Handbook

appropriate communication for behavior change

information/education/communication

UNESCO

UNAIDS

A cultural approach to HIV/AIDS prevention and care

Special series

HIV/AIDS Prevention and Care: A Cultural Approach

Since the mid-eighties, the fight against HIV/AIDS has gradually mobilized governments, international agencies and non-governmental organizations. However, it became evident that despite massive action to inform the public about the risks, behavioral changes were not occurring as expected. The infection continued to expand rapidly and serious questions began to emerge as to the efficiency of the efforts undertaken in combating the illness. Experience has demonstrated that the HIV/AIDS epidemic is a complex, multifaceted issue that requires close co-operation and therefore multidimensional strategies.

The establishment of the Joint United Nations Program on HIV/AIDS (UNAIDS) in 1994 initiated a new approach to the prevention and care of this disease. The first requirement stressed was the need for increased co-ordination between institutions. An emphasis was also made on the need to work on both prevention and treatment while considering the significant social factors involved. As a result UNAIDS was involved in several studies focusing on developing new methodological strategies with which to tackle the issue.

Following a proposal made by UNESCO's Culture Sector to the UNAIDS Program, on taking a cultural approach to HIV/AIDS prevention and treatment for sustainable development, a joint project "A Cultural Approach to HIV/AIDS: Prevention and Care" was launched in May 1998. The goals were to stimulate thinking and discussion and reconsider existing tools.

Taking a cultural approach means considering a population's characteristics – including lifestyles and beliefs- as essential references to the creation of action plans. This is indispensable if behavior patterns are to be changed on a long term basis, a vital condition for slowing down or for stopping the expansion of the epidemic.

In the first phase of the project (1998 –1999) nine country assessments were carried out in three regions: Sub-Saharan Africa (Angola, Malawi, South Africa, Uganda, Zimbabwe), Asia and the Pacific (Thailand and bordering countries) and the Caribbean (Cuba, Dominican Republic, Jamaica). The findings of these studies were discussed in three sub-regional workshops held in Cuba, Zimbabwe and Thailand, between April and June 1999.

The second phase of the project (2000-2001), concentrated on several activities. One was the Inter-regional conference on "A Cultural Approach to HIV/AIDS Prevention and Care", held on 2 - 4 October 2000 in Nairobi, Kenya. In addition two sub-regional training workshops were organized in Uganda (Kampala, 8-12 May, 2000) and Egypt (Cairo, 20-24 May, 2000). Also, the first local version of the Handbook for culturally appropriate project design was prepared for India. Finally, the first phase in the implementation of a Pilot Project (Kampala, Kawempe Division), was completed. Based on the lessons learnt from the different country reports, four Handbooks were drawn up for target audiences involved directly in policy building, project design, field work and communication.

The nine country reports and the proceedings of the workshops have been published within the Special Series of Studies and Reports of the Culture and Development Unit. The handbooks are being published within the present Methodological Handbooks Series of the Division of Cultural Policies.

A CULTURAL APPROACH TO HIV/AIDS PREVENTION AND CARE

UNESCO/UNAIDS RESEARCH PROJECT

HANDBOOK 1

Culturally Appropriate

Information/Education/Communication

Elaboration and Delivery

Methodological Handbooks, Special Series, Issue No. 1
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The opinions expressed in this document are the responsibility of the authors and do not necessarily reflect the official position of UNESCO

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FOREWORD

This handbook is one of a series of four methodological documents:

- *Appropriate Information/Education/Communication*
- *A cultural approach to strategy and policy building*
- *Culturally sensitive project design and implementation*
- *Field work: building local response*

Each specific handbook deals with two major topics:

- *A general explanation of the cultural approach to HIV/AIDS in relation to risk itself, situations of vulnerability and appropriate prevention, support and impact reduction;*
- *Specific sections focus on the levels of action to be considered: strategy/policy, project design and field work. These are intended to assess the current situation and to propose innovative methods and tools.*

The present handbook comprises two major divisions: situation analysis and information, education and communication strategies and includes cross-references to the other three handbooks. Numerous UNAIDS documents were consulted during the elaboration of this work, footnotes reference those quoted directly.

EXECUTIVE SUMMARY

The Joint UNESCO/UNAIDS Project "A Cultural Approach to HIV/AIDS Prevention and Care" was launched in mid-1998, in relation to the new approach to HIV/AIDS prevention and care inaugurated by UNAIDS. The UNAIDS strategy emphasizes the necessity of giving priority to the multi-dimensional configuration of the issue and to the diversity of its environment, in order to build comprehensive and adaptable strategies and policies.

In this sense, "A Cultural Approach to HIV/AIDS Prevention and Care", represents a new contribution towards finding solutions to this apparently insuperable challenge. Its major methodological output aims at tailoring the content and pace of action to people's mentalities, beliefs, value systems, capacity to mobilize and, as a consequence to accordingly modify international and national strategies and policies, project design and field work.

In this respect, this initiative clearly meets the principles and orientations of the Declaration of commitment on HIV/AIDS adopted by the Special Session of the United Nations General Assembly on HIV/AIDS (June 2001), that states the importance of ***emphasizing the role of cultural, family, ethical and religious factors*** *in the prevention of the epidemic and in treatment, care and support, taking into account the particularities of each country as well as the importance of respecting all human rights and fundamental freedoms* (paragraph 20).

On the basis of the research carried out to date, this handbook deals with building culturally appropriate Information/Education/Communication (IEC) material. After a conceptual introduction, it presents the methodological research to be carried out: evaluation of the current activities, understanding, sensitizing and mobilizing cultural references and resources accordingly. Then it identifies the proposed target audiences and their specific characteristics. Finally, it proposes appropriate IEC models, combining message elaboration and delivery.

1- THE CULTURAL APPROACH: A REMINDER

1.1- ASSUMPTIONS

In the light of experience, it is increasingly being recognized that the HIV/AIDS epidemic is a problem which concerns not only the medical sector, but is above all, a multifaceted issue, which requires a multidimensional response. If the question is limited to medical considerations or to purely cognitive information, modern-type information, education and communication for safe practices, namely the promotion of condom use, the expected results will not be achieved. It is, indeed, a complex socio-economic, societal and cultural phenomenon to be considered in the perspective of sustainable human development. Thus, a cultural approach is necessary for the prevention and treatment of the epidemic in order to deal with all the aspects of the problem.

Generally speaking, a cultural approach to development must meet two conditions, derived from the UNESCO Mexico definition of culture, and which can be summarized as follows:

- **Grounding development** on mentalities, traditions, beliefs and value systems, for practical and ethical reasons, in so far as they may enhance needed changes, or hamper them, if they are not correctly identified, and will necessarily interfere in the action taken;
- **Mobilizing the cultural resources** of the given populations, in order to benefit from their support, when bringing about, through the joint identification of needs and action, the necessary changes in thinking and behaviour for endogenous sustainable human development.

These cultural references and resources are sometimes misinterpreted as monolithic systems, which cannot be modified, since they are supposed to represent an intangible asset, to be protected unconditionally. Observing real situations clearly shows that there is not necessarily a contradiction between culture and change, since all societies and cultures evolve over time:

- First, because of their intrinsic dynamic aspects;
- Secondly, because they interact with all kinds of external economic, social and cultural transformation processes.

These evolutions can result in destabilizing situations if these processes are not monitored and mastered. HIV/AIDS prevention and care policies and methods will be improved and made more efficient by making them culturally-appropriate (acceptable and relevant), fully understood and highly valued (culturally integrated) among given groups and persons, according to their priorities. This will enhance a new awareness of responsibility and motivate a subsequent willingness for mobilization against the expansion of the epidemic.

Over the last 15 years, many different approaches have been adopted in an attempt to curb the expansion of HIV and minimize its negative effects on individuals, families, and society. It is now clear that there is no simple formula that works for all countries. The most effective national responses are those designed to meet the specific needs of a country. They address the specific situations that make people vulnerable to HIV and its effects, and make use of the particular strengths of the country's people and institutions. These practices are outlined in the UNAIDS *Guide to the Strategic Planning Process for a National Response to HIV/AIDS* (1998-1999) and the UNAIDS *Methodological Review* (1999).

The cultural approach is fully consistent with the policy and planning principles advocated in the UNAIDS documents. Its specific input consists of a detailed analysis of the particular and changing aspects of a given situation and population, and in proposing working methods derived from this detailed analysis.

1.2- OBJECTIVES AND IMPLICATIONS

This handbook is meant to facilitate the design of more efficient and relevant strategies and policies aimed at HIV/AIDS prevention and care, through improving the understanding of cultural references and resources and integrating them into building relevant responses at the national level.

In the light of these goals, this handbook proposes concepts, criteria and methodological tools in order to adopt a cultural approach in building, implementing and evaluating HIV/AIDS prevention and care strategies and policies. These strategies and policies will thus be better equipped to face risk and vulnerability situations and reduce the impact of the epidemic through building more efficient prevention and support systems, including the appropriate preventive education.

These proposals are derived from the analysis of the current conditions, the assessment of institutional action taken to date at all levels and an in-depth investigation of field situations. This analysis is meant to show the gap between the current approach and the scope of prevention and care systems in relation to the complexity of concrete situations. More detailed evaluation of these interactions is presented at length in the three other methodological handbooks. The present handbook focuses on proposing methods for identifying major orientations and priorities, ways and means, cooperation and partnerships in order to build a response through culturally-appropriate methods for elaboration and delivery of media, education and communication messages.

Taking a cultural approach to HIV/AIDS prevention and care

In terms of HIV/AIDS prevention and care, adopting a cultural approach means that any given population's cultural references and resources (ways of life, value systems, traditions and beliefs, and the fundamental human rights) will be considered as key references in building a framework for strategies and project planning. These key references will also serve as the resources and basis for building a relevant response and sustainable action in prevention and care, as well as in impact reduction. This is an indispensable condition in order to achieve in-depth and long-term changes in people's behaviour and to give full consistency to medical and sanitary strategies and projects.

2- FOUR MAJOR CHALLENGES

As emphasized by UNAIDS, building a response to HIV/AIDS at all levels requires a preliminary diagnosis in clear terms. Risk in itself, and vulnerability as its environment, are two major challenges to be faced in all their facets before attempting to find reliable solutions. Developing relevant prevention and support systems in order to alleviate the impact of the epidemic represents a key issue in strategy building, policy-making, project design and field work. This is why these different questions are identified as the four major challenges of HIV/AIDS.

These issues have to be analysed in detail, individually and in their context, with due consideration of their socio-economic and societal/cultural determinants and effects at all levels. They are reflected in the evaluation of the present situation concerning policies and the appropriate response to building, in terms of national strategies, regional initiatives and local response.

2.1- RISK

High-risk behaviour is directly associated with the physical proximity between infected and non-infected persons. This is a fact in all situations and regions. Nevertheless this behaviour differs significantly according to the various contexts.

- The main cause of infection is **sexual relations**, whether heterosexual, as in Africa and in other regions, and/or bi-sexual or homosexual, as recognized in the Caribbean, Latin America and South-East Asia. The risk is aggravated by certain sexual practices such as having multiple sexual partners, casual sexual relations, violent sexual intercourse and prostitution. It is also related to other STDs, past, co-existing or confused with HIV/AIDS.
- **Mother-to-child transmission** of HIV/AIDS appears as another major cause, either during pregnancy, at birth, or during breastfeeding. The latter represents half of this type of infection, especially for women who have numerous children and breastfeed. This practice is often maintained because safer alternatives, such as hygienically safe milk for babies, are not available to them.
- The growing use of **intravenous drugs** with infected needles and the simultaneous consumption of drugs and alcohol are also causes of infection, more specifically in eastern Europe and central Asia.
- The transfusion of **contaminated blood** is estimated to be the cause of 10% of the HIV/AIDS infections in sub-Saharan Africa. Contamination can also occur during sexual intercourse when the reproductive organs of one partner are bleeding. It can also occur through rituals of blood exchange in certain initiation ceremonies involving young men, unhygienic excision or circumcision operations, tattooing and skin piercing. However, recent research in certain African countries tends to show that male circumcision may entail a lower sexual contamination risk. Factual evidence corroborates that violent fighting can also result in contamination through bleeding wounds.

Despite this factual evidence, identifying these various high-risk situations raises two questions that go beyond the epidemiological approach, and are of an obviously more societal and cultural nature:

- Personal, family and community awareness of the risk and its consequences in matters of infection and, in optimal situations, the subsequent choice of protected contact or abstinence;
- Public acceptance and formal acknowledgement of the risk and its implication and/or the disclosure of the infection by the group, community, society or public authorities as opposed to silence and denial.

This in itself leads to issues of prevention and care, at the individual and collective level.

2.2- VULNERABILITY

Epidemiological research has made important contributions to the identification of the direct determinants of HIV infection. However, it tells little or nothing about the social, economic and cultural factors, which influence people's behaviour in relation to the risk. Social and economic conditions and societal/cultural features have to be analysed in turn, first at the various levels, then as interwoven groups of causes and effects.

The first AIDS cases in sub-Saharan Africa were reported in scientific literature in 1983. These patients did not share the main risk factors associated with the disease in Europe and North America, i.e. principally homosexual intercourse and intravenous drug use. It soon emerged that epidemiological HIV/AIDS in Africa was quite different from that of high-income countries: heterosexual intercourse, blood transfusion and mother-to-child transmission being the predominant modes of transmission. While common risk behaviour such as intravenous drug use and unprotected homosexual intercourse can be targeted with interventions aimed at reducing the risk, it is much harder to design interventions for larger populations engaging in heterosexual intercourse.

Source: CARAEL (Michel), "The Dynamic of HIV Epidemic in sub-Saharan Africa: what are the determinants?" Proceedings of the Nairobi International Conference, UNESCO, 2001.

2.2.1- SOCIO-ECONOMIC CONDITIONS

The analysis of these conditions should be carried out at two levels:

- Macro-level: economic crisis, globalization (and its impact on communication and transportation, internationalization of markets – including drugs and prostitution), environmental degradation, wars, population displacements, international migrations, mass tourism;
- Micro-level: poverty, unemployment, housing conditions, lack of access to health-care services and education, rural exodus, urban violence.

2.2.2- SOCIETAL AND CULTURAL REFERENCES AND THEIR EVOLUTION

A few examples can be given in this respect, bearing in mind the multifaceted character of many cultural features. Thus, certain aspects of local cultures are conducive to risk behaviour while others induce direct or indirect protection attitudes with respect to spiritual and ethical rules:

- Representations of health and disease, life and death, fate and human responsibility;
- Strong control on the part/behalf of society and the family;
- Prescription of attitudes and sexual norms through certain rituals, traditions and religious beliefs;
- Disruption or collapse of traditional norms and value systems;
- Inequitable gender relations and underestimation of women's potential in daily life continuity or change;
- Young people's status and situation in society;
- Linguistic and semantic habits for discussing sexuality.

2.2.3- SOCIAL/POLITICAL ENVIRONMENT: HISTORICAL AND PRESENT SITUATIONS

Even if not directly linked to the material and medical aspects of risk, the overall social and political conditions at national level have a strong impact on the scope and feasibility of prevention and care policies. More specific issues can be mentioned in this respect, for instance:

- Institutional weaknesses, including the chronic instability of public authorities and subsequent fragility of administrative structures;
- Lack of communication between public authorities and population;
- Imbalance in internal/external decision-making capacity;
- Weight of external debt and structural adjustment policies;
- Non-respect of fundamental human rights.

2.2.4- IDENTIFICATION OF VULNERABLE GROUPS

In general, the categorization of vulnerable groups should fully take into account people's situation in the context of overall development: poverty, insecurity and fundamental human rights. In this respect, the poor, women, and youth, and more specifically, refugees and minorities, are at maximum risk exposure. Specialized target audiences have to be defined.

Underprivileged populations:	**Culturally-destabilized groups:**	**Specific risk groups:**
• The poor • Young people • Women and girls • Uneducated people (out-of-school children and the illiterate)	• Disintegrated families • Unemployed persons • Refugees and displaced people • Domestic and international migrants • Mobile workers	• Segregated groups and communities • Homosexuals • Prostitutes

2.3- PREVENTION AND SUPPORT

In response to the high risk and vulnerability situations described above, national strategies and policies have to be elaborated and implemented in the following fields:

- National health-care policy;
- Preventive education and communication care and support within relevant national policies;
- Medical, social and psychological follow-up for infected people;
- In the context of social welfare policies, special action in order to alleviate the social impact of the infection.

The range of these policies and the number of people being educated and assisted require a coordinated action, not only between national public authorities, but also among all types of stakeholders involved. More specifically:

- International cooperation institutions;
- International and national NGOs.

In this respect, however, no public or institutional policy will reach a significant stage if it is not complemented by the input of civil society in all of its aspects. The various categories of economic, social and cultural actors (sports and cultural movements, business associations, trade unions, political parties, religious communities, traditional community leaders, traditional healers, midwives) are important stakeholders in the joint mobilization against the epidemic.

Needless to say, medical and sanitary personnel at all levels are partners in the overall effort to provide testing facilities and care to infected people, especially pregnant women intending to breastfeed their infants.

Another category of professionals actively involved in preventive education can be found not only among school and out-of-school educators but also in the media (both in audiovisual media and the written press).

2.4- IMPACT REDUCTION

2.4.1- ECONOMIC IMPACT

The high mortality rate due to AIDS among the most active sector of the adult population can be expected to have a radical effect on every aspect of social and economic life. This is due to the fact that this sector of the population is typically at an age when they have already started to form their own families and have become economically productive. While it is difficult to measure the precise impact of HIV at national level in most hard-hit countries, a great deal of information exists about the disastrous impact, direct or indirect, of the epidemic on households as well as on the public and private sectors of the economy.[1]

1. UNAIDS, *Report on the global HIV/AIDS epidemic,* June 2000.

However impact reduction policies should not focus exclusively on the economic disruptions caused by the epidemic, such as manpower shortage and decreased production. The education sector is also hard hit by the disease: teachers, already insufficient in number to face overcrowded school classes, and new generations of trained specialists in other sectors of national development are also decimated by the virus.

2.4.2- SOCIAL IMPACT

Reducing the social impact of the disease is another **major challenge for national social development** and welfare policies. Giving support to abandoned and widowed women, unable to provide the minimum care for their children, or developing solidarity systems for HIV/AIDS orphans, abandoned street children and youngsters places an additional burden on an already fragile national public budget.

2.4.3- SOCIETAL AND CULTURAL IMPACT

The societal and cultural impact of the infection and disease can result in a general collapse of energy and hope for fighting the virus. The taboo itself and the widely spread rule of silence are just a few of the disastrous cultural effects of the revelation of the disease by the infected person or his/her family. Stigmatization and rejection have been observed in many instances, especially in rural zones and among the poorest populations. In some countries, at least in the first phase of the epidemic, numerous cases of hesitation or denial were recorded in respect to the recognition of the scope of the disease and the seriousness of the challenge it posed for the country.

The pressing character of this situation clearly requires urgent action, but different approaches. This has to be done with the necessary respect for the populations' societal cultural norms and basic human rights, especially if breaking the silence is imperative. Moreover, there may be significant misunderstanding on the issue of sexuality arising from semantics and language. This may lead external prevention and care agents to erroneously consider that women are frequently ignorant of their physiological functions.

HIV/AIDS and the private sector

The impact of the HIV/AIDS epidemic on the private business sector has been growing steadily over the last years, and has become quite visible in some places. Still many business leaders need to be persuaded that AIDS prevention programmes for their employees are in their own rational self-interest. In economic terms, such prevention programmes can be marketed as "minimizing cost" or "profit-loss prevention" and protection of a valuable fixed investment in "human capital". The advantage of developing new partnerships with private business is that they have substantial resources available. At the same time, workplaces provide an excellent opportunity to reach the labour force in large numbers and with high impact.

Source: UNAIDS, *Guide to the strategic planning process for a national response to HIV/AIDS, resource mobilization.*
(http://www.unaids.org/aidspub/list.asp)

Dominican Republic: linguistic hiatus, silence and disclosure regarding HIV/AIDS

In most cases, couples with HIV inform friends, families and neighbours of their condition when one member of the couple has the disease. When the husband is ill, men's groups tend to hide the infection from the families of their wives and the majority of their neighbours. The family and friends of the wife will only be notified of the infection when the husband is tested positive. In other cases, mothers of HIV positive patients revealed the condition of their sons to their friends and neighbours, and subsequently received the solidarity and support of many of them, in spite of the general poverty. Women do the housework and attend to the ill, while men work and help to move the ill from one place to another.

Men and women tend to react differently when they discover their diagnosis: resignation among men, panic and depression in the case of women. There is evidence of apathy, family rejection and stigmatization, as well as other reactions, which seem to motivate secrecy.

Source: A cultural approach to HIV/AIDS prevention and care: Dominican Republic's experience, UNESCO, 1999.

3- ASSESSING THE CURRENT SITUATION

3.1- EVALUATION OF CURRENT IEC PRACTICES

The first phase of the battle against HIV/AIDS focused mainly on epidemiological action and research concerning the disease itself. However, scientific progress has revealed that a long period of time (from 5 to 10 years) can elapse between the first infection and the manifestation of the disease. Thus greater attention was paid, not only to the medical, but also to the educational management of prevention and the post-infection intermediary phase.

As a key instrument in preventive action, IEC programmes have been developed for HIV/AIDS and other issues involving radical behaviour change, such as population policies. In this framework, the prominent role of the school system and the mass media has of course been emphasized.

Unfortunately, international cooperation institutions, NGOs and national authorities have not developed appropriate programmes, materials and projects within school and university curricula. However, television and radio programmes and, to some extent, direct communication with populations at risk have been more effective.

3.1.1 - IEC: PRESENT SITUATION

In the area of **preventive education against** HIV/AIDS and drug abuse, UNESCO's activities over the last two years have been mainly concerned with helping Member States prepare and set up programmes for curriculum planners, teachers, young people (both in and out-of-school), and illiterate young women. Strategic guidelines and culturally appropriate prototype educational materials were researched and designed, in order to make them accessible to the specific target groups. During the next two years, special attention will be given to youth empowerment through preventive education against HIV/AIDS and drugs. Assisting national health educational systems in teacher training and curriculum development programmes and undertaking international campaigns for and by youth will accomplish this effort.

In 1996, as a follow-up to the Cairo Conference on Population and Development (1994), UNFPA and UNESCO initiated a joint programme on IEC strategies on the relationship between population, environment and development. Its purpose is to promote widespread awareness on these subjects among decision-makers, educators, students and the general public, in formal and non-formal sectors. Subsequently, IEC strategies and projects were launched in various fields related to UNESCO: information (i.e. mostly mass media), in and out-of-school education and live communication concerning population issues and HIV/AIDS prevention.

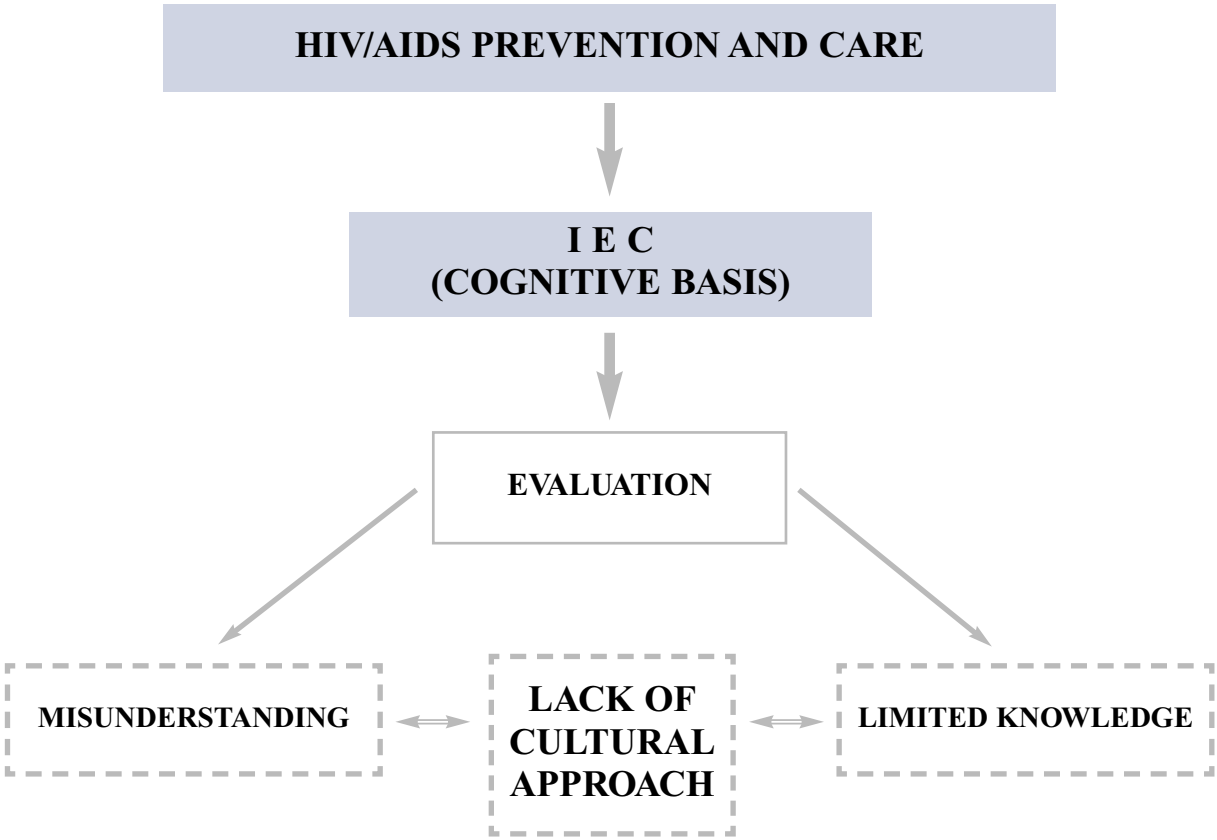
In the UNFPA Evaluation Report (1999), the following observations were made (based on country assessments in Burkina Faso, Mexico, Morocco, Nepal, Philippines, and Uganda):

- IEC strategies focus too much on imparting knowledge (cognitive approach) and not on bringing about behaviour changes;
- They also miss target audiences because of lack of specification or by being too general IEC projects, underestimating and misunderstanding specific women's, men's and young people's life issues and over-emphasizing individualistic rather than community models;

- Available research on sexual behaviours (major aspects and underlying value systems) is either absent or misused;
- Information based communication procedures are unidirectional and artificially didactic;
- Media programmes or articles are not related to available services and other IEC activities;
- Traditional media are not well identified and poorly used;
- There is some confusion between increasing knowledge and inducing change in behaviour; the latter would require encouragement and an emotional approach.

UNESCO's current **preventive education** activities and their development have similar shortcomings. Change in the content and role of education regarding HIV/AIDS is required in order to meet student needs, focus more on life-skills and adapt curricula to marginalized groups. These include out-of-school children and young people, the illiterate, and especially girls and women. In all cases, the relative inefficiency results from the lack of consideration for peoples' cultural and daily life background.

Thus, further effort is necessary in order to build culturally appropriate prototype educational material, and new information and communication channels using an inter-sector approach. This would require the cooperation of other stakeholders, whether institutions or NGOs, at the international and national level, possibly along the lines of UNAIDS' *Communication Framework on HIV/AIDS.*



3.1.2- IEC COMPONENTS

Until now, the various components of IEC, as defined by UNFPA for population policies and HIV/AIDS prevention and care, have been incorporated into their strategies and methods, often resulting in a lack of efficiency, relevance and mutual support. The need for integrated strategies, even if expressed in theory, has not led to a real joint action. Thus, each medium must still be evaluated independently.

Information (mass media)

The mass media have a significant role in creating and sustaining public opinion and the political will to deal with the HIV/AIDS epidemic. The media can expose certain trends and phenomena in the community or society that facilitate the spread of HIV/AIDS and inform the public about them. They can also play a central role in educating the public about the importance of preventive measures and serve to point out threats. They can help create public awareness and mobilize public opinion against trends, phenomena and practices, which favour the spread of the epidemic. Active involvement of media organizations and communication practitioners in the effort to deal with HIV/AIDS is critical, if knowledge and awareness are to be increased and risk behaviour reduced among different population segments in African countries.[2]

Generally speaking, the current situation is less satisfactory. Specialized **television and radio programmes**, especially those broadcast at the national or international level, have developed some degree of behaviour change as regards HIV/AIDS prevention in the most educated and audiovisually reactive audiences (i.e. Thailand). Radio programmes, which are nowadays widely accessible to populations at large, including rural areas, lack interaction with the public. The technical accessibility and flexibility in elaborating interactive programmes make it a potentially appropriate and people-friendly medium, which is far from being the case with television given the huge difference in the number of television receivers according to the world regions and countries.

Despite the progress achieved thus far, in many countries the media cannot address the issue properly. Important groups are not reached by media prevention messages due to multiple factors, such as political barriers and the fear of a possible repressive attitude from authorities. Communities in remote areas and/or speaking minority languages are also difficult to reach by the established media channels. Moreover, in many cases, the message is inefficient in its form and content, because it is not adapted to the specific cultural context.

The major factors, which contribute to the inefficiency of the mass media, are:

1) The ignorance and relative indifference of the "gatekeepers" in the media to HIV/AIDS issues. Editors and managers in media institutions decide which stories are to be published/broadcast or not. News selection depends on their choice;
2) The inability of media practitioners to conduct investigative reporting on HIV/AIDS.

2. "Media and HIV/AIDS in East and Southern Africa, A Resource Book", UNESCO, 1999, pp. 11-12.

Beyond these limited achievements, more complex shortcomings have been encountered in IEC projects. The lack of understanding with respect to the medical or informative content of the message, as well as the subsequent behaviour involved. For instance, in South African countries, media messages broadcast to the rural, urban, uneducated or poor populations have not been understood. Instead they have conveyed or reinforced irrational fears and provoked rejection from possibly infected or sick people, resulting in a fatalist attitude concerning prevention and self-protection.

In South-East Asia, tribal populations were so scared by images broadcast on television and showing the physical degradation of people with AIDS, that they refused to hear any more about the disease. Thus, information on prevention and care action was made much more complicated and, in some cases, impossible.

Preventive education

School education achievements

From UNESCO's experience, education, and more specifically at school and university, is a key instrument in prevention. Specific information courses are being developed in many countries, as an integral part of the school curriculum on topics such as: life skills, the mutual respect and understanding of women and men and peer education. Practical information about body physiology, sexual education and the importance of protection (i.e. condoms) is also taught. This effort needs to be reinforced, widened and made accessible to all school-age children throughout the world, within the context of basic learning, using well adapted methods and contents, in other words, culturally-appropriate education for all. In this respect, UNESCO's priorities concerning the reform of education in the perspective of education for all throughout life will give priority to the development of secondary level education with emphasis on preventive education against HIV/AIDS and drug abuse. After the World Education Forum held in Dakar in April 2000, UNESCO committed itself to making HIV/AIDS one of its highest priorities, through preventive education, formal and non-formal, with special attention to the effectiveness of different preventive strategies in securing change in behaviour and attitude.

South Africa: policy paper on HIV/AIDS school education

1. Education principles

A continuing life-skills and HIV/AIDS education programme must be implemented at all schools and institutions for all learners, students, educators and other staff members. Measures must also be implemented at hostels.

2. Age-appropriate education on HIV/AIDS

It must form a part of the curriculum for all learners and students, and should be integrated in the life-skills education programme for pre-primary, primary and secondary school learners. This should include the following:

2.1 Providing information on HIV/AIDS and developing the life skills necessary for prevention;

2.2 Inculcating basic first-aid principles from an early age, including how to deal with the necessary safety precautions when bleeding;

2.3 Emphasizing the role of drugs, sexual abuse and violence, and sexually transmitted diseases (STDs) in the transmission of HIV and empowering learners to deal with these situations;

2.4 Encouraging learners and students to make use of health care, counselling and support services (including services related to reproductive health care and the prevention and treatment of sexually transmitted diseases) offered by community service organizations and other institutions;

2.5 Teaching learners and students how to behave towards persons with HIV/AIDS, raising awareness on prejudice and stereotypes surrounding HIV/AIDS;

2.6 Cultivating an enabling environment and a culture of non-discrimination towards persons with HIV/AIDS, and

2.7 Providing information on appropriate prevention and avoidance measures, including abstinence from sexual intercourse and immorality, the use of condoms, faithfulness to one's partner, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, avoiding traumatic contact with blood, and the application of universal precautions.

3. Education and information

Education and information regarding HIV/AIDS must be given in an accurate and scientific manner using comprehensible language and terminology.

4. School, education and parents

Parents of learners and students must be informed about all life-skills and HIV/AIDS education offered at schools and institutions, the learning content and methodology to be used, as well as values that will be imparted. They should be invited to participate in parental guidance sessions and should be made aware of their role as sexuality educators and importers of values at home.

5. Educators, pupils and students

Educators may not have sexual relations with learners or students and, should this happen, the matter has to be handled in terms of the Employment of Educators' Act, 1998.

6. Infection and teaching activity

If learners, students or educators are infected with HIV, they should be informed

that they can still lead a normal life for many years by taking care of their health.

7. Duties and responsibilities

All learners, students and educators should respect the rights of other learners, students and educators.

The Code of Conduct adopted for learners at a school or for students at an institution should include provisions regarding the unacceptability of behaviour that may create the risk of HIV transmission.

The ultimate responsibility for a learner's or a student's behaviour rests with his or her parents. Parents of all learners and students:

- Are expected to require learners or students to observe all rules aimed at preventing behaviour which may create a risk of HIV transmission;

- Are encouraged to take an active interest in acquiring any information or knowledge on HIV/AIDS supplied by the school or institution, and to attend meetings convened for them by the governing body or council.

It is recommended that a learner, student or educator with HIV/AIDS (and his or her parent, in the case of learners or students) should consult medical opinion to assess whether the learner, student or educator, owing to his or her condition or conduct, poses a medically recognized, significant health risk to others. If such a risk is established, the principal of the school or institution should be informed. The principal of the school or institution must take the necessary steps to ensure the health and safety of the other learners, students, educators and other staff members.

Educators have a particular duty to ensure that the rights and dignity of all learners, students and educators are respected and protected.

Source: A cultural approach to HIV/AIDS prevention and care: South Africa's experience, UNESCO, 1998.

Limits and deficiencies

Although these activities have brought about significant changes for students, their impact has highlighted the differences between education levels, societal/cultural background and local situations, all of which are not always reflected in national education policies.

Moreover, children and young people outside of the formal education system have not been efficiently reached through other educational channels and activities. The situation is even worse for the vast number of illiterate youngsters and adults, especially girls and women, for whom alternative educational channels must be used.

Furthermore, schools do not always work in coordination with other education partners, such as: religious and spiritual leaders, traditional cultural representatives, major social and economic actors in society, families and parents, and above all the mass media, whose potential is far from being adequately exploited. Lastly, well-understood cognitive information does not necessarily result in behaviour change, as will be shown below.

The limits and deficiencies of the action taken in the field of in-school and out-of-school education were emphasized in the UNFPA evaluation report (1999):

- *School education:* in many cases, great difficulty was encountered when discussing sexuality in general and the sexual practices of young people. These difficulties were also met on the teaching side (schoolteachers, administrators and even education policy-makers) as well as on the family side, since many parents disapproved of the open discussion of sexual matters with children and adolescents. In addition, the advocated safe behaviour (i.e. abstinence), did not appear credible to older students, while the younger ones accepted it more easily, in so far as they were not directly concerned – but not necessarily as a sustainable behaviour rule;
- *Out-of-school education:* the most serious problem was the lack of contact between educators and out-of-school youngsters, especially girls, and illiterate young people, making it very difficult to develop peer education between educated and non-educated young people in different age categories;
- *Illiterate populations:* women in particular should receive specific well-targeted educational messages, as they are particularly susceptible to a higher risk of infection as a result of situations where they cannot refuse sexual relations.

Communication (non-media)

Communication, in the sense of a non-mediatized information process, is an exchange of information between both professional information advisers/counsellors and key representatives of the population. The general communication process, however, does not incorporate measures necessary for the appropriate exchange of information with respect to prevention at the level of young men and women exposed to the risk of HIV. These measures must integrate a much "warmer" approach to the issue, characterized by mutual confidence, empathy and a full appreciation of the cultural references and resources of the given population.

In this respect, the UNFPA Evaluation Report "IEC Findings" (1999) emphasized the following deficiencies and unmet needs:

- Counselling should always go along with testing, not only to make people aware of the risk, but also to inform them about their infection and help them to make life plans for the future;
- Counsellors often lack commitment and listening skills, as they spend too little time in individual sessions. They do not know how to behave when infected people have negative reactions. Finally, they do not feel at ease when discussing sexual issues, especially with young people who have their own way of expressing their rules, practices and needs.

Advocacy, which means positive recommendations of safe attitudes and practices, including the use of condoms, often lacks support from political leaders, communities, parents and other "gatekeepers". There is a serious deficiency in the design of communication strategies, which aim at building a political will and a supportive societal and cultural environment, in order to make advocacy more acceptable at all levels.

3.1.3- LESSONS LEARNT FROM IEC ACTIVITIES TO DATE

All cooperation institutions recognize the principle of Participatory Development, but it appears that it takes time to put the principle into practice. Implementing participatory activities would be an asset to prevention and care projects, even though this principle has not yet been translated into IEC activities.

The two major reasons, which help to explain the present situation, are the following:

- Institutions underestimate culture as the essential force which triggers development in general, information/education/communication in particular;
- Local populations do not really subscribe to institutional approaches to HIV/AIDS issues and do not integrate IEC messages into their thought and behaviour patterns.

Institutional actions to date need to be re-assessed with respect to *media* systems, *school and non-school education and communication processes* between institutions and populations. Major elements have been identified in both the UNFPA *Evaluation Report* (1999) and the UNAIDS *Communication Framework on HIV/AIDS* (2000).

The prevalence of institutional culture, and its excessive confidence in "scientific" methods in education and communication, account for part of the problem. However, the major weakness in the institutional approach is its lack of understanding of cultural references and resources leading to an inefficient remodelling of strategies and methods. Most of these are still grounded in a rational set of theories and models of sexual behaviour change (epidemiology and sexology-oriented).

Given the present situation, it is important to investigate, and thus better understand cultural references and resources.

3.2.- UNDERSTANDING CULTURAL REFERENCES AND RESOURCES

Cultural references and resources may be better understood through major methodological approaches, such as in-depth case investigation and pilot projects.

3.2.1- IN-DEPTH CASE INVESTIGATION

An in-depth investigation of field situations requires the following tasks:

- Identifying cultural features/references and resources, including religious, spiritual, ethical values, taboos, which interact significantly in preventing or expanding HIV/AIDS, medical and non-medical care to infected and sick people;
- Assessing the specific role of these references and resources in securing the relevance and efficiency of the current prevention and care actions;
- Improved analysis of the interactions between culture, the evolution of the HIV/AIDS virus and general development problems and policies;
- Identifying the specific needs of disadvantaged risk groups and the methods needed to address their problems through the cultural approach.

3.2.2- EXPERIMENTAL WORK, PILOT PROJECTS AND INNOVATIVE ACTION

Research will have to be complemented by experimental action through various systems:

- Promoting participatory process, community support and care for people with AIDS (PWAs), PWA networking and initiatives, interactive learning and communication among the sick and between the infected and non-infected;
- Enhancing, through all IEC channels, awareness, a sense of responsibility, mutual respect, emotional attachment and compassion, up-dating cultural traditions and references, mobilizing traditional knowledge and spiritual resources;
- Mobilizing traditional knowledge, spiritual resources, empathic attitudes and customary solidarity towards preventive action, medical and human care for infected people and PWAs, in order to gradually eliminate frequent rejection and stigmatization practices.

3.2.3- ASSESSING CULTURAL/SOCIETAL COMMON TRENDS AND DIVERSITY

The elaboration of culturally appropriate information/education/communication material and activities has not been sufficiently based on the cultural and societal references and resources of the various target populations. It is therefore necessary to assess their efficiency, adaptability and sustainability with respect to the preparation and implementation of preventive and care action in order to achieve behaviour change.

In this perspective, it is necessary to identify cultural/societal common trends and diversity in a given geographical area.

Common trends

Identified common trends are above all related to the perception of risk: widespread awareness versus insufficient understanding of the epidemic is a recurring theme in prevention and care. As HIV/AIDS is not a purely medical problem, but a complex socio-economic and societal/cultural phenomenon, socio-economic conditions impact heavily on societal/cultural references and resources and, therefore, on HIV/AIDS.

The impact of the disease is multifaceted, whether in the economic and social field or in cultural and societal systems. The latest analyses have identified HIV/AIDS as a world destabilization crisis, which impacts on family patterns, rural traditional cultures, women's and young people's status, above all through the global urban explosion.

Societal/cultural diversity

Given the multiple aspects of diversity encountered on the field, prevention and care actions to date have been relatively inefficient. Large regional societal/cultural areas with specific issues can be identified. Other major aspects of cultural diversity are related to traditions, religious beliefs, representation of health and disease, life and death, sexual norms and practices.

Culturally fragile groups vulnerable to risk are generally the poor, women, children and young people. Smaller groups specifically at risk include youngsters exposed to street subculture, mobile professions,

sexual workers and homosexuals.[3] The culturally specific systems affected by the epidemic include family, men/women relations, and community links disrupted by migration.

3.3- NECESSARY CONDITIONS FOR SENSITIZATION/MOBILIZATION THROUGH EDUCATION

The most important issue in bringing about change in behaviour is the **identification and mobilization of the motivations** of a given group. According to observations by high-level medical and IEC specialists, the actual content of messages is not appropriately disseminated and applied. These messages are devised to give people a clear understanding of the origins and manifestations of infection. Unfortunately, though these messages may be learned and "memorized" from an intellectual standpoint, they are neither appropriated by the given target group, nor integrated into their everyday habits and behaviour. Therefore, **understanding the message does not entail an inward conviction,** which would make people modify their sexual and non-sexual practices regarding HIV/AIDS. Therefore, cultural references and resources play a more important role in the development of perceptions and attitudes for communities, groups and individuals, than the medical, educational, or institutional approach.

3.3.1- MASS MOBILIZATION: FROM DUTY TO CONSENSUS

First, a fundamental distinction has to be clearly established between institutional action/reaction and society's response:

- Through their professional culture, **institutional networks and agents** play a certain role in interpreting decision-makers' instructions. To this extent, institutional echelons and their staff are used to implement instructions from above, which they understand and integrate through their training, experience and institutional culture. This includes HIV/AIDS Prevention and Care policies and projects. Thus, a fundamental "rethinking" effort is necessary in order to shift from carrying out plans and instructions in a top-down process to adapting working methods to people's cultures and life habits. Innovative training/sensitizing methods and curricula have to be developed for professionals working in specialized agencies and institutions;
- As demonstrated through the many examples given in country assessments, **civil society** has recourse to its own cultural references and resources, before modelling its response to the challenge and the institutional pressure to change behaviour. Thus, the response will be built on the basis of group and personal consensus, acceptance, conviction and motivations. More precisely, its cultural references and resources (i.e. knowledge and perceptions, traditions, beliefs, and behaviour norms) will be the foundation of new cultural practices, which will respond to the constraints and evolution of the socio-economic environment.

Therefore, **community-based project clusters** will have to be built on a fully participatory basis, with local key leaders, informants and families, including the HIV-positive and even sick persons. People will mobilize themselves only if they are reached where they are and on an equal footing.

3. For more detailed analysis of common trends and diversities see our publication "Summary of country assessments", UNESCO 2000.

3.3.2- IEC PARTNERSHIPS

IEC partnerships will have to be tailored to people's knowledge, value systems and cultural acceptance. Efficient IEC will only be secured as a two-way information system, which integrates local values and knowledge with modern medical data and explanation system. These must be phrased and conveyed using the appropriate language (international, national and local) and semantics of the group in question and not the purely medical, epidemiological and sexological terminology:

a) In matters of mobilization, the role of **religious communities, social movements** (women, young people, sports associations, etc.), **labour, trade and business unions** will be essential. They convey their own value systems, and will evaluate HIV/AIDS prevention and care activities according to their own spiritual, ethical and practical mandates and duties;

b) **Traditional cultural leaders**, more specifically **traditional healers** may also be consulted to establish links with the modern-type medical and educational system. It is indispensable to consider their role in prevention and care, because many people consult them when afraid of being infected or effectively HIV-positive, not only as medical experts, but also as social and psychological advisers. They play a recognized role in South Africa and Zimbabwe, Western Africa as well as in other types of societies;

c) **Individuals:** advocating abstinence, monogamy and condom use raises complex practical and moral issues. These will only be accepted if people's principles, sexual culture and real life conditions fit with such practices. The same difficulty arises in the transmission of the infection and disease to a sexual partner (or partners). Notification in this case means breaking taboos, models and losing "prestige". Moreover, traditional family rules can impose silence on the subject, especially with respect to women and girls;

d) **Risk groups**, or culturally and socially endangered groups, are susceptible to socio-economic, educational and cultural factors, which interact dramatically with medical and health issues. These groups are endangered by various types of difficulties at the same time, all of them with seriously destabilizing and segregating effects: massive unemployment, poor or absent housing, economic distress, lack of education;

e) Each of these factors is aggravated by a **general societal/cultural destabilization**. This could be due to migration, rural decline, instability in certain countries and regions, prominence of short-term economic strategies in production activities, fast urbanization, as opposed to the much slower pace needed for cultures and societies to build new configurations in response to change;

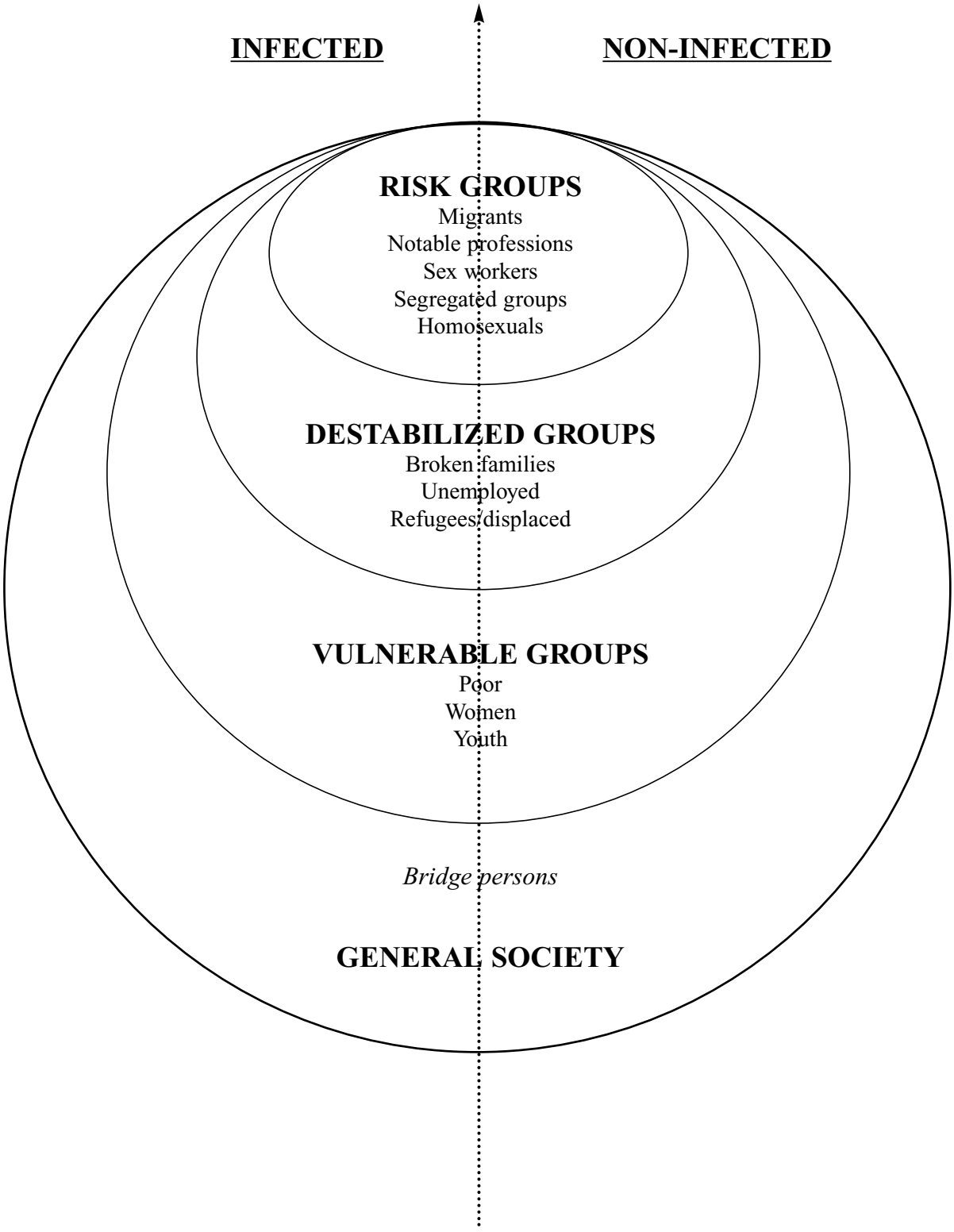
f) In this context, unsafe practices, refusal of the condom use, drug abuse and smuggling, alcoholism, sexual and all forms of violence, prostitution and procuring are all aspects of the emerging sub-cultures, which are linked to mere survival concerns in a world of brutal power and materialistic interest. They may create serious obstacles to HIV/AIDS prevention and care, and subsequently, must also be addressed in order to reach significant results in fighting the epidemic.

3.3.3- APPROPRIATE MESSAGES AND PROCESSES

It is against this background that **major lines of culturally appropriate IEC messages and processes** (including the use of local languages and modes of expression) have to be defined and qualified in order to design and implement the following strategies:

- Initiate mass mobilization in institutions, the society, families and individuals;
- Raise public awareness towards behaviour change;
- Develop proximity relations between the prevention and care system and populations;
- Cooperate with the civil society, religious communities and traditional healers;
- Build community-based prevention and care projects;
- Elaborate or adapt training systems for planners, civil servants, the media, school- and non-school educators, social workers and medical staff;
- Support new creativity linked to HIV/AIDS (preventive/informative creative material, literary and artistic initiatives) improve its correlation with sports;
- Give special attention to endangered groups;
- More in depth investigation of the “grey zones”.

4- IEC AUDIENCE IDENTIFICATION (VULNERABLE AND RISK GROUPS)



4.1- PEOPLE, VULNERABILITY AND RISK

From the initial infection to the development of the disease, HIV/AIDS produces dramatic consequences on the socio-economic, societal and cultural environment of the infected people and their close family or sexual/emotional partner. For example, loss of employment; rejection by spouse or partner, family, community; disruption of inter-personal relationships due to guilt and shame; taboo, social stigmatization and fear from his/her human environment.

4.1.1- ECONOMIC AND SOCIAL IMPACT OF THE INFECTION

For the general population, the infection means either the development of free care systems or less expensive medication, as well as physical and cultural accessibility to medical centres or specialists. Frequently, it results in unemployment for infected people, making it impossible for them to provide a living for their families, villages or tribes, especially in poor areas and emigration countries. This is often the case in Southern Africa and countries bordering Thailand.

The case of orphaned children illustrates the interaction between the disease and its socio-economic dimensions. If a parent dies of AIDS, the orphan child is often taken care of by the family (i.e. grand-parents) within the limits of their resources. In other cases, widowed mothers and their children may be expelled from their homes and/or abandoned in the streets. In these circumstances, the children are more susceptible to enter into high-risk situations (malnutrition, gangs, early prostitution, etc.). Assistance to orphaned children is dramatically insufficient, especially in African countries, where AIDS related mortality is the highest in the world.

4.1.2- CULTURAL/SOCIETAL IMPACT OF HIV/AIDS

Many infected people remain unaware that they are HIV-positive, because testing systems are far from being available everywhere. When detected through HIV screening, the short- and long-term societal and cultural effects are generally disastrous for them and their families (or group). The professional and social rejection of the infected and sick frequently results in a serious crisis: destruction of personal and community ties, and deep moral, cultural and economic distress.

For these reasons, infected people often tend not to inform their spouses or regular sexual/emotional partner. In other cases, people are not concerned with HIV/AIDS infection due to more pressing concerns associated with their “underprivileged” socio-economic situation. As for people in economically and socially superior positions (i.e. “sugar daddies”, people with authority in business, public, or educational sectors) they tend to regard themselves as “immune” from the disease because of their socio-economic standing. Many of those with professions that involve frequent mobility do not assume their responsibility towards occasional sexual partners. These professions include: truck drivers, peddlers, sailors, soldiers, mercenaries, itinerant merchants, officials, temporary workers in mining, industrial fishing, agriculture or construction. Thus the epidemic and prostitution are highly concentrated in activity zones related to these professions, especially along national borders.

In the most extreme situations, the disease can result in an “AIDS rage”, where infected persons deliberately infect new sexual partners as a revenge or as a response to a supposed curse. Another attitude encountered among certain urban segregated groups of young people, is the deliberate

participation in high-risk activities. Although they are conscious of the risk, they perceive it as a challenge, akin to a gambling-type behaviour.

Finally, in areas where epidemiological risks are high and multiple (malaria, typhus, cholera, sleeping sickness, TB, STDs in general) and deadly dangers frequent (war zones, mined areas), people do not feel the same urge to crusade against a specific disease or deadly danger among others.

The most serious obstacle to prevention, however, is the **cultural shock** experienced by the younger generations. The brutal immersion into the urban/modern world, where new migrants, domestic or foreign, from rural and tribal or semi-tribal zones (i.e. the Upper Mekong region in South-East Asia), come together. They must at the same time face a world of materialistic interest, individualistic/selfish behaviour, harsh competition for employment, mass unemployment, poor housing or lack of accommodation, in other words daily "struggle for life".

A particularly dramatic example of this is the situation of young girls from the border zones of Thailand, with no other educational and cultural references than those of their original communities and who are thrown by commercial sex businessmen into organized prostitution.

The same cultural and human shock occurs for instance in the Dominican Republic with young girls and boys, far from intellectual, moral and even physiological adulthood, forced into prostitution for mere economic survival, because of highly insufficient education, mass unemployment and a prosperous sex tourist industry. In such situations, becoming infected results in an economic, social and cultural disaster often reinforced by drug addiction, due to mental depression, cultural dereliction and loss of vital references.

4.2- GENERAL VULNERABLE GROUPS

4.2.1- THE POOR

A lower socio-economic status renders a group more susceptible to many diseases, including HIV/AIDS. People in poor health have repeatedly been shown to be more likely to develop AIDS soon after infection with HIV. In resource-poor countries, various studies and reports have dealt with socio-economic status and other factors related to HIV/AIDS. In Thailand, for example, women with more education and greater household income demonstrated a better understanding of HIV/AIDS, than lower-income, less-educated women. There is new evidence that the 100 per cent condom policy that was adhered to by sex workers is increasingly difficult for them to uphold, due to the economic downturn in Thailand.

Knowledge of HIV/AIDS was found to be almost non-existent among respondents in urban slums in India, especially women. Another study in India found that illiteracy, linked to poverty, created a gap in knowledge about HIV/AIDS. Low socio-economic status among urban women in Argentina showed that they are particularly vulnerable to AIDS as a result of their class and gender.

Source: UNAIDS Communication Framework on HIV/AIDS.

4.2.2- WOMEN AND GIRLS

The most serious consequence of this crisis is its impact on women and young girls. High levels of illiteracy, lack of education and unstable housing for women and young girls are all factors, which increase their vulnerability to high-risk situations (i.e. the abuse of young girls, possibly incestuous). These conditions may lead to serious socio-economic issues, such as: under- or unpaid employment (especially in-home service), child labour, an increase in pregnancies among married (or unmarried) young women, or forced prostitution. Sometimes girls or, in certain countries, young boys and men, are forced into prostitution at an early age. Opportunities for stable and well-paid jobs are still very uncommon for women in many countries.

Thus, in the current gender/family patterns prevailing in most regions, illiteracy and lack of education result in the **economic dependence of women**, except in the newly emerging urban middle classes, where the nuclear family model is valued. In most cases, women with children depend on men for their economic survival – a situation seriously complicated by men's departure to find jobs in big cities and foreign countries. In addition to unwanted sexual relations and pregnancies, breastfeeding remains a prevalent habit, deeply rooted in the mother-child relationship, as a symbol of giving life and fertility. This remains an immemorial belief in traditional cultures, but also a necessity when hygienically safe milk for babies is not available. Mother-to-child infection is common in many such situations.

4.2.3- YOUNG PEOPLE

Given the demographic situation in most developing countries, young people are the majority. An incomplete or absent education and high unemployment may lead to a total lack of prospects for building a better future.

Due to this incomplete, absent or irrelevant education, most of them have no or poor qualifications when entering the work market. Unemployment is then the rule. The situation for teenagers and children (with or without parents) is made worse by insufficient housing or miserable shacks.

The massive migration of young people to cities, however, continues to grow. The **city is a mythic place** where many expect to make a living, through regular work or informal sector activities, even at minimal pay. This results in extreme poverty and the emergence of sub-cultures, possibly in the form of counter-cultures.

Many young people, who do not find jobs in the informal sector, will shift to the above-mentioned illegal activities. Even those who can find a job often live in squalid slums or hostels, isolated from their families. Heavily exposed to the "wild" urban culture, as well as to the modern market-oriented way of life, these young people are faced with restless competition, where **making money seems both easy and inaccessible**.

Under such conditions, these young people will feel segregated, concerned only with day-to-day survival. Some of them will gather in small groups, where risk behaviour will become a part of their overall situation. Drug abuse and the almost unavoidable recourse to prostitution will make them particularly susceptible to HIV/AIDS infection.

4.3- CULTURALLY DESTABILIZED GROUPS

Generally speaking, the segmentation of specific risk groups should fully consider their situation in the context of overall development: poverty, insecurity, human rights, and other diseases. In this respect,

the poor, women, refugees, minorities are at maximum risk exposure. However, more specific target audiences must be defined.

4.3.1- MIGRANTS: CULTURAL IDENTITY BREAKDOWN

An important factor in the spread of the epidemic is the movement of populations (i.e. domestic or country-to-country migration; work activities involving high mobility). Refugees, migrant workers and, in certain cases, nomad or semi-nomad tribal communities, contribute to the dissemination of the virus and to the difficulty in assessing and caring for possibly infected populations. The cultural impact of migration also affects those communities, families, wives and children, left behind in the villages.

In the mining and industrial sectors, migrant workers, who may represent the majority of the manual labour force, are specifically at risk of losing their societal and cultural identity and thus more susceptible to the virus. They can be easily lured into finding relief and relaxation in the evening, at all costs.

Moreover, most of them live in **collective hostels or dormitories**, far from their regular sex partners or wives. Thus, they turn towards prostitutes, occasional sex mates or practice women sharing. These practices are often associated with drugs and alcohol, especially among the younger generations.

Solidarity networks, however, can survive in the urban world. People belonging to the same community will possibly live in the same area and build mutual assistance systems, pressure groups and, in certain cases, semi-criminal groups. This networking often occurs among the poorest groups, where cultural identity remains one of the rare assets of otherwise dispossessed individuals.

4.3.2- DISINTEGRATED FAMILIES

One of the most critical destabilizing factors is the family pattern crisis, particularly in societies where it is the cornerstone of the whole economic, societal and cultural system (i.e. Africa, Asia, the Caribbean and Latin America).

The extended family system can be felt as an **overwhelming responsibility**. For instance, one woman or girl may find herself providing for a number of more or less close, unemployed relatives. At the same time, the extended family pattern may act as a **solidarity system**, as in the case of economic or health difficulties, drawing from its specific style, emotional support, counselling and compassion.

Therefore, both the urban revolution and the rigid nuclear family pattern (parents with 2 children) have had a significant impact on society, hence on HIV/AIDS, aggravating the situation of infected and sick people, as well as their spouses and children. Moreover, family solidarity may be distorted by the separation of parents due to economic reasons, or the excessive burden of family power structures.

Insufficient nutrition and miserable life conditions shape resistance to HIV prevention campaigns supported by inefficient sanitary or health facilities. These difficulties, of course, increase the risk of catching diseases, including STDs and HIV/AIDS. The infection then leads to work incapacitation, hence poverty, and another shock to the stability of family life.

4.3.3- NEW URBAN POPULATIONS AND SUB-CULTURES: VIOLENCE, DRUG ADDICTION AND SEXUAL CARELESSNESS

Whereas formal polygamy is traditional in certain societies, sexual intercourse with multiple partners is increasingly common in urban society. In this respect, significant differences may be noted between men and women.

The reasons men tend toward **multi-partner sexuality** are complex: separation from their families, professional mobility, and male group culture are but a few. A deeply rooted feeling of superiority expressed through the sexual "conquest" of many different girls or women, even in a short period of time, has been observed in many societies. Moreover, in the absence of other interest or leisure time activities, sex is the most obvious recreational activity among young men, for whom multiple sexual conquests are an important prestige factor.

The new urban middle class has also seen an increased number of women and girls taking on a more active social role with respect to boys and men, especially in the context of the "disco" culture as seen in South Africa.

In many fast growing cities and megalopoles all over the world, especially in shantytowns and shacks, frequent in developing countries, the role of **crime and violence** has rapidly increased since the 1970s. Parallely, the urban rush and the economically disastrous situation of most new immigrants has resulted in massive unemployment and new forms of criminal activity (i.e. drug smuggling, robbery, and firearm trafficking).

The incidence of **drug addiction and smuggling** (cannabis, cocaine, amphetamines, and other new chemical drugs), as well as alcoholism, is also increasing, mainly among young people. Some tend to be both consumers and providers of various types of "daily-life escapism" products. Masses of unemployed and insufficiently educated youngsters, then, turn to highly illegal activities, as a ready way for moneymaking. This is especially the case in popular areas where security services are frequently absent or passive.

All these manifestations of violence and the increase in crime (armed robbery, rapes, murders etc.) can to some extent be considered as **indicators of despair.** They derive from the enduring social, economic and cultural exploitation of the poor by domestic or foreign powerful minorities, and the failure of the educational systems.

Another important aspect of urban sub-culture is the growing aggressive and xenophobic attitude towards people of other cultural groups, even after long periods of cohabitation, as in the case of recent immigrants.

4.4 - SPECIFIC RISK GROUPS

4.4.1- MOBILE PROFESSIONS

Thus **professional mobility** is an important factor in the dissemination of the virus. Some professions are specifically at risk of catching and transmitting the disease (i.e. long distance truck drivers, seasonal farm workers, employed on plantations or big farms, for fruit, vegetable or grape picking or harvesting). Other professions that may be involved in HIV transmission are peddlers and itinerant tradesmen, soldiers and mercenaries and, poor students living away from home (i.e. Thailand, Uganda).

4.4.2- COMMERCIAL SEX WORKERS

Commercial sex workers are both a high-risk and a socio-cultural endangered group. Therefore, prostitutes, mainly female (in some countries, male and child prostitution also occurs), are consequently more exposed to the infection, while at the same time facing specific difficulties gaining access to consistent medical care.

For girls and women, entering prostitution often comes as a result of being abandoned by a husband/regular partner or by parents/single mothers. In the Dominican Republic, child prostitution is the obvious consequence of rural exodus to large urban areas. The ensuing structural unemployment, extreme poverty and lack of basic education are an obstacle to basic living needs. Some even find it necessary to turn to prostitution to finance their school or university education.

Moreover, due to the societal/cultural stigmatization associated with prostitution, especially homosexual commercial sex, **professional sex workers cannot refuse unsafe sexual practices** and frequently, when infected, **cannot identify their customers.** Young girls forced into early sexual practices are also at risk, mainly because older men or "connoisseurs" are keen on having intercourse with virgins. Some young prostitutes may even have been forced into sex within the family group or raped by infected men for sexual "cleansing" purposes. In addition, among the poorest populations, women can turn to occasional prostitution as an informal means to pay for food or transportation.

Other types of prostitutes are "thrown" into **brothel prostitution,** without any previous life experience, away from their village or tribe, in exchange for money to the family or local procurers, solely because the sex industry wants "fresh meat".

Nevertheless, a feeling of solidarity against HIV/AIDS is emerging in the commercial sex industry of certain countries (i.e. the Caribbean or Latin America). Prostitutes, including transvestites, are striving to build **groups and associations** in order to develop contacts with public authorities, notably the public health system, to gain access to protection and care facilities. Condom use is often advocated among sex workers and their customers. Unfortunately, extra payment for unprotected sexual contact makes it difficult for prostitutes to refuse these dangerous practices.

4.4.3- HOMOSEXUALITY AND SOCIETAL/CULTURAL ACCEPTABILITY

Although female homosexual practices and communities do not appear to be much discussed in relation to HIV/AIDS, discussions on male homosexuality provoke strong reactions, not only with respect to the medical aspects of the epidemic, but mainly due to issues of societal and cultural acceptability.

The main reason for this is historical. The first cases of AIDS were identified among gay communities in North America and in some West European countries. Thus, the fear of the disease was intensified by the negative societal and cultural attitudes associated with homosexual relations, which stemmed from moral principles surrounding the role of male/female relations in society. Patriarchal and Christian societies, in particular, view male/female relations in terms of human reproduction and trans-generation continuity.

In the western world, male homosexuality has developed into a legally protected, recognized and accepted way of life. This evolution, which started in Western countries, is currently extending to

certain developing countries, in spite of the negative societal/cultural image of male homosexuality (i.e. Jamaica, Thailand and certain Latin American countries).

In response to the HIV/AIDS epidemic, **collective movements, associations and pressure groups** are now asking for civic recognition and assistance from health systems, solidarity movements and projects, especially with respect to preventive education, medical and social care and support to the sick. Homosexual communities have developed highly motivated and efficient medical, social and psychological support systems in a number of Western countries.

4.5- INTERFACE WITH THE GENERAL SOCIETY

When discussing HIV/AIDS prevention and dissemination, it is inappropriate to speak only of risk groups, one should rather emphasize **responsible or irresponsible behaviour** in matters of prevention and care. This is often more relevant than pointing to specific social, societal and cultural groups or minorities as the only ones responsible for the dissemination of the epidemic.

In reality, the epidemic is disseminated among people, regardless of their association to a specific "risk group". As underlined in a recent UNAIDS publication Looking Deeper into the HIV Epidemic (1998), if people mix within relatively **closed groups** (the so-called risk groups), HIV may spread quickly among them, but will have a limited impact on the population as a whole. If, however, there is **more widespread mixing** between members of these groups and supposedly non-risk categories of the general population (i.e. spouses or regular partners), the disease may take off slowly, but will penetrate many more sectors of society. Moreover, members of so-called risk groups may in fact be HIV-negative and conscious of the risk, while infected members of general society will act irresponsibly and infect their casual mate or partner. Bridge populations, which form a link between otherwise unconnected groups, may be of particular importance for the dynamic of the epidemic, by linking low and high risk populations through their real practices.

4.6- CONCLUSIONS

a) Though there is worldwide awareness of the danger, it is not enough to motivate people to adopt significant changes in their sexual and non-sexual behaviour with respect to prevention and care. This is due to non-medical or health-related factors, which must be better understood and integrated into new strategies. Moreover, information methods are often unsuited to the understanding capacity of a given population.

b) HIV/AIDS is in permanent interaction with people's cultures and overall socio-economic development.

c) These interactions, as any two-way process, develop situations and obstacles, which prevent medical and informative action from being fully effective. These can be summarized as follows:

- economic and social development issues heavily influence the spread of the epidemic, in so far as they seriously affect people's life conditions;
- socio-economic evolution also seriously impacts on societal/cultural previous value systems and life models, especially in developing countries, mainly through population movements, migrations, miserable housing and living conditions, thus aggravating infection risks;

- HIV/AIDS in turn develops important economic, social/societal and cultural effects.

d) Thus, reliable prevention and care IEC has to consider the relationship between cultural references and resources, and socio-economic development issues.

5- APPROPRIATE IEC: COMBINING ELABORATION AND DELIVERY

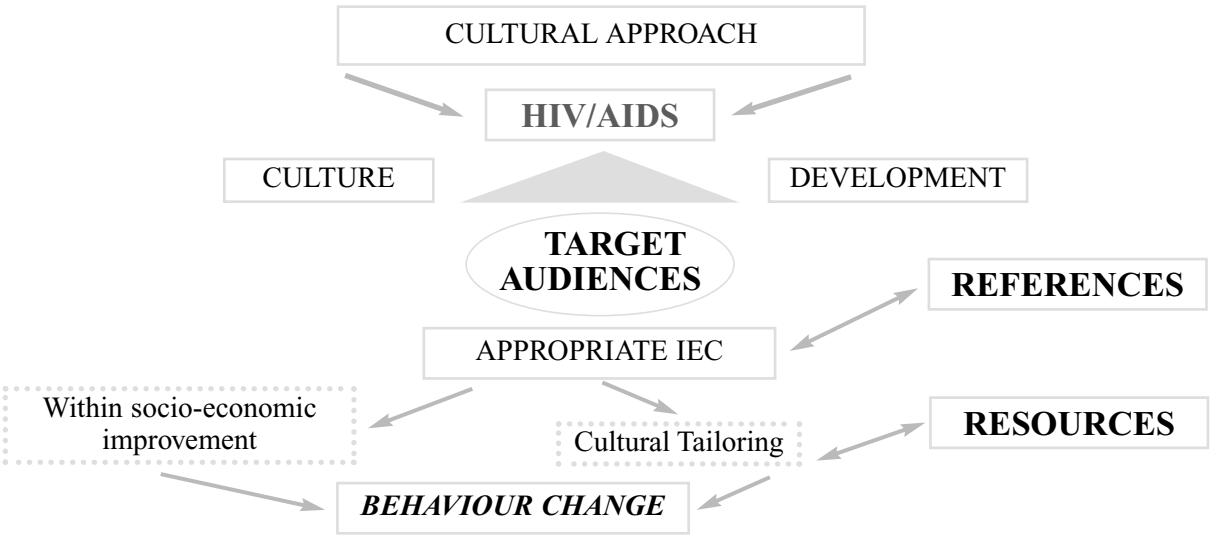
A national AIDS programme should provide HIV/AIDS education to all schoolchildren

Obstacles to HIV/AIDS education in school include:	Ways to overcome these obstacles include:
• The subject is considered too controversial • The curriculum is already overloaded • Education may be limited to certain age groups • Behaviour skills are not taught, only facts about AIDS • There may be only partial coverage in a country	• Designing a good curriculum adapted to local culture and circumstances • Establishing a partnership between policy-makers, religious and community leaders, parents and teachers • Establishing sound policies on AIDS education through this partnership

Source: UNAIDS, 1997: Learning and teaching about AIDS at school, p. 2.

In its more general sense, communication is a **process** of exchange of information and questions between two or more people or groups. In this respect, it can describe any activity carried out in the more specific fields of mediatized information, education or live process of delivering knowledge or values and receiving in turn new elements of other categories of knowledge and values.

As a consequence, the **elaboration and delivery** of any type of message are part of a wider system of communication, the different phases of which cannot be separated without losing their specific characters. This is why any culturally appropriate action in information/education/communication should be viewed in this comprehensive framework. In this respect, *UNAIDS Communication Framework on HIV/AIDS* should be considered as a key strategic document.



5.1- MEDIA INFORMATION

Generally speaking, **radio and television channels** broadcast mainly general non-targeted information on HIV/AIDS Prevention and Care to a vast media audience. Their impact, even if significant, is limited by several factors. These limiting factors, although sometimes technical, are generally due to the form and content of the messages, which are not tailored to be understood and integrated by a diverse population. Moreover, depending on local conditions, radio receivers may be widely available, whereas, for economic or technical reasons, television sets are not as easily accessible. Finally, generalized media messages may advocate irresponsible and high-risk behaviour, possibly leading to contracting or transmitting the infection, hence counteracting the effort of specialized HIV/AIDS programming. For these reasons, in spite of their potential to mobilize the public, mass media in many regions have not yet been optimized to facilitate the development of a massive, national or regional response to fight the disease.

However, **local radio programmes,** whether urban or rural, are increasingly being developed, through a community/participatory approach. Their technical simplicity, low purchase and production costs, make them a well-adapted instrument to facilitate participation and the exchange of information and experiences through easily accessible discussions.

An example of this type of project is being developed in Southern African countries, under the general name "Women Speaking to Women". It consists of establishing a radio station owned and managed by **women's associations.** The general idea of these projects is to enable the more educated and enlightened women in the community to help inform and educate other less fortunate women about current daily life challenges and their consequences. These programmes are of course phrased using appropriate wording and language.

New training initiatives are also being developed. The challenge is to prepare journalists, and other media professionals, to use media resources to arouse, mobilize and sustain public opinion to support efforts against harmful practices. The initial step in this process involves generating interest, awareness, knowledge and understanding among media practitioners about the disease, its modes of transmission, prevention and management. It also promotes their commitment to the effort in prevention and control of the spread of the epidemic.

Preventive information: a UNESCO project

In response to the need to inform journalists and media professionals of their responsibility concerning HIV/AIDS, in 1998, UNESCO initiated a Project on Preventive Information based on investigative journalism and HIV/AIDS in Eastern and Southern Africa. The project objectives were:

- To identify pertinent trends in the region which contribute to the spread of HIV/AIDS.
- To carry out an in-depth investigation on the relationship between these trends and the prevalence of the disease.
- To study the extent to which the incidence of HIV/AIDS is reported in the media.

Source: Media & HIV/AIDS in East and Southern Africa, UNESCO, 1999.

5.2- EDUCATION

5.2.1- UNESCO PREVENTIVE EDUCATION IN RESPONSE TO HIV/AIDS

In its new strategy for preventive education in response to HIV/AIDS, UNESCO identified new criteria and priorities for improving preventive education. In particular, it paid specific attention to evaluating the effectiveness of existing preventive education strategies and the generalization of the best practices. Emphasis is placed on changing risk behaviour through the promotion of formal and informal education programmes directed towards pupils, university students, out-of-school youth and adults. These programmes will be complemented by more intensive campaigns using different media, including booklets, press information and radio messages in an effort to mobilize opinion leaders.

5.2.2- EDUCATION AND CULTURE: A CONTINUUM

In conceptual terms, education and culture can be understood as a homogeneous field of human activity, defined as the creation, transmission and preservation of knowledge, know-how and value systems of a given society, in relation to its past, present and future evolution.

Thus, given the diversities of groups concerned, designing, implementing and evaluating education policies and educative action is a cultural challenge, which requires a cultural approach. Since education is primarily aimed at children and young people, there is a need to combine urgent action with a long-term perspective.

School education is, however, only one component of the education process, which also develops through other channels: family, community and society in general. As modern life models and instruments penetrate deeper and deeper into the international, national and local social fabric, the media are and will be as important as school education (if not more). Moreover, education, in a broad sense, is a life-long process, which involves all generations and is conveyed through all communication channels.

Tailoring school education to culture

Is the school education system adequate? This issue will be efficiently addressed only if actions are adjusted to actual circumstances and needs of, not only easily accessible groups, but **under-served populations** as well (i.e. the poor, street and working children, rural and remote populations, migrant workers and nomads, indigenous people, ethnic, racial and linguistic minorities, refugees, displaced persons, the disabled, populations living under foreign occupation).

Moreover, appropriate education will enable people to build upon their common cultural, spiritual and linguistic heritage. It will also pay attention to the diversity, complexity and changing characteristics of children, youth, and adults, in-school and non-school education. Thus, education should adapt itself to conditions and circumstances at the local level: language, participatory development, family and community support, traditional educative system, societal, cultural and ethical dimensions of the education process. More specifically, it should build on child and youth life conditions, cultural references and resources thus establishing priority systems and motivations for change.[4]

4. *World Declaration on Education for All and Framework of Action to Meet Basic Learning Needs*, Jomtien, Thailand, 1990.

Adult education

Many adults and sexually active young people are working for daily survival and hence cannot access preventive IEC through the school system. It may be appropriate to develop IEC targeting them in their work or in other places through adult education activities.

Women's education should also be reconsidered from this perspective, in order to reach them where they are (in their village, market places, nursing consultation centres, workplace, church, services, etc.).

South Africa: the work place: a strategic site for prevention

Two examples of successful prevention programmes are given in the handbook elaborated by the South Africa Health Department for developing a workplace policy and programmes on HIV/AIDS and STDs. These examples are described as follows:

David Whitehead Textiles: "to show workers that the company cares"

The main points in this example are the following:

- production of a theatre play and a comic book in various languages and places, including theatre rooms, night clubs and school halls;
- informal information and advice to employees, individually or in small groups, including sex workers, possibly outside working teams, in bars and beer-halls, farms or local soccer matches.

STD cases in the company decreased by about 50 to 75% from 1989 to 1992 due to: the wider distribution of condoms, less male sexual "wandering", the collaboration between management and employees, staff education.

Mutare HIV Prevention Project (Zimbabwe)

The Health Department of MUTARE City, where 20,000 cases of STDs were already treated in 1990 (25% of the adult population) is developing a prevention programme focused on high risk groups and formal sector employees. Meetings with peer educators are held in social settings, including beer-halls and sports fields, in meetings and at work. The educators were selected on the basis of age (18-30 years old), enthusiasm and capacity to communicate and give information. The STD rate fell by 48% within the first year of the programme.

Source: A cultural approach to HIV/AIDS prevention and care, South Africa Experience, UNESCO, 1999.

5.2.3- FAMILY EDUCATION: AN UNDERESTIMATED POTENTIAL

In all societal and cultural traditions the role of the family (fathers, grandfathers and relatives) has been essential in the education of children. Today, all societies undergo a process of modernization, which may lead to a family pattern crisis, particularly with respect to education. School, the social education system and "street life" have therefore, substituted the family's role.

Angola: Sexual education, traditional family values and HIV/AIDS

Family education, in general, exerts an indispensable influence on youth behaviour. However, HIV/AIDS is very rarely discussed between parents and children, in so far as sex issues are considered "taboo". From a study carried out in Luanda among teenagers aged 14 to 20, it is demonstrated that most of them do not talk about sex with their parents. Generally, this subject is tackled with friends, school acquaintances or partners. According to some authors, parents avoid this issue, because they believe it encourages the early practice of sex.

As regards family patterns, the idea of the family in Angola is very complex, due to the diversity of patterns of family organization. The idea of family brought from European countries does not fit with the local reality, since it is narrowly related to the socio-cultural context of each group, community or society. The traditional idea of family encompasses criteria of blood, marriage links and sometimes housing.

Family is the space where children get along with their siblings, where community norms and values are transmitted and social control is exercised. (Locoh, 1988). Therefore, the family may exert control over sexuality.

Likewise, kinship systems may influence sexual behaviour. For example, in a matrilineal system, male sexual dominance is weaker because of women's control over domestic production. Thus, this system contributes to the autonomy and even independence of women.

Concerning the structure of the household, the control over sexuality would be more severe in the extended families in which, unlike nuclear families, several generations live together.

The loss of traditional values regarding sexuality is another critical factor in HIV/AIDS prevention and care. Angolan traditional societies have suffered severe changes as part of the "modernization" process. These transformations have led to the loss of some traditional cultural norms and values that once influenced individual sexual behaviours. Urbanization and formal education moved individuals away from their groups. Then decisions regarding sex became an individual issue rather than a family or community subject.

The socio-economic crisis has exacerbated these transformations. Nowadays elders have progressively less control over youth, and men have less influence over women. Some cases of family deterioration have forced the children to leave their homes and live in the streets, where they have to set up their own strategies to survive. Prostitution, drug trafficking, delinquency and other high risk practices and behaviour are prone to facilitate the spread of HIV/AIDS.

Another study shows that sexual education at school can influence youth sexual behaviour (delay age of starting sexual relations and increase the use of condoms). Sexual education programmes at schools are more effective when social norms and responsibilities are highlighted. However, these programmes should be completed before young people have had their first sexual experience.

Source: A cultural approach to HIV/AIDS prevention and care, Angola's experience, UNESCO, 1999.

5.2.4- RELIGIOUS AND TRADITIONAL CHANNELS

However, in the present HIV/AIDS crisis, it appears that, as compared with other IEC systems, the family remains an irreplaceable educational system. Thus its role should be re-emphasized, and preserved when collapsing. Family education should permanently interact with the school system (parents' association), civil society movements and cultural and spiritual authorities within the framework and critical eye of the mass media. At the same time, its norms should be reconsidered in the case of taboo and subsequent silence concerning sexuality between parents and children. Sensitization should be developed in this respect towards parents and other family "leaders". More specifically, the role of mothers should be better emphasized and promoted as a key element in family education.

Among the most culturally appropriate IEC processes is the role of religious beliefs and communities. The social prestige and activity of traditional leaders and healers should be considered as crucial in culturally appropriate education for HIV/AIDS prevention and care.

The role of religious beliefs and the community in information and care

As seen in the various country reports, religious beliefs are closely related to representations of HIV/AIDS, its causes and effects. The spiritual and moral attitudes associated with these beliefs may be used to develop responsibility towards oneself and others with respect to the infection, and may also develop solidarity toward infected and sick people. Such solidarity is more specifically active among certain religious communities and spiritual leaders, for instance, Christian missionaries and Muslim Imams.

One of the most original initiatives in enhancing IEC through the appropriate use of religious beliefs and community links was developed through the Islamic Medical Association in Uganda (IMAU). Its network includes a great number of mosques active in this field all over the country.

Uganda: AIDS education through Imams

"AIDS Education Through Imams" arose out of the need to increase awareness of the HIV/AIDS prevention and control message in Uganda's muslim communities. Designing the project was a complex task because of the social and cultural diversity in the various regions of the country. Different groups tend to receive and perceive these messages differently. Moreover, spread of AIDS information remained largely inadequate and often inaccurate.

In order to allow more appropriate IEC work, the Islamic Medical Association of Uganda (IMAU) launched a creative initiative to implement the multi-sector AIDS control approach. Uganda's government adopted this strategy after having realized that AIDS was not only a health issue but also a social, cultural, and economic issue that needed the collective effort of other institutions and sectors. The high level of HIV/AIDS awareness and the declining levels of infection are the direct result of the commitment of persons and institutions who chose to confront the epidemic, through integrating Islamic religious values and wisdom with scientific medical information on HIV/AIDS.

Source: UNAIDS Best Practice Collection, Case Study: Uganda, October 1998.

In Thailand, certain Buddhist monks are involved in the care of PWAs, especially women and prostitutes who cannot go back to their villages or families.

Thailand: Buddhist monks, women and PWA

Among various aspects of HIV/AIDS in North and Northeast Thailand, the involvement of Buddhist monks in the care of PWAs differs, depending on the overall situation in each region.

In the Northeast, the migrants who contracted HIV did not go back to their village. They were afraid there would be discrimination against their family. In the same region, forest monks cared for some PWAs who, during the rice transplanting season would return to their villages to help their parents with transplanting, hiding their illness. One woman who admitted to having AIDS and returned to help her parents was originally made to stay in a small shack in the rice field, outside the village, but gradually the villagers came to believe she didn't have AIDS because she didn't die.

Often women would not return home because their parents and children depended on them, and they did not want to be a burden to their parents. Not only were the daughters unable to support their parents but, in their opinion, they would have been a drain on the parents' resources.

In the Northeast, some forest monks, who were not an integral part of a larger village social structure, took care of PWAs with whom they were not connected. In the North, monks in the Chiang Rai area were linked to the people and the village. In the rural areas, monks were very respected and accepted by families. They would go into the village to visit sick people, especially PWAs and their families. The monks would instruct these families on how to care for the PWAs. Monks also cooperated with the hospital, where they visited patients and maintained a consulting room for counselling.

The difference in the cultures of urban and rural areas made a difference in how monks dealt with PWAs. In rural areas, people had time to look after their families. In urban areas, people had little time. Thus monks often took in PWAs no one else would look after.

In some places, it was difficult to have PWAs in the temple, because they were associated with sex and an "unclean" disease, which was perceived as diminishing the "purity" of the temple. This is why, in the Northeast, the forest monks, who are not in the temples, can serve as caregivers to PWAs.

Source: Cultural factors in the transmission, prevention and care of HIV/AIDS in the Upper Mekong Region (Chiang Mai Workshop, June 1999).

Traditional medicine and HIV/AIDS

The Zimbabwe National Traditional Healers' Association (ZINATHA)

ZINATHA is the coordination body of the 45,000 registered traditional healers, recognized by the Traditional Medical Practitioners' Act of 1981. Traditional medicine is extensively practiced in Zimbabwe, especially in rural areas, whereas modern medical facilities and trained medical doctors and nurses are limited in number. Traditional healers, together with chiefs and headmen, are the custodians of the indigenous culture and the first recourse for treatment among an estimated 80% of the rural and urban populations.

In addition, they act as community counsellors and are accorded a high degree of respect. Traditional healers treat a wide range of illnesses including AIDS-related indispositions. The Ministry of Health, together with ZINATHA, launched a series of health education workshops on HIV/AIDS for ZINATHA members. This exercise marked the beginning of ZINATHA's involvement in HIV/AIDS prevention work.

ZINATHA has three main areas of activities: treatment and healing, research into medicinal plants and herbs, and health education.

Treatment and healing

Under this programme, activities are more supervisory than practical.

Health and education

This is a relatively new programme arising from the impact of the AIDS pandemic on the Zimbabwean population. A series of health education workshops on HIV/AIDS were launched, in conjunction with the Ministry, for ZINATHA members. The objectives were to educate traditional healers on HIV/AIDS (awareness and prevention), to increase awareness regarding traditional medical practices and HIV/AIDS, and to promote cooperation between Western and traditional medicine in AIDS Prevention and Care. Currently the programme has much broader objectives focusing on IEC activities, with special emphasis on culturally appropriate techniques, cultural stigmas and culturally controversial issues. A total of 2,150 ZINATHA members attended the HIV/AIDS training workshops. The programme's positive impact was a marked increase in the knowledge, not only on basic facts about HIV/AIDS, but also of hygienic handling of the clients. However, the HIV prevention programmes have not resulted in widespread behaviour change. Even though discussions on cultural practices take place in IEC programmes, no attempt has been made to check their impact on prevention programmes.

While more healers are discussing HIV/AIDS with their clients, the impact of these discussions has not been measured. Clinical trials continue with the Drug Control Programme and certificates of effectiveness have been issued for more than 13 herbs used in the treatment of AIDS related illnesses. There is need for proper research and documentation of cultural and social factors and how they can be incorporated into HIV/AIDS prevention programmes: for instance, documenting cultural values and teachings for use in the educational processes. Most of the values are transmitted orally and by example, but considering the existing clash between traditional and modern culture and the fast declining number of wise elders, a lot of these values will be lost. One way of preserving the values is to document and teach them in schools. ZINATHA is actually planning to set up a school of traditional medicine, which is something that will go a long way in preserving and fine-tuning the field. It will also be used for working with rural communities and mobilizing them for research and collecting authentic and useful data.

Source: Zimbabwe, country case study, April 1999.

5.3- COMMUNICATION

Besides media and education, "live" communication is the major channel for developing relevant dialogue, discussion and counselling concerning HIV/AIDS prevention, care and support. It needs openness to initiating and strengthening relations with local stakeholders, community leaders, population key informants and opinion leaders. If they respect the local culture and people's life conditions, the arts, sports and creativity can provide opportunities in this respect.

5.3.1- COMMUNICATION: AN INTERACTIVE PROCESS

Institutions should try to obtain more, and more relevant, information on the needs of the communities and the impact of HIV/AIDS on their cultures and the possible roles of those in prevention and care.

They should strive towards increased participation, partnership, and ultimately, total control by the populations of decisions concerning their responsibility and mobilization in preventing and combatting the epidemic.

Field workers are in the best position to "manage" the dysfunctions occurring in developing a two-way communication process in this respect. Their role should be re-interpreted according to these new perspectives:

- Facilitating problem identification and implementation of solutions by the concerned populations;
- Transmitting to the institutions information about the situations they are called upon to intervene, and about the identified needs of the populations concerned.

Informing/sensitizing at the local level

Informing and sensitizing activities are at the core of culturally appropriate prevention projects and of the development of new attitudes toward people with AIDS. Non-school education associations and groups can work in this perspective, provided they adapt a tailored approach using the following methods of communication:

- Discussion sessions (group or personal) with local leaders, modern or traditional, political and social (trade unions) or spiritual, including traditional healers;
- Medical/sanitary training for people working in prevention and care projects and welfare centres;
- Encouraging peer educators (individuals or groups) to speak to their family, age group, work or leisure time partners, with emphasis on prevention and care;
- Mobilizing infected or sick people to speak about their experiences;
- Opportunities: workplace, public events, sports game, cultural festivals, religious celebrations, funerals, markets, school meetings;
- Informal opportunities: discussions in bars, hostels, discotheques, sports fields, other entertainment places.

Thailand: PWAs networking for prevention and care

In 1994, PWAs began to form support groups. PWAs and these new NGOs presented other attitudes towards AIDS to the public, resulting in the government granting more social space to PWAs.

The public sphere, however, was still dominated by government and bureaucrats. Technology and medicine dominated questions of health. Inhabitants of rural areas and minorities were not part of the decision-making process. People from these groups with HIV/AIDS were doubly marginalized.

They argued that HIV required social medicine, and that this could be achieved through drawing on community culture. They believed that PWAs required love and care. This means involving the community and the family in the care of the sick. The family and the community needed to take responsibility for their members, some of whom had sacrificed themselves for their families and communities, in brothels or by working in high-risk situations. HIV/AIDS was thus viewed as a community problem, not an individual one.

This attempt to draw on community culture was successful in spite of a rapid change due to the processes of modernization and urbanization. Various PWA groups developed interesting approaches to the care of infected or sick people. Church-based NGOs initiated the "home visit" concept. Ministers, monks, and senior health people made these visits. Respected community members spoke out against the discrimination of PWAs. The visits also showed families how to care for PWAs and were a mechanism through which more information about HIV and AIDS was imparted to the community.

Both the public health sector and the NGOs helped to open up the social space. The public health authority stopped perceiving PWAs as useless and on the point of death. This helped facilitate "self-disclosure".

The public health authority also began to establish relationships and partnerships with the PWA NGOs. The government recognized that NGOs were good at grass-root level activities and these began to be used in various projects concerning HIV/AIDS. They have been used to sell the messages of AIDS work to the civil society. NGOs have also been used to foster research on traditional medical practices and to encourage the use of traditional healers. Traditional doctors now work with NGOs on how to use the traditional medicine and plants in the care of HIV/AIDS.

NGOs encouraged people to exchange their views and to benefit from their own and others' experiences. They assisted PWAs in gaining more social space. In the North, there is little emphasis on vaccine trials. PWA groups have focused on social welfare and the treatment PWAs receive at hospitals, especially when medicine is so expensive.

District hospitals have also responded more to people with AIDS, because of the work of the NGOs. The NGOs did not provide treatment: they contacted the hospital and fought until PWAs could receive medical attention, which at times hospitals were reluctant to provide. But some hospitals have become more open and now encourage people with AIDS to discuss their problems with monks and NGOs. Space has been created so that work can be done with public health sector people. The next question is how to sustain the level of activity and how to integrate PWAs into the common culture and society.

Source: Cultural factors in prevention, transmission and care of HIV/AIDS in the Upper Mekong Region (Chiang Mai, June 1999).

From participation to partnership

Participation is the most basic IEC method when it comes to developing awareness and responsibility among people, especially young men, about protecting themselves and their partners from HIV/AIDS infection contracted through sexual practices, drug consumption and violent behaviour.

Participation can be put into practice in many different ways:

- Collaboration with authorities or NGOs: this very common practice does not imply direct contact with the local population and consequently, is less effective;
- Limited on-going consultation of the local populations: this, however, will not secure sustainability;
- Mobilization of the community to prepare and implement activities;
- Peer education/information/communication: this is in principle the best possible channel, but it can result in rivalries and conflicts if not well moderated.

Partnership represents an optimal balance in the relationship between external agents and the population, until a local team is ready to take full responsibility.

In both cases **two conditions** should be met:

- Enough time (and, therefore, funding) to achieve full participation;
- Communication between the field of action and institutions should not be too slow and unduly formal so as to prevent institutions from misunderstanding available resources and issues facing the community.

Uganda: The Aids Support Organization (TASO)

Created in 1987 by Ugandans to provide psychological support to people living with AIDS, TASO is meant to contribute to the process of restoring hope and improving the quality of life of people and communities affected by HIV/AIDS. By 1994, TASO had expanded to seven districts of Uganda and was providing counselling, medical care and social support to 22,795 people with HIV/AIDS and their families. In addition to providing a care package, TASO also offers training in counselling, provides material support to clients and their families, and supports community efforts in responding to the AIDS epidemic.

TASO gives a good example of using the cultural approach to the problem of HIV/AIDS. The social and psychological support provided by the organization includes a very high level of participation. All the stakeholders, the clients, community and staff contribute to the design, planning and implementation of the programme activities. This participatory approach enables the stakeholders to get a sense of ownership, to build capacity and to define concepts and methods related to living with HIV/AIDS and to involve people in the evaluation process.

Through counselling, TASO empowers people to cope with the problem. However, those infected and affected must accept being HIV positive and take on a positive attitude towards the prospect of a shortened life expectancy. This way, counselling helps clients to cope with the infection. Counsellors and clients discuss topics related to coping mechanisms. The end result is a very high level of acceptance by the concerned persons, their families and communities.

In matters of medical and home support, TASO provides treatment for opportunistic infections. Care comprises medical treatment, counselling and nursing care. In 1993-94 twelve of the fourteen Focus Group Discussions were satisfied with TASO medical services. The majority of the clients sought early medical treatment (i.e. within two weeks of onset of symptoms).

Social support services essentially involve PWAs and their families receiving material support (food, clothing, day care centre activities for people with AIDS, income generating activities), and support to needy children in school sponsorship programmes. These services are well intentioned, but they are sometimes affected by lack of funds.

Source: Cultural factors in the prevention, transmission and care of HIV/AIDS in Uganda, June 1999.

Creativity, sports, HIV/AIDS prevention and IEC

If people, in particular the young, tend to pay little attention to official or traditional channels of education and information, they may be more likely to listen to their favourite artists and sportsmen.

Creativity is already emerging in artistic and cultural circles in the context of HIV/AIDS and its consequences: it deserves to be better known and publicized.

Following the lessons learnt from the "Arts in Hospital" project, carried out during the World Decade for Cultural Development, group initiatives focusing on HIV-positive patients and PWAs should be enhanced, whether in hospitals or in their daily life environment.

The interest of young people in **sports** and its cultural significance has opened new opportunities for developing original IEC initiatives.

South Africa: Sports passion against HIV/AIDS (the LADUMA Project)

A photocomic was initiated by the National AIDS Committee of South Africa to use the passion for sports (especially soccer) among young South African boys, to raise awareness about HIV. **The scenario** deals with what happens to a young African from Khayalitsha, "who has big dreams for the future and a beautiful

girlfriend to share them with". Moreover, he is a brilliant soccer player, who may "head for the top of the soccer league". Unfortunately, he has an occasional sexual relation with a girl already infected by one of his friends, without using a condom and thus gets infected. He in turn infects his regular girlfriend and this almost leads to the break up of their relationship and his dreams of a soccer career. There is however reconciliation, mutual notification and promise to practice safe sex onwards.

The story was generated through **workshops** with youth from Khayalitsha and Gujalitu, two townships in the Greater Cape Town area. **Focus groups** were also held with youth in Kwanashu, Inanado and Thornwood (Kwazalu-Natal).

This photocomic includes a set of discussion **questions**, destined for schools, youth groups, sports teams, church groups, political groups or even informal parties with friends. **Role-playing** can also be developed on the basis of the story. Then, there is **practical demonstration** on how to wear a condom. An **information section** is presented afterwards, in the form of questions/answers. The final section summarizes the **pedagogical content of the story** by subject: healers and clinics, partner notification, love, trust, clinic attendance, gaining respect.

Source: A cultural approach to HIV/AIDS prevention and care. South Africa's experience, UNESCO, 1999.

5.3.2- THE CULTURAL APPROACH TO HIV/AIDS COMMUNICATION

Communication between field workers and the population implies a **two-way information exchange system.**

In prevention as in care to PWAs, field workers must be considered as resource persons, catalysts or "activators" in the process of identifying problems and resources (internal/external), solving problems and sharing responsibility.

As external agents they should discuss with the community its priorities, aims, expected results from the action undertaken, and the costs (sacrifices) and benefits which they anticipate.

Cultural conditions for good communication:

- *Cultural knowledge and awareness:* before field work, field workers should gather information and documentation on the culture of the community they are going to work with;
- *Cultural commitment:* from the moment of their arrival, field workers should try to get acquainted with the group, with their languages, opinions, knowledge, judgments, know-how, needs for meaning myths and legends, religion, popular art and oral traditions. They should seek to understand the existing relations within the group, and the personalities and roles of opinion leaders, in order to gain the confidence and friendship of the population;
- *Cooperation in systematizing information collection and use in the field.* To this effects they can use the following tools:

- sampling method;
- modelling interactions so as to mobilize the population to design and carry out necessary activities;
- calendar of community activities;
- maps and sketches of the action area.

Multi-channel culture, information, education and communication process in Viet Nam

In Ho Chi Minh City, the Department of Culture and Information is significantly involved in the production of HIV/AIDS information material. As regards movies, the Health Education Centre always acts as adviser in order to keep films from scaring the general population. On the radio, a woman writer draws upon popular HIV/AIDS soap-operas with a sense of humour, as a means of transmitting information. Great attention has to be given to maintaining the integrity of tribal communities, which can also be destabilized by uncontrolled tourist activity.

A small group has been founded in Viet Nam, "Friends Helping Friends", which is involved in the exchange of information among PWAs. Supported by the health authorities, it is a small organization, which owns a house in Ho Chi Minh City and has been granted an official role. PWAs are very influential agents for prevention and care work, due to their obvious motivation towards other PWAs and non-infected people. Moving away from a moralistic, medical approach to an empowering approach will help people to accept themselves.

In addition, networks of PWA groups are supported by officials, on the principle of HIV/AIDS acceptance by the community and themselves. Social workers and public health workers are encouraged to understand and accept PWAs, in order to help local communities evaluate their practices and attitudes.

Source: UNESCO workshop on cultural factors in the transmission, prevention and care of HIV/AIDS in the Upper Mekong Region, Chiang Mai, Thailand, June 1999.

Cultural communication for behaviour change

- *Informing people:*
  - "Translating" the initial situation, bringing together local and external resources, explaining constraints linked to the institutional context, emphasizing the "invisible" aspects of the epidemic expansion;
  - Ascertaining that the community grasps the problem, can identify the means to solve it and the expected improvement, and is ready to get fully involved to ensure the success of prevention and care activities already undertaken.

- *Keeping informed:*
  - What are the needs (as expressed by people after discussion)?
  - What are the conflicts of interest within the group, the local resources available, the critical moments in the action to be taken?
  - What image do field workers have among the population?

- *Facilitating. Field workers should:*
  - Support internal processes of change;
  - Stimulate debate (including internal self-criticism);
  - Give concrete expression to interests and motivations (political, economic, symbolic, power-related, acquired advantages, and the interests of underprivileged sub-groups);
  - Act as impartial mediators in case of conflict, with all the necessary discretion;
  - Help in designing activities and distributing tasks;
  - Maintain the population's involvement throughout the duration of the planned activities;
  - Enhance the value of local resources (knowledge, know-how, material contributions, local payment, even if symbolic);
  - Carry out frequent assessments of the effort made and the changes obtained, with the population.

5.3.3- CULTURALLY-APROPRIATE IEC: FIELD WORK AND FIELD WORKERS

Various types of field workers

Field workers' educational and professional background is very heterogeneous. They may belong to the following categories:

- Staff members or contracted agents belonging to a health or medical institution;
- Permanent agents in an NGO;
- Voluntary cooperation agents.

They may be members of a team or work individually with local agents or with the local community.

In prevention and care work, it is especially important that they should be selected and appointed according to their personal and professional profile, in relation to the implementation of the tasks mentioned above or trained accordingly.

Field work, field workers and HIV/AIDS prevention and care

- Developing **participation** in the preparation and implementation of projects at the local level, for and with a given population.
- Helping populations to bring to light their **priority problems** concerning the disease and their objectives, so as to identify the solutions they could put into practice by themselves, and those for which they will need external assistance (initial mobilization and eventual disappointment).
- Providing **timely and indispensable information** to carry out efficient activities, at the request of the people, including the joint permanent evaluation of the progress achieved and problems encountered.
- Integrating their support into indigenous cultural processes of change.

6- GENERAL CONCLUSIONS

Alongside the international effort towards a more comprehensive scientific view of the epidemic and general availability of medical treatment, Information/Education/Communication is a key instrument in efficient prevention and support to infected and sick people, in the perspective of sustainable human development. In order to give it full significance and long-term effects, it has to be elaborated and developed within the context of the cultural approach. In other words, the validity of IEC is and will be tested through the response of populations that will result either in continuity or change in their ways of thinking, value systems and styles of life in relation to the epidemic.

For this reason methodological research has to be focused first on understanding peoples' cultural references and resources and defining conditions for their sensitization and mobilization in prevention and care.

Secondly, as no valuable IEC activity can work without analysing in-depth specific characters of target audiences, identification and segmentation of the various "risk groups", in their cultural relation with socio-economic development and general society, have to be described at length, in view of really communicating with all components of a given population.

Finally, proposals are made for more appropriate IEC methods, combining elaboration and delivery, in a cultural approach to all types of communication and exchange, including media and education.

This handbook is complementary to the other ones, devoted to taking a cultural approach to strategy and project design.

N.B.: As mentioned in the Foreword, three other handbooks will be devoted respectively to: strategy and policy building, field work and project design.

List of Publications elaborated within the Project:

A Cultural Approach to HIV/AIDS Prevention and Care UNESCO/UNAIDS Research Project

Studies and Reports, Special Series –

No. 1 Country Report: Uganda's Experience (English, French), 1999
No. 2 Country Report: Zimbabwe's Experience (English), 1999
No. 3 Country Report: South Africa's Experience (English), 1999
No. 4 Country Report: Angola's Experience (English), 1999
No. 5 Country Report: Malawi's Experience (English), 1999
No. 6 Country Report: Thailand's Experience (English), 1999
No. 7 Country Report: Dominican Republic's Experience (English, Spanish), 1999
No. 8 Country Report: Jamaica's Experience (English) , 1999
No. 9 Country Report: Cuba's Experience (English, Spanish) , 2000
No. 10 Summary of Country Assessments and Project Design Handbook (English, French), 2000
No. 11 Proceedings of the Kampala Regional Workshop (English), 2001
No. 12 Proceedings of the Nairobi International Conference (English), 2001

Methodological Handbooks–

No. 1 Handbook for appropriate communication for behavior change (English, French), 2001
No. 2 Handbook for strategy and policy building (English, French), 2001
No. 3 Handbook for field work: building local response (English, French), 2001
No. 4 Handbook for project design, implementation and evaluation (English, French), 2001

All of these documents are available for consultation on Internet at:
http://www.unesco.org/culture/aids/

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