Much more than information

At the individual level, people need opportunities to build on their personal knowledge, skills and confidence, and to re-consider their attitudes and beliefs about, for example, male and female sexual responsibilities and pleasure.

These opportunities enable individuals to understand why and how they are at risk of HIV, and to feel motivated to try and reduce the risk to themselves and their partners. But even if they want to, most people do not feel able to change what they do sexually (or what others do to them).

So, in the wider community, programmes need to work with local organisations, decision makers and the media to encourage changes in social attitudes and in people’s economic and cultural situations (see page 2).

Participation is key

The authors of the case study on page 6 explain how they have begun to broaden the focus of an HIV prevention campaign with sex workers in rural India to make changes in their wider social and economic environment. Articles on pages 3 and 7 describe how programmes are working with key influential individuals to generate shifts in social influences and local policy.

The case studies illustrate the importance of enabling people to identify their own priorities, and to respond in an appropriate way. Health and education programmes can never do this for people, but can only work with them to help with the process.

As one trainer asks: ‘Do you agree or disagree with the statement: it is very difficult to change people’s sexual behaviour.’ Usually, everyone agrees – except for the trainer herself. She responds: ‘I disagree, because it’s not just difficult, it’s impossible!’ Participants usually laugh in agreement, and go on to discuss why.

Continued on page 2
Continued from page 1

Fulfilling individual needs
Clear and consistent information and participatory education programmes can help both young people and adults to change their sexual behaviour. People need opportunities to:

- learn about HIV/STD transmission, personal and sexual development, reproduction, contraception and relationships
- accept that they themselves are vulnerable to HIV/STDs or could be a risk to others
- learn the relevant skills, to help in effective communication, assertiveness and condom use
- have confidence and belief in their ability to try to reduce their risk (self-efficacy and self-esteem)
- understand how they are influenced by other people, and feel able to act differently (understanding and challenging norms)

But it is difficult — if not impossible — for most individuals to act upon what they have learnt. There are many barriers that prevent people taking steps to protect themselves or their sexual partners.

Making environments supportive
Individuals can reduce their risk of HIV infection only if safer behaviour is easy and widely accepted as part of everyday life. Changes in two key areas can help to make people's environments more 'supportive', not only for safer sexual behaviour, but also for people who know they are living with the virus. These are:

- shifts in social and cultural influences or pressures; and
- overcoming barriers in wider society (such as restrictive policies and legislation, poor health services and education, lack of human rights, poor economic opportunities).

Social and cultural influences
Often both women and men feel they have no choice about what they do, and that they have to behave in traditionally expected ways. Women, in particular, may have few options because of emotional or financial pressure, or may be forced to have sex against their will. Programmes are working with people to develop new sexual norms, and to make traditional practices safer, as described on page 3.

Policies and legislation
Many people now accept that laws criminalising prostitution, for example, greatly hinder HIV/STD prevention by making it difficult for sex workers and clients to have access to information and STD care. While it may take a long time to change national policy, organisations in many countries are liaising with local authorities to ensure that sex workers can work openly in safe environments without fear of detention or compulsory HIV testing.

Economic opportunities
Poverty — especially for women — is a major factor in the epidemic spread. Again, while long term strategies are needed, local efforts can help greatly. For example, in Ghana elders are supporting young women's education and loan schemes to help them start up their own businesses, rather than leaving home to become sex workers.

Condom supply and health services
Often, even if people want to have safer sex, condoms are too expensive or unobtainable. People often feel reluctant to use STD services because of stigmatisation. HIV/STD care needs to be integrated into other community health services, and include liaison with traditional practitioners.

Open environment
Barriers to providing relevant information about HIV/STDs need to be overcome, especially for young people. Reducing discrimination against people with HIV, and marginalised groups such as sex workers or drug users, means that more individuals can live openly and with dignity, and be able to protect themselves and others.

With thanks to Nancy Fee and Rakesh Rajani.


In many countries condoms are now openly promoted, sometimes after much national debate.
Policy and practice

Changes at the national level require great political commitment and resources. But it is possible to support local changes.

Changing community policy and norms can be difficult because concerns about sex are rarely discussed openly. Participatory research or community discussion can help people to acknowledge the issues, and to look for solutions.

Experience is showing that this process can take a few years, and needs to involve key decision makers. Often health or education team staff begin by raising the issue with community leaders. This enables people to explore the problems and decide on appropriate strategies. In many cases, people decide to select a few individuals to be trained as 'community counsellors'. They act as advisers and also link the community with the health service.

Private to public

In Agomanya, a town in Ghana, many young women were being invited by businessmen to work as prostitutes in a neighbouring country. Their families tolerated this because of the money they sent back, but did not talk about what was happening. When the women started to return home with AIDS related illnesses, people became fearful and angry but were unable to discuss what to do. The women faced discrimination and rejection.

Health workers who had been visiting the women at home decided to begin discussions with leaders and others. This helped people to acknowledge the involvement of the whole community, instead of blaming the individual women. The community leaders decided to ban the businessmen from coming to the villages, and to consider how to improve people's economic situations.

After four years of an AIDS education and care programme in a rural area of Tanzania, it became clear that while people knew a lot about AIDS, high rates of HIV/STD and unwanted pregnancies persisted. The Red Cross Society decided to initiate a participatory study involving about 280 people, including community leaders, teachers, other adult men and women, and young people.

The study design enabled people to discuss the social and economic influences on sexual behaviour, why behaviour change was not happening, and what could be done to enable knowledge to be put into action. Participants discussed a wide range of social customs, economic pressures and sexual practices which contributed to increased vulnerability.

Overall, people thought they should be more actively involved in deciding appropriate changes and in planning community strategies. They felt that providing economic opportunities such as loan schemes should be a priority, especially to help women and young people.

While many people thought that postponing sex and marital fidelity was the ideal, they wanted more publicity about condoms to increase acceptance and use. They suggested setting up HIV/STD information and condom distribution points in the villages. They wanted sex education for young people and a community-based review of customs and traditions relating to sexual activity.

With thanks to Drs Clement Chela and Margaret Mensah.

Tanzania Red Cross Society, PO Box 1133, Dar es Salaam, Tanzania.

Involving community members is essential when planning HIV prevention and care programmes and appropriate local strategies.
This diagram divides the influences on individual behaviour into five key areas. The top levels represent the wider political, economic and social influences. The lower levels refer to individual attitudes, knowledge and skills.

On the left side, possible barriers to HIV and STD prevention are listed. The right shows strategies that can enable people to reduce their risk.

Of course, health and education programmes cannot address all these issues on their own! But it is useful to think about what can be done to enable individuals to reduce their risk, and to support safer behaviour, both in the short and longer term.

Group activity
A group activity based on the diagram can be used during training or education sessions as a planning exercise.

You will need:
3 large boards or sheets of paper

On one sheet, write the headings from the 'barriers' section. Leave one sheet blank. On the third sheet, write the headings from the 'ways to reduce risk' section.

First ask participants to suggest the main things that prevent the people they work with from reducing their risk of HIV or STDs. Write up all the suggestions randomly on the blank sheet.

Then ask them to group these suggestions under the relevant headings on the barriers sheet. Ask them to suggest more if necessary.

Finally, ask them to think of ways to overcome these barriers, and write them down on the third sheet under the relevant heading.

Possible barriers to HIV prevention

1. RESTRICTIVE ENVIRONMENT
   - working without community participation
   - inappropriate policies e.g. mandatory HIV testing
   - uninformed and inaccurate media
   - poverty and lack of resources
   - lack of appropriate services and trained personnel
   - unemployment and migration
   - lack of human rights, restrictive legislation
   - low legal status of women
   - limited access to education
   - limited availability of condoms

2. SOCIAL AND CULTURAL PRESSURES
   - men expected to be decision makers
   - subordinate status of women
   - stigmatisation of people with HIV
   - discrimination e.g. against gay men, sex workers
   - intolerant attitudes towards marginalised groups
   - some religious and traditional influences
   - poor acceptance of abstinence, non-penetrative sex and condoms

3. UNHELPFUL ATTITUDES AND BELIEFS
   - belief that young people cannot make their own decisions
   - belief that women should not be independent or make decisions
   - fear of being seen as different
   - friends encourage risk taking
   - unwillingness to accept personal risk
   - denial of HIV
   - fear of people with HIV

4. LACK OF KNOWLEDGE
   - lack of knowledge about HIV, STDs and reproductive health
   - limited access to information
   - inappropriate education and information

5. LACK OF SKILLS
   - limited opportunity for learning skills
   - lack of opportunities for practising skills e.g. in condom use
   - lack of practice in safer sex

Source: Charlotte Piede/Johannesburg City Health AIDS Prevention Programme

Published by AHRTAG in the UK
**Ways to reduce risk**

1. **SUPPORTIVE ENVIRONMENT**
   - **Policy and laws/human rights**
     - Legal access to condoms
     - Decriminalising same-sex relationships and sex work
     - Sex education in schools
     - Legal rights for women e.g. property and safety
     - Legal rights for people with HIV

   - **Access to materials and services**
     - Integration of HIV/STD programmes into primary health care services
     - Safe blood supply
     - Health services for young people
     - Access to clean injecting equipment
     - Collaboration between government, church and NGOs
     - Voluntary HIV testing and counselling
     - Affordable condoms

   - **Economic opportunities**
     - Employment for women and young people
     - Adequate income for men and women
     - Adequate alternatives to sex work
     - Employment for people with HIV

   - **Open environment**
     - Positive media images about people with HIV
     - Clear and frank messages about HIV
     - Condom advertising

2. **HELPFUL SOCIAL AND CULTURAL INFLUENCES**
   - Challenging early sexual activity
   - Challenging alcohol-related violence
   - Women have right to refuse sex or leave violent partners

   - Accepting abstinence, faithfulness, condom use as normal practice
   - Challenging traditions such as widow inheritance
   - Promoting practices and traditions that reduce risk

   - Support for opportunities for girls and women
   - Less stigma about STDs

   - Include people living with HIV in making decisions
   - Involve community and religious leaders
   - Men and women sharing sexual responsibility

3. **POSITIVE ATTITUDES AND BELIEFS**
   - Believing men and women are equal
   - Working with people as equals
   - Wanting to make sex safer and enjoyable

   - Accepting people’s right to different ways of life and sexuality
   - Caring for others

   - Understanding personal risk
   - Accepting young people’s rights
   - Personal motivation to reduce risk

   - Belief and confidence in yourself and abilities
   - Having respect for others including people with HIV
   - Seeking STD care if needed

   - Feeling able to be different e.g. postpone sex
   - Being involved in community activities

4. **INCREASING KNOWLEDGE**
   - Reproductive health
   - Facts about HIV and STDs
   - Enjoyable safer sex

   - Infection control
   - How to care for sick people

   - Human sexual and emotional development

   - Safe injecting drug use

5. **MORE SKILLS**
   - Leadership
   - Participatory teaching
   - Counselling
   - Income generation skills
   - Basic nursing and caring
   - Assertiveness for women and young people

   - Being able to use a condom

---

*Published by AHRTAG in the UK*
‘Dirty water kills us, not AIDS!’

HIV is rarely a priority for communities who already face hardship. Gram Bharati Samiti (GBS) explain why their programme took on broader social issues.

During our work with rural villages we were told about communities where the women have traditionally worked as sex workers for generations. Isolated because of discrimination, most of these women are non-literate, and very few have access to services.

In 1991 we started an AIDS education programme with people from both the sex worker communities and local villages, where the clients live. Knowledge about HIV was very limited and there was no access to condoms. We planned an HIV prevention campaign with one-day ‘training camps’ and designed leaflets, a traditional puppet show and a video with basic HIV information.

Training camps with the sex workers also included information on STDs and negotiating condom use with clients.

Listening to the women

Peer educators were chosen from among older, well respected women who receive food to compensate for their loss of earnings. Free condoms are provided where the women work, and at local distribution points such as truck stops.

However, HIV education could not provide all the answers. The women could not afford to spend much time away from their work and found it hard to insist on condom use. Concern about AIDS was a very low priority. When asked about their biggest worries, they noted problems such as lack of water or fear of police harassment. Local communities did not allow sex workers to take water from the village wells nor their children to attend village schools.

We realised that only if we took into account the women’s own priorities could they develop the confidence and ability to improve their working and living conditions, and so be in a position to achieve better sexual health. We also needed to work with others to challenge prejudice against the women, and work with the clients themselves. We began working in one of the sex worker villages to put these aims into practice.

Challenging attitudes

Our doctor now visits regularly. A full-time school has been opened nearby by the state education department. GBS funded a bore well to provide clean drinking water.

As well as improving conditions in the sex worker communities it was essential to challenge the attitudes of the local communities. We had meetings with village groups such as young people, heads of villages and local government workers. We talked about how HIV spreads, showing that clients can be responsible for transmitting HIV. This challenges the assumption that sex workers are the ‘cause’ of HIV. GBS workers who are well respected willingly work in the sex worker villages now and that has helped many local people to change their attitudes.

Through our contact with the women and the slow improvement in their situation the women themselves are able to challenge people’s prejudices. For example, when a new well was dug local villagers were invited to use it. The doctor who visits the sex worker communities also sees clients and other villagers free of charge. We also worked with the women to enable them to gain legal access to land. The women have better living and working conditions and so feel more confident. Some go out and speak to other sex workers to share their achievements. One community has decided on a ‘condom only’ policy. Others are calling for unionisation to fight for their human rights.

Local attitudes are shifting enormously. During recent local elections people decided to elect one of the women from a nearby sex worker village to fill a designated women’s seat on the committee. They felt that she was confident and outspoken so could represent women’s interests.

Our HIV programme has become a broader development programme. Most importantly, it has given the women more control over their lives and has reduced prejudice against them from neighbouring communities.

Bhawani Shanker Kusum and Kusum Jain, Gram Bharati Samiti, 2/12 Nagar Nigam Colony, Amer Road, Jaipur 302003, India.
Talking about tradition

STD/HIV prevention programmes can stimulate community discussion about behaviour change.

In 1993 Yayasan Haumeni, a local NGO in Timor, South East Asia, started an STD/HIV prevention programme when local voluntary village health workers reported a high level of STDs.

First the NGO carried out a study in 12 villages to identify the main causes of HIV transmission. The team was made up of NGO staff, two retired nurses, a religious leader and several village health workers. All of them were known and respected by local people. Information was gathered though in-depth interviews and focus group discussions with traditional healers, religious leaders and young people.

The interviews usually started with a conversation about health in the community. Once the issue of sexual health had been mentioned, staff explained the aim of the study and people were invited to participate, emphasising that anything they said would be anonymous. The discussions were usually held in small single-sex groups. People were very open, providing the setting was relaxed and informal.

One practice that could lead to HIV/STD transmission is the custom of male circumcision at puberty. After the circumcision has been done by traditional practitioners, young men are required to have sexual intercourse with two to four different women. People also discussed issues such as multiple sexual partners, abortion, teenage pregnancy, family planning (including access to condoms), and young people leaving the area. The study findings were presented to officials at district level, who agreed to support an HIV/STD education programme. The programme began in co-operation with the health service, churches, schools and government.

Discussing sexuality

The programme aims to stimulate discussion about sexuality, including the ritual of male circumcision, male and female roles and perceptions of male sexual power. It does not give answers but encourages people to discuss culturally appropriate alternatives to risky sexual behaviour.

A typical education session includes the following:

- Body mapping, where the participants are asked to draw their own genitals. There is usually much laughter at the beginning, but after a while most participants start to draw seriously. After the exercise participants usually speak more openly about sexuality.
- Explanations of STDs, including HIV. The group learns about the spread of STDs in other parts of the world and locally, STD transmission and how individuals are at risk, using cloth pictures (see TALC resources page 8).
- Discussion about types of sexual behaviour which might be a risk for STD transmission. Role plays have led to lively debates about issues such as traditional sexual practices and perceptions of virility.

The key successes of the programme have been openness about sexuality, a relaxed atmosphere, involvement of all groups within the community and the avoidance of moralising.

In one case older people themselves, after initial hesitation, insisted on organising more sessions for younger people. On a few occasions, it has been necessary to hold single-sex sessions to give women more opportunity to speak up.

Continuing discussion

It is too early to see how much the programme has resulted in changes in sexual behaviour, but it has provoked discussion. Some young men and their families have started to question traditional circumcision and have chosen to go to the local health clinic for medical circumcision.

Although some do continue to undergo the ritual of sex with two to four women, others are choosing not to have unprotected sex after circumcision. Behaviour change is slow. What is important is that people are starting to question for themselves the importance of their own behaviour in transmission of STDs, and in other areas of sexual health.

Despite the sensitivity of the subject, people are prepared to talk about sexuality but often they lack the opportunity. This programme has been able to facilitate such discussion, rather than giving general STD and HIV education.

Irko Zuurmont, former STD/AIDS Prevention Worker, Yayasan Haumeni, c/o Engelserf 3, NL 3843 BD Harderwijk, The Netherlands.

Drawing ‘maps’ of male and female bodies promotes open discussion.
Family warmth heals

Experience has taught me that Thai women are expected to be soft, gentle and patient. These days things are changing. AIDS is becoming widespread, especially amongst men. They have difficulty in coping and tend to die early. Women have found themselves looking after the physical and mental well being of men. I have experienced this looking after my husband.

I have had a series of chronic illnesses since I was young. This has helped me to understand that life is uncertain. Because I’ve been practising meditation I am now able to face any situation. Consequently I was not upset when I contracted HIV from my husband five years ago. I studied about AIDS and took my husband to public talks to learn how to look after ourselves. I enrolled in a home care training programme offered by the Red Cross Society.

In 1994 my husband’s health began to fail. The doctors said he wouldn’t last long. I believed that he could be cured and so I checked him out of the hospital and took him back home. The love and warmth of his relatives gave his condition improved and eventually the opportunistic diseases disappeared.

This made me believe that if the families of other sick people were taught about self-care it would help boost the morale of the sick and increase their life span.

I gave talks to the public and to youth groups and went out to visit the sick whose relatives had come seeking advice. I now have support from NAPAC (a local NGO). Most of the work I have done is home visits, giving moral support, providing education on self-care and co-ordinating with hospitals when people become ill.

Through making home visits I have come to realise that people with HIV have an important role to play. If they make home visits or give talks, the people who are sick begin to confide in them. Now the ones who do home care visits are able to understand more about the problems faced by people with AIDS.

I am determined to show that if families work together with determination and sincerity, then people with HIV will have fewer illnesses and live for longer.

Phimchai Inthamun, Community Health Project, Tambon Don Kaeo, Mae Rim District, Chiang Mai, Thailand.

Communicating health contains practical guidelines and training techniques in health promotion. Available for £5.80 from TALC, PO Box 49, St. Albans AL1 4AX, Herts, UK.

AIDS is our problem is a series of six booklets looking at planning HIV prevention programmes in Africa. Available in English and French free to individuals and community organisations in Africa and 50 French francs or £6.50 + postage for funded organisations from Arid Lands Information Network, CP 3, Dakar-Fann, Senegal.

 Helpers for a healing community is a manual which looks at HIV prevention from a Christian perspective. Available in English (US$ 1.50), French and Kiswahili (both US$ 2.00) plus postage from MAP International, PO Box 21663, Nairobi.

Using flannelgraphs to communicate ideas in family planning, STDs, and AIDS comes with a series of flannel pictures. Available for £19.50 from TALC.

My story is written by Bongi, who describes the changes in her life on discovering her diagnosis. Available free from Matabeleland AIDS Council, PO Box 1280, Bulawayo, Zimbabwe.

Videos

A window of hope is made by the Positive and Living Squad in Zambia who describe how they are coping with HIV and what support they can offer in HIV prevention. Contact Kara Counselling, PO Box 37559, Lusaka, Zambia, for details.

No need to blame shows the personal experiences of five Zimbabwean men and women, living with HIV. Available free in WHS/PAL format to developing countries from UNICEF Zimbabwe, PO Box 1250, Harare, Zimbabwe.

The faces of AIDS interviews people with HIV/AIDS from Cameroon and Zimbabwe, and health workers who describe how HIV/AIDS affects them and the lives of people in the community. Available in PAL format for US$19.95 from Media for Development International, PO Box 281, Columbia MD 21045, USA.

AIDS Action is published quarterly in seven editions in English, French, Portuguese and Spanish. It has a worldwide circulation of 169,000. The original edition of AIDS Action is produced and distributed by AHRTAG.

Executive editor: Nel Druce
Assistant editor: Siân Long
Design and production: Ingrid Emsden
Editorial advisory group
Calle Almedal
Kathy Attawell (AHRTAG Sabbatical leave)
Nina Castillos
Dr Kevin De Cock
Professor E. M. Esiens
Theresa Kaigje
Dr Sam Kalbala
Ashok Row Kavi
Dr Ute Kipper
Dr Tutu Parwati Merati
Dr Claudia Garcia Moreno
Dr Chandra Mouli
Professor Anthony Pinching
Dr Peter Poore
Barbara Wallace
Dr Michael Wolff

Publishing partners
ABIA (Brazil)
Colectivo Sol (Mexico)
ENDA (Senegal)
HAIN (The Philippines)
SANASO Secretariat (Zimbabwe)
Consultants based at University Eduardo Mondlane (Mozambique)

AHRTAG’s AIDS programme is supported by CAFOD, Charity Projects, Christian Aid, FINNIDA, HIVOS, ICCO, Memisa Medicus Mundi, Miseror, Norwegian Red Cross, Oxfam, Redd Barna, Save the Children Fund, SIDA, UNICEF and WHO/GPA.

SUBSCRIPTION DETAILS
If you would like to be put on the mailing list to receive AIDS Action, please write with details about your work to:

AHRTAG
Farringdon Point, 29-35 Farringdon Road
London EC1M 3BJ, UK.
Telephone +44 171 242 0606
Fax +44 171 242 0041
E-mail: ahrtag@gn.apc.org
ahrtag@geo2.poptel.org.uk

Annual subscription charges
Free Reader’s in developing countries and students from developing countries
£5 Other students
£10/$20 Individuals elsewhere
£20/$40 Institutions elsewhere

REPRODUCING ARTICLES
AHRTAG encourages the reproduction of articles in this newsletter for non-profit making and educational uses. Please clearly credit AIDS Action/AHRTAG as the source and, if possible, send us a copy of the reprinted article.

AHRTAG is committed to strengthening primary health care and community-based rehabilitation in the South by maximising the use and impact of information, providing training and resources, and actively supporting the capacity-building of partner organisations.

Registered charity no. 274260
Printed by Russell Press
ISSN 0953-0096