpersonal communication campaigns in rural and underexposed areas.

4. Monitoring and Evaluation

Since monitoring and evaluation determine whether a program has accomplished its goals and objectives, IMPACT put in place mechanisms to monitor the implementation of its complex BCC program. In the communities, forms were used to collect information on various activities, based on agreed-upon indicators. These data were used to measure progress toward achievements of targets. Pre-intervention and post-intervention surveys were conducted for selected interventions (special studies), and a population-based survey was used to determine the extent of exposure to IMPACT interventions. The VCT campaign was also evaluated through an August 2004 baseline survey and a follow-up survey conducted in April 2005.

Survey of Sex Workers in Mombasa



Pre- and post-intervention cross-sectional surveys were conducted among 503 female sex workers in 2000 and 506 female sex workers in 2005. The same location and study methods were used for both surveys, and participants had similar baseline characteristics—age, marital status, education, ethnicity, and religion. The sex workers were recruited through the snowball method over a two-month period. Structured questionnaires were used to collect information on demographics and sexual behaviors, and gynecological examinations and laboratory investigations established the prevalence of HIV and other STIs.

Between 2000 and 2005, sex work had changed from a mainly part-time to a full-time activity for these women. While 67 percent had alternative incomes in 2000, only 37.7 percent had alternative incomes in 2005. While their mean number of sexual partners increased from 2.8 to 4.9 over the period, consistent condom use with paying clients increased from 28.8 (145/503) to 70.6 percent (356/506).

Knowledge and attitudes regarding HIV and other STIs and prevention remained unchanged between 2000 and 2005, though the proportion of women who saw benefit in knowing their HIV status increased from 78.3 to 94.4 percent. The percentage who could cite two or more correct ways to prevent HIV increased from 65.3 to 76.1 percent in the five-year period, and the percentage who could cite two or more correct ways of preventing STIs increased from 44 to 49 percent.

In both surveys, 90 percent of women reported condom use during last sex with paying clients and claimed this had been their idea. About 70 percent said they had provided the condom. In addition, 77.7 percent said they had refused clients unwilling to use a condom, compared to 41.4 percent who were in this category in 2000.

Behavioral Surveillance Survey of Target Groups

The Kenya behavioral surveillance survey in 2002 was a probability-based, random survey of most at-risk populations that included the five IMPACT focus districts. This survey captured exposure to interventions of the IMPACT BCC program, as well as outcome effects of attitudes and risk behaviors of target groups in priority communities.

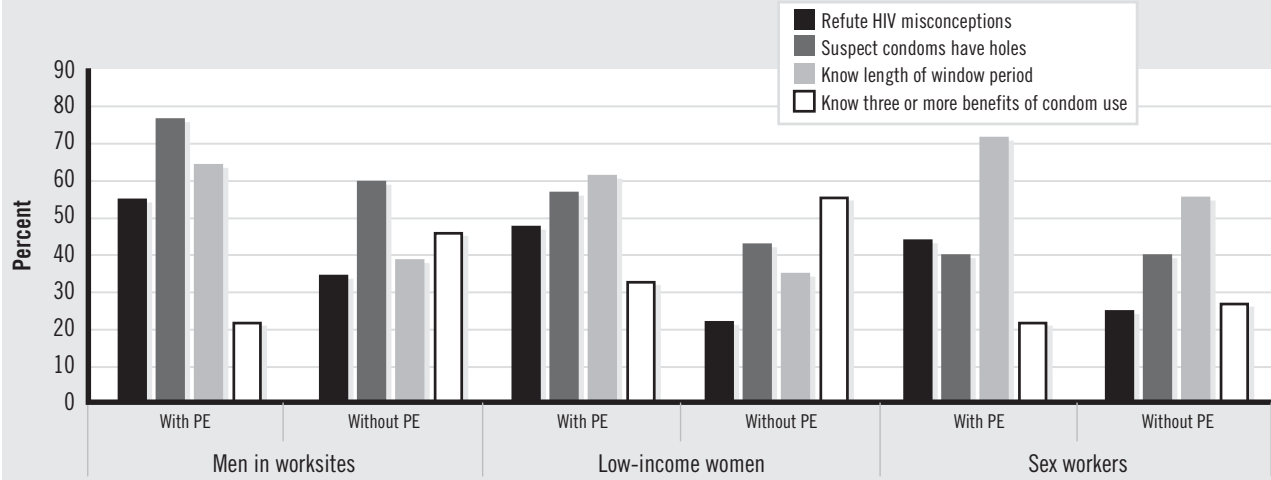
Attitudes and behaviors related to each BCC objective were investigated so that relationships between respondents' exposure to interventions and the objectives could be determined. A series of questions were added to the survey to assess the coverage of the *Kati Yetu* radio show. As with all communication programs, it is difficult to attribute success to one set of interventions. However, IMPACT was the main implementer of HIV communication programs and activities within priority communities at the time.

With the exception of female sex workers, all groups interviewed for the Kenya behavioral survey exhibited high levels of knowledge about HIV and AIDS. Even so, respondents exposed to IMPACT peer education were significantly more likely to score high on HIV and AIDS knowledge and refute commonly held misconceptions than respondents not so exposed. Similarly, respondents who had attended peer education sessions were better informed on condom use, and they believed that condoms were necessary after relationships became serious.

The evaluation also found that Magnet Theatre participants were significantly more likely than non-participants to know the difference between HIV and AIDS, along with how long it takes to test positive for HIV. They were also more likely to believe that condoms were necessary, "even if a relationship moves from casual to serious,"

Respondents who had participated in peer education were significantly more likely to have heard of VCT and know about benefits associated with it than respondents who had never been in peer education programs. In addition, HIV-positive respondents were more knowledgeable about VCT services than those who had tested negative. Theatre participants were also more

Figure 3. Knowledge of HIV/AIDS and attitudes toward condoms of target groups, with and without exposure to peer education (PE)



likely to name two or more benefits of VCT for those testing negative and those testing positive.

The *Kati Yetu* radio show was meant to extend BCC reach; improve HIV and AIDS knowledge; increase confidence in condoms and interest in VCT; and foster positive attitudes toward reducing partners, abstinence before marriage, and delay in sexual initiation. To determine whether the radio show had its intended effect within the four target communities, the evaluation compared the responses of recent listeners (within the past four weeks) with respondents who had listened to *Kati Yetu* but not in the past four weeks (non-recent listeners), and with non-listeners (respondents who had never listened to the program).

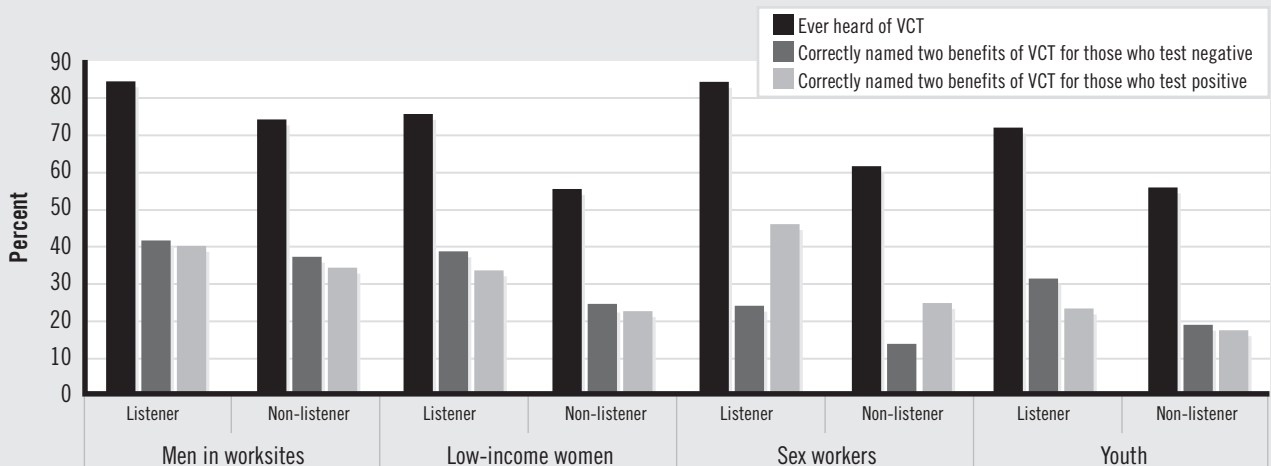
Young listeners were likely to know the difference between HIV and AIDS than non-listeners, even after controlling for education. Recent listeners were more likely than non-recent listeners and non-listeners to be aware of the interval between infection and testing positive for HIV. Recent listeners were also significantly less likely than non-recent or non-listeners to believe myths about HIV, including that it can be transmitted by mos-

quitoes or the sharing of meals, that healthy-looking people do not have it, and that HIV can be cured by having sex with a virgin or with many partners.. Sex workers who were recent listeners were significantly more likely than non-recent listeners and non-listeners to know the difference between HIV and AIDS and answer correctly all questions related to the sequence of HIV infection, illness, and death.

Nearly all respondents had heard of condoms. Even after controlling for education, recent young listeners were more likely to believe that condom use protects against HIV. Three-quarters of men believed that correct, consistent use of condoms could protect against HIV, and they could name three or more benefits of condom use. Among men in large worksites, 95 percent believed that “having one uninfected, faithful sex partner” was protective against HIV, and 93 percent believed this to be true of “abstaining from sexual intercourse.”

Women and sex workers who listened to *Kati Yetu* were significantly more likely to possess a greater level of knowledge and positive attitudes toward condoms than non-listeners. In addi-

Figure 4. Target group knowledge of VCT among listeners to *Kati Yetu* program and non-listeners



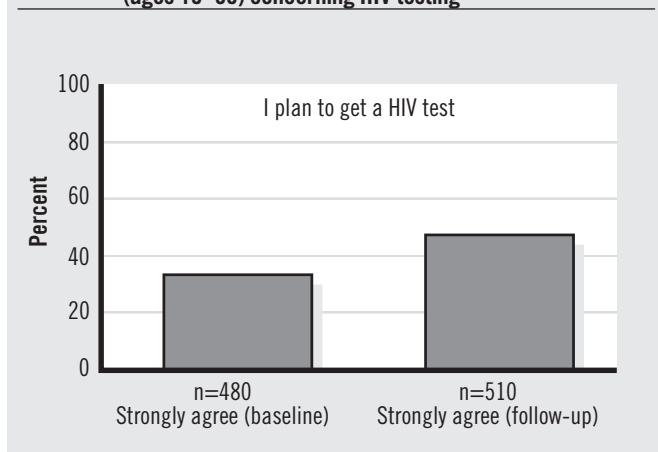
tion, listeners were more likely to believe that condoms can prevent HIV and to name three or more benefits of condom use. Nearly half the youth and over 70 percent of female sex workers who were recent listeners reported that they had discussed pertinent issues heard on *Kati Yetu* with friends and family.

All recent listeners were significantly more likely to have heard of VCT than non-recent and non-listeners. Recent listeners were also more likely to name two or more benefits of VCT for those testing negative, and they were significantly more likely to name two or more benefits for those testing HIV-positive.

Evaluations of the VCT Communication Campaigns

Two surveys among over 23,000 people ages 15–35 were conducted in randomly selected households in 13 of Kenya’s largest towns and cities. Two-thirds of samples were from urban residential areas and one-third from peri-urban areas of selected study sites. Both surveys were conducted in the same sites and used the same sampling methodology. Results showed that 71 percent of married or cohabiting respondents (n=933) were exposed to at least one channel of the VCT campaign—whether radio, TV, print ad, billboard, or poster. Over half of these respondents (53 percent, n=671) discussed the campaign with family or friends, and 97 percent said they wanted to continue seeing it aired in the media.

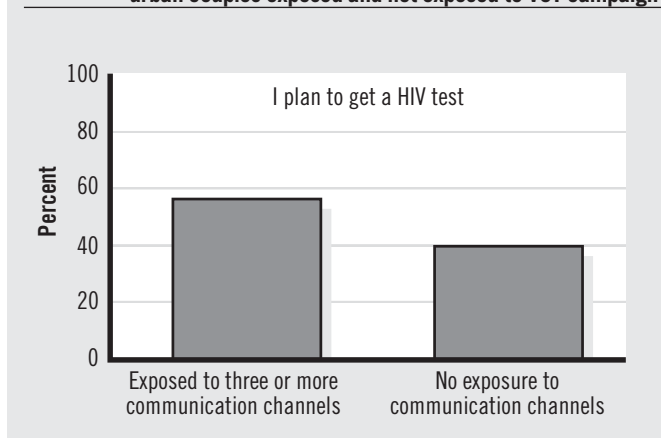
Figure 5. Stated intentions of all surveyed urban couples (ages 15–35) concerning HIV testing



Among married or cohabiting couples who had never received a HIV test, the intention to go for testing increased significantly between the baseline and follow-up surveys. This was true even after controlling for differences in sociodemographic characteristics between the two survey rounds: at baseline, 34 percent of married couples (n=480) strongly agreed with the statement, “I plan to get a HIV test,” and 46 percent (n=510) strongly agreed at follow-up, after the campaign. In addition, 57 percent of respondents exposed to three or more channels of the campaign strongly agreed, compared to 40 percent of those who reported no exposure.

Nevertheless, few married couples reported that they had gone for a HIV test together, either before or immediately after the campaign, and this percentage did not increase within a few

Figure 6. Stated intentions concerning HIV texting of surveyed urban couples exposed and not exposed to VCT campaign



months of the campaign or over the campaign. About 8 percent of all married respondents (n=1760, both surveys combined) reported taking a voluntary HIV test with a partner in the year previous to each survey.

A segmentation analysis of respondents who went for voluntary testing as married couples the previous year indicated that this was more likely for those who were employed, had a least some secondary education (or higher), read a newspaper or magazine at least once a week, and were in their mid-20s to mid-30s. Couples who went for voluntary testing were also reported to be more likely to trust their spouse or partner. In addition, these couples reported they had received some kind of interpersonal communication about HIV in the past three months, and they had seen three or more channels of the most recent national VCT campaign.

Married respondents from the Rift Valley, Coast, and Nyanza were significantly less likely to go for voluntary testing as couples than respondents residing in Nairobi or Central Province. However, religiosity (feeling strongly religious) made little difference, and neither did variables related to self-risk and locus of control concerning HIV.

One of the communications challenges in promoting VCT is that most people get tested for a disease when they feel unwell and when they know medical treatment is available. Generally speaking, Kenyans are still learning about the range of treatment options and medications for HIV and AIDS. If they perceive that the health of a person with AIDS cannot be improved by treatment, marketing VCT services as an entry to treatment for PLWA will not be effective.

The baseline and follow-up survey asked questions about the advantages of testing and, for those who said they had never been tested, the factors that were likely to prevent someone from going for a test, such as fear of testing positive, lack of awareness of sites, and affordability of services. Specific questions were also asked to determine if the hypothetical availability of ARVs would be an inducement. None of these factors, however, changed significantly, both over time (from baseline to follow-up) or as a result of exposure to the campaign. While married

respondents' willingness and interest to get tested increased significantly, potential access to ARVs was not a major inducement to get tested. Only 7 percent of married or cohabitating respondents who had never been tested and reported no interest in receiving a HIV test said they would be interested in a HIV test if ARVs were affordable and available in their community.

Qualitative research gathered over the past five years on VCT-seeking patterns of Kenyans confirms this analysis: that couples are more likely to go for testing when they are in their mid to late 20s, have recently married or made a life commitment to their partners, and when they are working, urban, educated, and exposed to health messages. The research also revealed that men are more likely to go for testing on their own than as part of a couple

Future campaigns should continue to stress VCT as a choice for engaged or recently married couples and should also target men as decision makers. While it may be important to continue stressing messages on the possibility of testing HIV-positive and the availability of care and treatment, this research suggests that these messages are probably not likely to sway individuals who already feel healthy and at low risk of HIV.

5. Recommendations and Lessons Learned

1. Improve planning and coordination of communication interventions at the national level.

IMPACT was one among many programs in Kenya implementing communication interventions. Since there was no forum for sharing workplans and coordinating the efforts of different players in HIV/AIDS communication, valuable opportunities for leveraging communication interventions and campaigns were lost. For example, several HIV mass media campaigns were planned and executed with little linkage with IMPACT and other HIV/AIDS communication interventions taking place at grassroots levels. To maximize effectiveness and minimize AIDS information fatigue, an HIV/AIDS working group at the national level needs to be established to coordinate and harmonize the many BCC campaigns and create linkages between national mass media campaigns and community-level communication interventions.

2. Improve planning and coordination of communication interventions in communities.

During implementation of the IMPACT Project, other resources became available, such as the Global Fund and the World Bank Community Initiative Account. This meant that more community groups were able to implement prevention interventions. District-level HIV communications committees became important vehicles in ensuring quality and maintenance of standards in communities, regardless of the funding source. Future strategic communications for HIV in communities need to build in coordination at district and constituency levels. District HIV communications committees (established under IMPACT) and constituency AIDS control committees aim to ensure coordinated planning and execution of communication interventions at the community level.

3. Standardize peer education.

IMPACT invested in developing and improving the standards of peer education in Kenya through the development of a uniform curriculum across priority community sites and uniform quality assurance procedures. With the increased resources for HIV/AIDS in Kenya—and hence the increase in the number of community groups implementing HIV-prevention interventions—there is need to adapt a uniform peer education curriculum as a first step in assuring quality of HIV/AIDS communication interventions in Kenya.

4. Develop print materials cooperatively.

The need for print educational materials increased as the program evolved. Through decentralized communication program planning, IMPACT was able to help community groups develop materials relevant to their cultural settings, but the project did not have enough resources to print adequate quantities. While this was happening, other programs implementing communication interventions were also developing materials. This duplication of effort need not happen. Future community interventions should consider pooling resources to develop communication



An assortment of materials developed by the Impact Project

materials together. This will ensure that the materials are relevant, uniform messages reach the community, and an adequate number of copies are produced.

5. Scale up effective approaches without compromising quality.

Attention to quality is needed as HIV-related communication interventions scale up. When scaling up approaches, programs should invest in maintaining quality so that effects are maintained as more people are reached.

6. Widen the scope of communication programming in HIV.

Globally, the HIV/AIDS response has shifted from being primarily prevention-focused to comprehensive programs of HIV/AIDS prevention, care, treatment, and support. Experience and advances in medicine have made it possible for HIV/AIDS to be managed like other chronic illnesses. Thus HIV/AIDS communication strategies should move from being purely prevention-oriented to being integrated with comprehensive HIV/AIDS programming efforts, whatever the goals of different programmatic areas may be.

Communication program planners should provide related responses to move beneficiary audiences closer to the intended behavior. HIV/AIDS communication programming should thus aim at increasing knowledge among in-school youth about the basic facts of HIV/AIDS and its prevention and transmission to reduce risky behaviors and increase prevention. Communications should also aim to influence the adoption of positive health behaviors, such as abstinence, being faithful, and using condoms.

HIV/AIDS communication programming should also stimulate community dialogue on appropriate responses to issues relating to orphans and vulnerable children, create demand for VCT and services that prevent mother-to-child transmission, and help communities fully utilize available resources. In addition, programming should seek to change social norms so as to encour-

age more open discussions of sexuality between parents and children that may help delay the onset of sexual activity.

For PLHA and ARV clients, communication programming should seek to improve skills and self-efficacy that help them adhere to the ARV regimen and seek medical help, as needed. This requires increasing their knowledge of side effects and opportunistic infections and their awareness of the benefits of good nutrition and exercise. Trained healthcare outreach and home-based care workers can deliver appropriate messages during home visits, and healthworkers should be encouraged to reduce stigma and discrimination and improve care and treatment services for PLHA.

Finally, HIV/AIDS communication programming should promote essential attitude-change in policymakers to increase budget allocations for ARV drug purchase. Communication programmers should also work with mass media to stimulate more press coverage of HIV/AIDS so as to advocate for an effective response to the epidemic

The IMPACT communication intervention started the shift in these directions. However, there are many components in the continuum of prevention to care that require more emphasis. This can be achieved through the development of a comprehensive national communication strategy for HIV/AIDS that can be adapted for different communities in Kenya.

Appendix 1. Weekly Session Diary for Peer Educators

Weekly Session Diary for Peer Educator

Section 1: Introduction

Name of Group _____

Province Rift Valley Western
 Coast Nairobi

Priority Area _____

Zone _____

Peer Educator's Name _____

Monitor's Name _____

Group FSW Worksite
 Community Women Youth
 Community Men

Section 2: Details of Session

Session Held? Yes No

Day Month Year

Start time _____ AM/PM

End time _____ AM/PM

Duration _____ minutes/hours

Number of MALE participants

Number of FEMALE participants

Number of ALL participants

Section 3: Details of Session

Methods Used

Picture Code Role Play Timeline
 Experience Sharing Radio Listening
 Guest Speaker Discussion Guide
 Discussion Theatre
 Magnification Condom Demonstration

Topic _____

Name of Guest Speaker (if any) _____

Number of QUESTIONS harvested

Number of PEOPLE asking for condoms

Number of MALE CONDOMS distributed

Number of FEMALE CONDOMS distributed

Key questions and concerns raised

1. _____
2. _____
3. _____

Section 4: Other Activities During this Week

Number of outreaches conducted (if any)

Number of condoms distributed in outreaches

	MALES	FEMALES
Number of people reached in the outreaches	<input type="text"/>	<input type="text"/>
Number of male condoms distributed in outreaches	<input type="text"/>	<input type="text"/>
Number of male condoms distributed outside the session	<input type="text"/>	<input type="text"/>
Number of people reached through one-on-one discussions this week	<input type="text"/>	<input type="text"/>
Number of VCT referrals	<input type="text"/>	<input type="text"/>
Number of Sexually Transmitted Infections (STI) referrals	<input type="text"/>	<input type="text"/>
Number of TB referrals	<input type="text"/>	<input type="text"/>
Number of Opportunistic infections (OIs) referrals	<input type="text"/>	<input type="text"/>
Number of Home Based Care (HBC) referrals	<input type="text"/>	<input type="text"/>
Number of PMCT referrals	<input type="text"/>	<input type="text"/>
Number of CCC referrals	<input type="text"/>	<input type="text"/>

Date of submission _____

Signature _____

Appendix 2. Communication Materials Produced by the IMPACT Project

Titles	Type	Target Audience	Purpose
<p>Topic: VCT</p> <p>Just ask me about VCT</p> <p>Antiretroviral therapy (ART) improves health</p> <p>Healthy living: A counseling guide for health workers on opportunistic infections</p> <p>Healthy living: A counseling guide for health workers on antiretroviral therapy (ART) and management of ART side effects</p> <p><i>Chanuka</i> Mighty Kong Mercy Myra Redykyulass</p> <p><i>Chanukeni Pamoja</i> Robert and Eve Njoroge Waweru Kwach and Felicia</p>	<p>brochure</p> <p>flip chart</p> <p>guide</p> <p>posters</p>	<p>youth and young adults</p> <p>health personnel</p> <p>youth and young adults</p> <p>couples</p>	<ol style="list-style-type: none"> Promote information-seeking and discussions on VCT Help ART patients understand and better adhere to treatment Encourage young couples to discover their status together
<p>Topic: ART</p> <p>Antiretroviral therapy (ART): Managing the side effects <i>Maudhi yanayoweza kutokea unapotumia dawa za ART</i></p> <p>Antiretroviral therapy (ART). ART may help you feel strong even if your immune system is weak <i>Maelezo kuhusu dawa za ART, Dawa za ART zinaweza kukuongezea nguvu hata kama kinga yako ya mwili imedhoofika</i></p> <p>Understanding opportunistic infections</p> <p>Antiretroviral therapy (ART) improves health</p> <p>TB can be cured <i>Maelezo kuhusu Magonjwa Tegemezi</i></p> <p><i>Vyakula vyetu kwa afya bora</i></p> <p>Antiretroviral therapy (ART) What you need to know about</p> <p>Making your TB treatment a success <i>Jinsi ya kufanya tiba ya TB ifanyike</i></p> <p>How to use ART drugs <i>Jinsi ya kutumia dawa za antiretroviral (ART)</i></p>	<p>brochures</p> <p>book</p> <p>brochure</p> <p>brochure</p> <p>booklet</p> <p>booklet</p> <p>card</p>	<p>low-literacy audience with HIV, TB, or opportunistic infections</p> <p>HIV-positive persons, caregivers, and community</p> <p>TB patients</p> <p>ART patients</p>	<ol style="list-style-type: none"> Reach out to low-literacy audience with basic facts and help them to manage and cope with ART side effects Educate people that TB can be cured Educate public on opportunistic infections Educate on locally available foods Support adherence to ART and make adherence easier. Educate community on good nutrition
<p>Topic: Youth</p> <p>Go for an "A": Abstain</p> <p>Smart teens: "Chill" it is a good thing!</p> <p>Say no to excess alcohol consumption</p> <p><i>Choose da best: Maisha iwe poa</i></p> <p>Talking points for peer educators (KGGA)</p> <p>Participatory peer education for HIV and AIDS prevention: A manual for trainers of peer educators (KGGA)</p> <p>Peer education for HIV and AIDS prevention</p> <p>Handbook for award of an HIV and AIDS badge (KGGA)</p>	<p>poster</p> <p>brochure</p> <p>brochure</p> <p>booklets</p> <p>manual</p> <p>manual</p> <p>handbook</p>	<p>youth in and out of school</p> <p>youth out of school</p> <p>youth in school</p> <p>youth in school</p> <p>youth in school</p> <p>youth in school</p>	<ol style="list-style-type: none"> Encourage youth to abstain Discourage excessive drinking of alcohol Provide choices for reproductive health

Titles	Type	Target Audience	Purpose
Topic: Uniformed Forces (Kenya Police)			
Protecting ourselves and those we love	picture	uniformed forces	1. Encourage prevention and self-protection among police
A community HIV and AIDS response: Protecting those we love	brochure		
Protecting our heritage, ourselves, and those we love	brochure		
A pocket calendar for Kenya police officers: Protecting ourselves and caring for those we love	pocket diary		
The purple diary (KWS) operation ABC <i>Tuangamize ukimwi</i>	pocket diary		
Knowing your HIV status is a step towards better living	poster		
<i>Kuwa na virusi sio mwisho wa maisha</i>	poster		
<i>Tunalinda na kuhifadhi urithi wetu</i>	calendar		
<i>Tunalinda na kuhifadhi urithi wetu</i>			
Topic: Orphans and Vulnerable Children			
Eat good food and maintain cleanliness to stay healthy	poster	PLHAs	
Preventing sexually transmitted diseases and pregnancy among HIV-positive persons	poster		
Keeping families affected by HIV together	poster		
Treatment of opportunistic infections and management of ARV side effects	booklet		
Topic: Pediatrics			
Children and HIV series Nutrition Basic facts Treatment side effects Emotion and feelings	brochures	public	
Basic facts Treatment side effects Emotion and feelings	booklets	caregivers	
A guide for health workers	guide book	healthworkers	

Appendix 3. The VCT Communication Campaign

VCT Promotion

Media placement May–September 2002 (5 months)

Radio: approx. 540 spots aired

Print: approx. 11 advertisements placed

Road signs: 60 distributed

Billboards: 15 used

Advertisements placed by City Clocks: 4

Youth Campaign

Media placement Aug 2002–January 2003

TV: 126: approx. spots aired

Radio: approx. 338 spots aired

Print: approx. 28 advertisements placed

Posters: approx. 15,000 distributed

Young Couples Campaign

Media placement August–December 2003

(no spots aired in November)

Radio: 340 spots aired

TV: 118 spots aired

Print: 27 advertisements placed

Posters: 26,000 distributed

Road signs: 60 distributed

Wall signs: 60 delivered

Billboards: 17 used

Established Couples Campaign

*Media placement December 2004–April 2005
and March–August 2006*

Radio: 1571 spots aired

TV: 341 spots aired

Print: 41 advertisements placed

Posters: 13,000 distributed

Road signs: 140 distributed

Wall signs 140 delivered

Billboards: 33 used

Appendix 4. Implementing Partner Organizations

African Medical Research Foundation
Anglican church of Kenya
Bungoma Organization for the Empowerment of Women
Family Planning Association of Kenya
Goal Ireland
International Center for Reproductive Health/University of Ghent
Kenya Association of Professional Counselors
Kenya Girl Guide Association
Kenya Police
Kenya Wild Life Service
Kima Integrated Community-Based Program
K-NOTE
Lifebloom Services
Malindi Education Development Association
Mkomani Clinic Society
Mumias Muslim Community Program
National Museums of Kenya
National Organization of Peer Educators
Program for Appropriate Technology in Health
St. Johns Ambulance
Society of Women and AIDS in Kenya
Solidarity with Women in Distress
Strengthening Community Partnership and Empowerment
Supreme Council of Muslims in Kenya
University of Nairobi /University of Manitoba Strengthening STD/HIV Control Project

