

Community-Level Behavioural Interventions for HIV Prevention in Sub-Saharan Africa

Brian van Wyk, Anna Strebel, Karl Peltzer & Donald Skinner



Social Aspects of HIV/AIDS and Health Research Programme, Occasional Paper 3

Series Editor: Olive Shisana, Executive Director: Social Aspects of HIV/AIDS and Health Research Programme of the Human Sciences Research Council

Published by HSRC Press

Private Bag X9182, Cape Town, 8000, South Africa

www.hsrcpress.ac.za

© 2006 Human Sciences Research Council

First published 2006

All rights reserved. No part of this book may be reprinted or reproduced or utilised in any form or by any electronic, mechanical, or other means, including photocopying and recording, or in any information storage or retrieval system, without permission in writing from the publishers.

ISSN 1810 5564

ISBN 0 7969 2138 5

Cover by Jenny Young

Production by comPress

Distributed in Africa by Blue Weaver Marketing and Distribution,

PO Box 30370, Tokai, Cape Town, 7966, South Africa.

Tel: +27 +21-701-4477

Fax: +27 +21-701-7302

email: booksales@hsrc.ac.za

Distributed worldwide, except Africa, by Independent Publishers Group,

814 North Franklin Street, Chicago, IL 60610, USA.

www.ipgbook.com

To order, call toll-free: 1-800-888-4741

All other inquiries, Tel: +1 +312-337-0747

Fax: +1 +312-337-5985

email: Frontdesk@ipgbook.com

Preface

The Social Aspects of HIV/AIDS and Health Research Programme of the Human Sciences Research Council publishes an Occasional Paper series which is designed to offer timely contributions to debates, disseminate research findings and otherwise engage with the broader research community. Authors invite comments and responses from readers.

About the Authors

Brian van Wyk is a doctoral intern in Social Aspects of HIV/AIDS and Health Research at the Human Sciences Research Council (HSRC). He recently completed a DPhil degree in Psychology at the University of Stellenbosch and subsequently trained in quantitative and qualitative research at the Health Systems Research Unit of the Medical Research Council (MRC) of South Africa. His dissertation reports on action research conducted in a public primary healthcare setting and aims at developing interventions to support and prevent burnout among health workers.

Anna Strelbel, Managing Partner at Headways Research Training and Development, Cape Town, is a former professor of Psychology at the University of the Western Cape. She is both a registered researcher and clinical psychologist and has worked in a number of psychiatric hospitals. Her DPhil in Psychology (UCT) deals with women and AIDS. Her current research interests include STI/HIV/AIDS, gender and sexuality, focusing especially on project evaluations.

Prof. Karl Peltzer is chief research specialist in Social Aspects of HIV/AIDS and Health Research at the HSRC. He obtained his master's, PhD and DrHabil degrees in clinical and health psychology from the Universities of Bremen, Hannover and Klagenfurt. Dr Peltzer researched and taught psychology and health at the Universities of Malawi, Zambia, Awolowo Obafemi, Klagenfurt and the North (South Africa). Previously he directed the National Research Foundation Health Behaviour Research Unit at the University of the North, South Africa.

Karl has extensive experience in research on psychology applied to health in Africa, especially in areas of health behaviour, health psychology, clinical psychology and psychotherapy, psychotrauma, substance abuse, chronic diseases of lifestyle, communicable diseases, injuries, traditional and faith healing. He wrote or edited eight books and has more than 230 scientific articles published in the area of psychosocial aspects of health and health promotion in Africa. He has worked with numerous organisations such as WHO, national governments, NGOs and foundations on a number of projects related to health and healthcare delivery in Africa.

Dr Donald Skinner is chief research specialist in Social Aspects of HIV/AIDS and Health Research at the HSRC. He holds a PhD in psychology and an MA in clinical psychology from the University of Cape Town. The PhD focused on behaviour theory in relation to HIV prevention.

Previously employed at the MRC in Cape Town as part of an AIDS research unit, he also worked at the Trauma Centre for Survivors of Violence and Torture as researcher and clinician. Before joining the HSRC, Donald was director of the AIDS and Society Research Unit at UCT where he participated in and was introduced to research across a range of disciplines and sectors.

He has training and experience in both quantitative and qualitative approaches, with a particular capacity in qualitative methods. Donald has acquired a good understanding of the operations of community-based work and the operations of NGOs and CBOs. Donald has written a book, many reports, working papers, and community-based and other publications in the areas of political violence, AIDS and research methodology.

Acknowledgements

Nompumelelo Zungu-Dirwayi and Prof. Leickness Simbayi for contributing papers for inclusion in the review. The project is made possible by the funding and commitment of the WK Kellogg Foundation.

Community-Level Behavioural Interventions for HIV Prevention in Sub-Saharan Africa

Introduction

The HIV pandemic is continuing almost unabated in many developing countries (UNAIDS, 2004). Particularly hard-hit is sub-Saharan Africa, of which the countries making up the Southern African Developing Community (SADC) have the highest prevalence of HIV/AIDS. South Africa (21.5%), Zimbabwe (24.6%) and Botswana (37.3%) were reported to have the fifth, fourth and second highest proportions respectively of people between the ages 15 and 49 years who are living with HIV/AIDS. The impact of HIV/AIDS can potentially devastate and cripple social and economic development particularly on the African continent. The current review – one in a series of papers (cf. Richter, Manegold & Pather, 2004; Strelbel, 2004) – looks into possibilities for prevention in the context of growing problems with and of orphans and vulnerable children (OVC) in southern Africa (UNAIDS, UNICEF & USAID, 2002).

Background

The growing problem with OVC should not be seen as only related to children, but needs to be understood in terms of the impact of AIDS on families, households and communities. Children may be impacted in material and non-material ways (Richter et al., 2004). Material problems relate to poverty, food security, education and health. Non-material problems relate to welfare, protection and emotional health. Children affected by AIDS are in themselves highly vulnerable to HIV infection. Their risk for

infection arises from the potential for early onset of sexual activity, commercial sex and sexual abuse; all of which may be precipitated by economic need, peer pressure, lack of supervision, exploitation and rape (Skinner, Tsheko, Mtero-Munyati, Segwabe, Chibatamoto et al., 2004). These authors recommended that interventions aimed at reducing vulnerability to HIV infection among children should include support to households – to keep children in school to complete their education, and to protect girls especially against sexual abuse and being forced into commercial sexual relations. Interventions targeting orphans should focus on the prevention of early sexual debut and of children taking up sex work to support themselves, as well as on preventing children from being sexually exploited (UNICEF, 2004). Where possible, it is recommended that children be kept within family safety nets (Richter et al., 2004). Other interventions aimed at indirectly preventing HIV infection include economic support to families affected with HIV/AIDS, support to orphans within families, and training parents and caregivers of vulnerable children to provide a supportive family environment that is nurturing, provides moral guidance and protects the children against stigma associated with HIV/AIDS.

Service provision in key areas such as health and education may decrease as the number of health workers and educators decline due to loss of lives and AIDS co-morbidities (Shisana, Hall, Maluleke, Stoker, Schwabe et al., 2002). Quality of services may also decline as a result of psychological stress and breakdown related to dealing with HIV within the profession and in the community (Van Wyk, Benjamin & Sandenbergh, 2003). HIV/AIDS directly impacts on families, households and children (Richter et al., 2004). The need for care and support interventions and treatment is crucial to ensure that adults living with HIV/AIDS are kept healthy for long enough to provide financially and emotionally for the needs of their children (Strebel, 2004).

The general lack of financial resources and the widespread impact of the AIDS pandemic are major challenges to governments and communities providing treatment and care to those affected and infected with HIV/AIDS (e.g. Blum, 2004). Many developing countries do not have the health infrastructure to scale up antiretroviral treatment in public health services (Ismail, Watt, Allen & Pepper, 2003; Ntuli, Ijumba, McCoy, Padarath & Berthiaume, 2003). The need for effective HIV prevention interventions has become pressing in the absence of antiretroviral treatment being widely available to most people in poverty-stricken areas in SADC (Cain, Schulze & Preston, 2000). Even in areas where treatment is available, the cost of treating opportunistic infections in primary caregivers causes huge and irrecoverable damage to already scarce financial resources of households. Children in such cases are

the first to suffer (Richter et al., 2004). Most often girls have to interrupt their education to take care of ill parents and adults. Also, due to financial difficulties they are the first ones to give up their education. This, in turn, increases their vulnerability to HIV infection due to poor socio-economic status.

Community-based organisations (CBOs) and non-government organisations (NGOs) are crucial for the successful combating of the HIV pandemic, as evidenced in Uganda (Parkhurst & Lush, 2004). Many community organisations are involved in community support programmes of various kinds. It is recognised that such community organisations could play an even greater role in HIV prevention, as they are in contact with those people most vulnerable to becoming infected with HIV (family members and associates of those who are already infected with HIV). Community organisations should base their programmes on sound evidence to maximise the impact of services that they provide to communities (Kelly, Parker & Oyosi, 2001). Currently there is little evidence, however, that behavioural sciences-based intervention technologies are actually used by community services providers (Low-Beer & Stoneburner, 2004). One of the reasons for this could be that studies of evidence-based prevention interventions are more often disseminated through media such as peer-reviewed journal articles, academic books and conferences that speak to their peers in the scientific community, but which are not readily available or accessible to community services providers (Patten & Ibanez-Carrasco, 2004). Typically dissemination of evidence-based interventions is not described or reported in sufficient detail to translate into implementation at grassroots levels. Although research is sometimes made available to communities through presentations and workshops, these are often not sufficiently intensive to allow community members and organisations to acquire the new and necessary skills to implement programmatic changes with confidence (Kalichman, Somlai & Sikkema, 2000). It is suggested that such dissemination should have a strong component of 'how to' to allow community organisations to translate research findings into community programmes. Members of community organisations may also lack the expertise to interpret scientific reports (Patten & Ibanez-Carrasco, 2004). Other common barriers to the implementation of evidence-based prevention interventions in communities include:

- structural barriers to transfer of new technology to the community;
- community resistance to new technologies; and
- poor fit between science-based prevention and community needs (Campbell, 2003; Gruber & Caffrey, 2004).

Gruber and Caffrey (2004) suggest that principles of community psychology and change management through a systems approach may be helpful in the design and implementation of community-based interventions. The idea is to reach beyond the individual to understand people in their social worlds and the influences that shape their attitudes and behaviour, in the way that community psychologists do. Within this understanding, careful note should be taken of various interactions with that environment, and how interrelated parts affect one another. The issue of power imbalances also needs to be addressed (Campbell, 2003). Community empowerment, and not just community participation, should be high on the agenda when developing models for HIV prevention (Becker, Guenther-Grey & Raj, 1998). Thus, the role of the HIV researcher should change from that of medical or public health expert only towards demonstrating the skills and competencies of a social activist and mentor to community participants (Petersen & Swartz, 2002). Some programmes, however, have reported outcomes that suggest that these barriers could be bridged and that 'successful' HIV prevention interventions could be implemented at community level (cf. Ainsworth, Beyrer & Soucat, 2002; Low-Beer & Stoneburner, 2004). Examples of these will be discussed in the sections to follow.

Types of prevention programmes

Effective prevention of HIV infection in communities requires intervention on several levels, because factors influencing risky sexual and other behaviours occur on personality, interpersonal and environmental (social, cultural, economic and political) levels (Campbell, 2003). In the discussion that follows we distinguish between *community-wide*, *community-based* and *institution-based* programmes. Community-wide programmes target proximal and distal factors in the environment in order to facilitate changes in individual sexual behaviour. Community-based interventions target specific factors within communities to facilitate changes in social values and norms that may promote protective behaviours and facilitate a decrease in sexual risk behaviours. Variations on the abovementioned types of programmes come in the form of various institutions being used as bases to launch prevention activities to the communities (Ross & Williams, 2002). In the current review, institution-based programmes refer to interventions operated from institutions such as health services, schools and places or networks of formal and informal employment. They also refer to interventions that target segments of the community within the institution, as well as members of the geographic community.

Community-wide prevention strategies

The most common community-wide programmes are national HIV/AIDS awareness programmes. These programmes are more commonly called information, education and communication (IEC) campaigns, because of their emphasis on giving *information* through mass media such as national and local radio, TV, newspapers and billboards. However, as an IEC intervention in Madagascar (Rakotonanahary, Rafransoa & Bensaïd, 2002) showed, simply giving information does not guarantee behaviour change. The outcomes of a mass media programme in South Africa, *loveLife*, illustrated the difficulties in reaching target population groups with effective messaging (Delate, 2001). In this section we will also relate experiences in Uganda, where mass communication (also known as behaviour change communication) has been successful in reaching target audiences and facilitating behaviour change towards safer sexual practices (Bessinger, Katende & Gupta, 2004).

Information, education and communication in Madagascar

The IEC campaign in Madagascar targeted a wide range of at-risk groups, which included youth (in- and out-of-school), truck drivers, commercial sex workers (CSWs), mothers and professionals (health workers, naval and police officers, and educators in tertiary institutions) (Rakotonanahary et al., 2002). A qualitative evaluation of the programme reported no improvement in self-reported knowledge about HIV/AIDS prevention or condom use among those who were targeted for the intervention. In certain cases the campaign actually caused harm, as was the case with truckers seeking out young rural girls for sexual contact when they were made aware of the dangers of HIV infection from having sex with CSWs. The Madagascar programme failed for several reasons, of which we will highlight only a few. Firstly, it did not take into consideration that high levels of illiteracy existed in the country, and that this was even more pronounced among those who were most at risk of HIV infection. The lesson to be learnt from this is that information messages should be tailored to specific at-risk groups regarding content, style and medium. Secondly, knowledge of the target audience(s) is critical to ensure that these messages reach them where they are – physically, psychologically and in a cultural or social sense (Amon, 2002). Thirdly, to reach out to marginalised or out-of-the-mainstream groups such as CSWs requires specific strategies, which should be based on an ethnographic understanding of the group's relative position in society. For example, agency needs to be created within groups with low socio-economic status (such as CSWs) to enable them to act on information received (Campbell, 2003).

Mass media communication in South Africa

LoveLife in South Africa presents an improvement on IEC campaigns in Madagascar, in the sense that the programme focuses on a specific age group – 12- to 17-year-olds as its primary target group – and that it uses a vast array of media (Stadler & Hlongwa, 2002). The *loveLife* programme consists of three main components, namely (1) a media campaign that includes television, radio and print advertising; (2) a social response which includes peer education, youth centres, adolescent-friendly clinic services for health promotion and prevention, tours and sport events; and (3) a research component that informs the development of the programme and undertakes evaluation and monitoring (Clacherty, 2003). The programme aims to break community-wide silence about HIV/AIDS by encouraging parents (and other adults) and teenage children to talk about sexual health issues. The communication component is based on a national survey of sexual and other risk behaviours and the determinants for sexual and reproductive health issues among adolescents. Additional qualitative research is aimed at understanding sexuality from an adolescent perspective. Messaging is tailored to youth in terms of content, discourse, style of presentation and medium, and aims to get youth ‘hooked’ on *loveLife*’s popular culture. The programme seeks to make condom use a normal part of youth culture, let young people make informed choices, encourage them to take responsibility and encourage positive sexuality. *LoveLife* has been exemplary in its ability to draw major and consistent funding from international donor agencies over the past five years (1999-2004). This is a major boost to the programme achieving its objective of sustaining education and prevention over many years at a sufficient level of intensity to hold public attention. Partnerships between locally based national NGOs, the research community and the international funding agency are ideal for implementing successful HIV prevention programmes in resource-poor developing countries.

However, elements of the *loveLife* programme have come under severe criticism (Parker, 2003). Although the billboard campaign succeeded in attracting adolescents’ attention, the messages that the programme sought to convey through their billboards were, at best, selectively understood (Delate, 2001). This problem relates to the difficulty of communicating to a diverse population such as in South Africa, with its stark differences between cultures and between urban and rural areas (Stadler & Hlongwa, 2002). Although *loveLife*’s Y-centres tend to fill a gap in communities by providing sports and recreation where these facilities were limited, the abundance of resources available to Y-centres compared to the lack of the same in communities and

other community organisations caused division in communities (Naidoo, 2003). The healthy lifestyle that *loveLife* was seeking to promote among young people was experienced as affirming individualism and aspirations to materialism. The effects of regularly attending the Y-centre in Naidoo's case study brought alienation between these youth and those who did not attend Y-centres regularly. It also estranged the first-mentioned group of youth from their parents and other adults in the community. The net result was a growing division between the Y-centre and the community, as *loveLife* expected the community to buy into a predetermined 'lifestyle' that did not account for realities that existed within the community. Parker (2003) recommended that the lack of rigour in *loveLife's* evaluative research needed to be addressed, and added that HIV prevention in South Africa should not be reduced to a single intervention as *loveLife* was perceived to be doing.

Other mass media programmes such as the multi-media *Soul City* project have been rigorously evaluated and shown to achieve great success in reaching and influencing individuals, communities and the socio-political environment in South Africa and beyond with health education messages (Social Surveys, 2002). The *Soul City* project is made up of a primetime television series, a daily radio drama, three booklets on the health topics covered in the broadcast media, a publicity campaign which keeps people talking and thinking about *Soul City*, and adult education and youth life skills materials. The evaluation study showed that *Soul City* reached 42% of the adult population (over 16 years old) with at least one of their three booklets, and that each booklet was seen by three people. The evaluation research was also very useful in highlighting which sections of the population had least access to any of the booklets, i.e. white people, people over 60 years, retired people and housewives, people living in rural areas and villages, residents from the Free State, Eastern Cape and Western Cape, as well as people on the extremes of the socio-economic groupings. *Soul City* reaches out to children (8 to 12-year-olds) with health information and behaviours that include HIV/AIDS through their *Soul Buddyz* programme. *Soul Buddyz* comprises a weekly television series, a radio series, a sex education video, a parenting booklet and life skills booklets distributed through schools to all Grade 7 pupils nationally. The successes achieved by the *Soul City* project could be attributed to its use of different media and the content of the stories, which is close to the lived experiences of most of the target population – thus addressing relevant issues in South African communities.

South Africa's national Department of Health (DoH) launched a project called the Beyond Awareness Campaign (BAC). It aims to move beyond mass media advertising in order to explore alternative approaches towards a national campaign aimed at

behaviour change among different populations (Parker, 2004). The campaign includes intensifying communication of key messages around the HIV/AIDS pandemic directed primarily at the youth; development and distribution of communication resources that could support action around HIV/AIDS; promoting social action through targeted projects; building capacity among HIV/AIDS communicators and strategists through research; and conducting evaluation research of various aspects of the HIV/AIDS communication campaign. The red ribbon was chosen as an icon to be associated with a wide range of HIV/AIDS communications and social action-oriented activities. An AIDS helpline was set up as a toll-free national service. The DoH committed itself to provide condoms to clinics and other sites for free-of-charge distribution. A range of AIDS information materials and educational resources were developed for use by smaller organisations for counselling, training, health education promotion, workshops, forums, cultural activities, youth camps, exhibitions, libraries and resource centres, clinic consultations, door-to-door visits, street campaign events and public transport campaigns. The AIDS Memorial Quilt Project was set up as a means to provide a creative symbol of remembrance for those whose lives have been touched by AIDS and to honour those who have died of AIDS. This project sought to break the silence around the disease, and promote greater understanding of the impact of AIDS while reducing hostility towards and discrimination against people living with AIDS. This project and many other projects such as the Tertiary Institution Project, Mediaworkers Project and capacity building for key communicators were means to promote social action in targeted areas of the population.

In addition, two evaluation studies were conducted (Kelly, 2000; Kelly & Parker, 2002), which shed some light on the impact of general (rather than specific) HIV prevention activities in South Africa. The first study was a contextual evaluation of youth responses to HIV/AIDS (Kelly, 2000). This study showed that youth had good access to accurate HIV/AIDS information, but that high perceptions of vulnerability did not consistently lead to preventive responses. In areas (research sites) where there were high levels of media penetration and evidence of community mobilisation around HIV/AIDS, youth showed signs of responding positively to reduce HIV infection risk. In these areas youth respondents stated that any further information that they needed was available through social networks rather than through health experts. The findings showed differences between rural and urban areas, with media penetration and uptake of prevention behaviours markedly less in rural and poor communities. The media tend to underplay risk prevention options such as sticking to one partner (be faithful), abstinence (both for those already sexually active and

those not yet active) and delay of onset of sexual experience. The report also indicated that though youth were very willing to become involved in HIV/AIDS work in their communities, there were few opportunities for this or, where opportunities existed, they were not aware of them.

The second evaluation study explored contextual mediators of youth responses to HIV/AIDS (Kelly & Parker, 2002). Findings suggested that media messages should be developed around the promotion of voluntary counselling and testing (VCT). Youth development should also become more central to community HIV prevention activities, so that issues such as sexual activity, sexual debut, age differentials between partners, factors affecting sexual negotiation and decision making, mediators of condom acquisition and use, sex partner turnover and abstinence, and HIV/AIDS care and support could be addressed. The findings from this research indicated that behaviour change occurred largely among youth who were low risk and whose life circumstances were most promising. Background (community) factors mediating youth vulnerability would be best addressed through community-based approaches as these programmes could be tailored to specific contexts and conditions that exist at local level. Sex education for young people may be best suited to community contexts when provided by churches, cultural networks and community organisations as seen in Ghana and Botswana (Hainsworth, 2004).

Behaviour change communication in Uganda

In Uganda behaviour change communication (BCC) campaigns were successful in increasing awareness of HIV/AIDS and the prevention thereof, and promoting protective behaviours, particularly a reduction in casual sex, in the population (Bessinger et al., 2004). The national AIDS prevention strategy included the ABC message (Abstinence, Be faithful, and Condoms), voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) (Blum, 2004). As a result of the BCC programme, HIV prevalence among antenatal clinic attendees dropped from 21.9% in 1991 to 6.4% in 2001 (Low-Beer & Stoneburner, 2004). Population surveys in 1989 and 1995 reported a decline of 60% in reported casual sex among men and women. The BCC campaign, which included mass media communication and condom promotion, was implemented by the National Department of Health, with funding from the United States Agency for International Development (USAID). The campaigns ran for five years and focused on educating men and women about the prevention of STIs through condom use; about the signs of infection and need for treatment; and on encouraging adolescents who were not

abstaining from sex to use condoms to prevent HIV infection. The media components included radio and television advertisements, billboards and posters, and a weekly reproductive health radio programme. Integrated reproductive health services and social marketing of condoms were included as strategies alongside the campaigns. Whereas the choice of radio as a medium to reach the majority of the population was well-thought of, Low-Beer and Stoneburner (2004) argued that it was the networks for social communication that contributed to population-wide behaviour change responses in Uganda. Younger people who experience risk behaviours, for example, were more exposed to the consequences of AIDS in older groups via the social networks. The BCC campaigns succeeded in mobilising political and social capital as they delivered clear and direct messages through local networks of chiefs, churches, health personnel and village meetings rather than with brands, slogans and declarations. The message communicated was that AIDS was to be feared, and that it needed to be dealt with forthrightly on every level – political, cultural and religion – by government, non-government and faith-based organisations and communities. The direct involvement of the Ugandan president in the fight against AIDS, the resultant political will to change towards a more flexible bureaucracy, and the continual engagement with donors and NGOs all contributed to the success of the BCC campaign (Parkhurst & Lush, 2004).

Information, education and communication for condom promotion in Thailand

Similar successes have been reported in Thailand with the ‘100% Condoms’ national BCC programme (Ainsworth et al., 2002). This programme targeted commercial sex facilities and aimed to promote consistent condom use among CSWs and their clients. As a result, it was reported that condom use in commercial sex acts increased from 25% in 1989 to 94% in 1995. The success of this programme had a significant impact on overall HIV prevalence in the country as the sex industry was driving the HIV pandemic. In addition to strong political leadership in the fight against HIV/AIDS, Thailand also engaged communities through community workshops facilitated by government staff to develop and implement local responses to fighting HIV/AIDS – thus mobilising the community into action (Duongsaa & Duangsa, 2004). The rationale behind this strategy was to create an enabling environment conducive to the prevention and alleviation of HIV/AIDS (Aheto & Gbesemete, 2004). The IEC campaign involved the mass media (radio) and entertainment (music and drama) to draw people’s attention to HIV/AIDS issues (Elkins, Kuyyakanood, Maticka-Tyndale, Rujkorakarn, & Haswell-Elkins, 1996). Thus, supporting information

networks were established among various population groups to increase the impact of the national IEC campaign. Aheto and Gbesemete (2004) contend that the reason for the tremendous success of HIV prevention campaigns in Thailand is that the policy environment was better co-ordinated and regulated with respect to various aspects of HIV prevention efforts, when compared to Ghana.

In summary, community-wide HIV prevention programmes such as mass media and IEC campaigns can make a valuable contribution towards bringing about increased awareness of and social concern about HIV/AIDS. These programmes should be regarded as the first step towards breaking the silence that often surrounds HIV/AIDS (Kelly et al., 2001). The translation of awareness into social action, as seen in BCC programmes, requires further interventions targeted at the contexts where prevention behaviours are (or are expected to be) exercised, in other words in interpersonal relationships, family relationships and at community level. Community-wide strategies have to be followed up with community level social mobilisation and development programmes as was the case in Uganda and Thailand (Campbell & Cornish, 2003).

Community-based prevention programmes

There are two mainstream approaches to developing HIV prevention programmes within communities:

- participatory approaches that develop the programme from the bottom up, starting at the level where the community is currently, and
- theoretical approaches that follow a predetermined course, mode of action or way of interpreting behaviour.

Traditionally, developing countries have favoured participatory approaches, whereas theoretical approaches tend to have their roots in western-based theories of psychology and health promotion. Community-based programmes that use participatory approaches are increasingly being favoured above individualistic approaches for HIV prevention, as many social scientists and community activists argue that social dynamics have as much influence, if not more, over individual decisions about sexual behaviour than individual cognition (Parker, 2003). Participatory programmes draw on the active participation of members of the community in the implementation of the intervention (e.g. peer educators) or in some or all the stages of development and implementation (e.g. community mobilisation). Although peer education and community mobilisation programmes are described separately, these are not mutually exclusive and may be combined in some programmes (cf. Campbell, 2003; Campbell & MacPhail, 2002; Campbell & Williams, 1999).

Peer education interventions

In developed countries as well as developing countries outside Africa it is found that those most at risk of HIV infection are often part of marginalised or out-of-mainstream groups, for instance CSWs, intravenous drug users (IDUs), their female sexual partners and men having sex with men (MSM) (Cain et al., 2000; Corby, Enguidanos & Kay, 1996; Schnell, Galavotti, Fishbein & Chan, 1996). Training members of these hard-to-reach groups as peer educators is an effective way of distributing information on health promotion and for advocacy. As a member of the at-risk group, the peer educator has access to these groups and may use this connection with the group to challenge norms and promote safer sexual behaviours. In developing countries, peer educators have been mostly used to promote condom use and other protective behaviours among in- and out-of-school youth (Campbell & MacPhail, 2002; Finger, Lapetina & Pribila, 2002; Hainsworth, 2002; Lopez, Gomez, Baez & Portes, 2004; Pozo, Argandona & Kane, 2004; Senderowitz, 2004; Stadler & Hlongwa, 2002; UNICEF-Ghana, 2002) and CSWs (Campbell, 2003; UNICEF-Ghana, 2002).

The advantages of using peer educators are numerous. The first advantage has already been mentioned – access to at-risk groups (Fishbein, Guenther-Grey, Johnson, Wolitski, McAlister et al., 1996). Secondly, peer educators know the target population and can be useful in tailoring interventions to suit local conditions (Boadi & Essandoh, 2004). Thirdly, by choosing the peer educators well, one can ensure that peer educators are chosen who are recognised as influencers within their peer group (Asthana & Oostvogels, 1996; Smith & DiClemente, 2000). The last-mentioned fact contributes to greater likelihood of success with interventions. Fourthly, involving adolescents in intervention delivery utilises a group in the population that is particularly strong in advocacy (Ramirez, Gosset, Ginsburg, Taylor, & Slap, 2000). Lastly, by training peer educators within the target community, the likelihood for sustainability of the intervention beyond the research study is increased (Baltazar, Fages, Nzima, Kironde, Mwachibuzi et al., 2004). However, care needs to be taken that peer educators are chosen who would stay in the community for some time after the intervention has been implemented (Pearlman, Camberg, Wallace, Symons & Finison, 2002). This is not always possible, as it often happens that peer educators use their newly improved status to negotiate economic mobility. It is not clear whether the fact that peer educators leave the community for better jobs constitutes a failure of the intervention in terms of sustainability or a success that could only be measured on a scale greater than implicitly stated research goals (social development).

Several programmes have found utilising youth as peer educators to be effective in health promotion among young people (Finger et al., 2002; Lopez et al., 2004). In Cameroon and Nigeria, youth peer educators were utilised to deliver prevention messages by holding discussion groups, referring youth to health services, distributing promotional material and developing HIV awareness activities for in- and out-of-school youth. These two programmes reported increased protective behaviours and spontaneous knowledge of contraception and STI symptoms among various groups in Cameroon and Nigeria respectively. A peer leader training intervention in school and community settings in Peru reported that, following the intervention, males delayed onset of sexual début, increased use of contraceptives and increased knowledge of reproductive health.

Training peer educators *per se* is not a guarantee for successful HIV prevention, though (Campbell, 2003; Asthana & Oostvogels, 1996). Concerted efforts need to be made to ensure that the environment or system in which the intervention takes place is conducive to or enabling of desired changes in behaviour in the target population. In the Summertown project, the strictly regulatory school system blocked efforts of peer educators to reach out to learners in the school (Campbell & MacPhail, 2002). Not only did the regimental school context stifle the creativity of the peer educators in reaching out effectively to fellow learners, but the school authorities also had the power to bring the intervention to a stop – which they did – when conflict arose between teachers and peer educators. Similarly, the peer education outreach component that targeted CSWs was derailed as a result of changes in power dynamics within the community. Initially a group of men were in power in the community and they were contracted (paid) to provide transport for various community activities related to the project. These men used their position of power and brute violence to force women to attend awareness-raising meetings. When these men lost their position of power in the community, attendance at meetings arranged by peer educators dropped dramatically.

The above case study illustrates the need for continual monitoring of the process to ensure that peer educators have the agency and space to act out their roles in the community. While efforts at training and deploying young people and others as peer educators and for condom distribution are important and effective, these are limited (Boadi & Essandoh, 2004). More meaningful involvement and capacity building of young people and other peer educators in programme planning, implementation and monitoring is needed to improve programme effectiveness and sustainability.

Moreover, broader structural constraints such as poverty, gender inequalities and migrant labour, as well as internal community dynamics need to be addressed at

community level to provide an enabling environment wherein peer educators could function (Campbell & Cornish, 2003). In many developing countries women and girls in lower socio-economic substrata have lower status than men, and are more vulnerable to HIV infection biologically and because of the coercive nature of sexual encounters (UNAIDS, UNFPA & UNIFEM, 2004). A peer educator outreach programme to them would not be effective, because such a horizontal intervention would not address societal factors that make these women vulnerable to infection in the first place. The same holds true for out-of-school youth, CSWs and other marginalised groups in the communities, who may not have the agency to negotiate safer sex with partners (Campbell, 2003; Rakotonanahary et al., 2002; Walters, 1999). In Tanzania the role of out-of-school youth peer educators was extended to include activities aimed at sensitising the community to issues broader than HIV/AIDS, such as OVC and widow legal issues, gender, promotion of children's rights, malaria control, modern farming methods and inheritance rights, *and* at mobilising the community to take action based on better knowledge (Baltazar et al., 2004). The above example shows that training programmes for peer educators could go beyond conventional HIV/AIDS topics to include issues related to actual needs of the target population so that the community could be aligned for further action. Sufficient time and energy need to be spent to safely negotiate the extent, content and intent of peer educator outreaches with relevant role-players and stakeholders in the community. In resource-poor settings where participation as a peer educator may improve social mobility, it is imperative that the selection of peer educators be conducted in a transparent manner so that the community could be convinced of the fairness of the process (Campbell, 2003). It is crucial for the sustainability of the programme that communities and relevant stakeholders be mobilised in some way around the programme to win their support for it, even when they are not directly targeted by the intervention.

Community mobilisation

The 100% Condoms programme in Thailand utilised a participatory approach to mobilise the communities around HIV prevention (Elkins et al., 1996). This combined approach used music and drama to gain public interest in the programme. In many African countries music and drama are very effective means of reaching target populations, because education initiatives are combined with entertainment. In Thailand the dramas that highlighted issues around HIV/AIDS were followed up by public discussions. The next step was to identify leaders within the community

and they would form an AIDS forum. This forum was then charged with designing and facilitating AIDS awareness activities in their community. Representatives of the government would oversee the process and take care of reporting on this process. The community forum members, however, would be charged to find their own resources to fund their activities. In this way the community was empowered not only to mobilise themselves for action, but also to 'own' the intervention. This improved the sustainability of interventions and facilitated a smoother transfer of knowledge to the community. It should be noted that community mobilisation programmes in Thailand were supported by various public sectors, including health and welfare. This community mobilisation intervention took place in the early stages of the HIV epidemic (before it turned into a pandemic) in the country, and was supported by highly developed infrastructures for health, education and social welfare. As was the case in Uganda, the Thai government demonstrated strong political will towards fighting HIV/AIDS in the early stages of the epidemic. This created a climate in which HIV/AIDS was openly talked about on various levels – from the community to the national government level.

In Mozambique a participatory approach of community mapping was used to involve youth in the process of identifying sexual reproductive health problems, gaps in knowledge and possible interventions for out-of-school youth (Hainsworth, 2002). Community mapping involved creating a physical map of the community that marked the location of various neighbourhoods, schools, health centres, vocational/training centres, counselling centres, clubs, discos, gardens and parks, churches, NGOs, youth associations and cultural groups, as well as capturing information about their activities, capacities, access, areas of influence and beneficiaries of each institution. Socio-cultural practices, which included youth recreational activities, meeting places, and topics of conversation among youth in various relationships (same sex, across sexes, boyfriend/girlfriend and married), were documented. Sexual behaviours, as well as knowledge and practices of protection were also noted. The results were summarised and shared during a workshop with all the youth associations. A thorough report on this workshop was presented to the community to sensitise them to AIDS, as well as sexual and reproductive health issues in the community, and to mobilise them to find their own solutions to these problems. Specific efforts were made to involve local elders, chiefs and religious leaders in mobilising the communities around outreach interventions. District-level leaders were then involved in designing outreach interventions based on the identified needs of the community. Members of youth associations played a significant role as

community activists in the implementation of outreach activities. Involving gatekeepers was critical to the success of community mobilisation efforts.

The AIDS Community Demonstration Project (ACDP) in the USA utilised gatekeepers and opinion leaders to distribute information, hand out condoms and bleach kits (for intravenous drug users), or arrange health promotion activities for targeted at-risk groups such as IDUs and their partners, CSWs (Corby et al., 1996; Fishbein et al., 1996; Higgins, O'Reilly, Tashima, Crain, Beeker et al., 1996; Valentine & Wright-De Agüero, 1996). Opinion leaders are those persons who are judged to be influential in changing knowledge, attitudes and behaviours in their respective groups. Gatekeepers are persons who have access to the target group, but do not belong to the group. Examples of gatekeepers that have been used in research programmes are restaurant and bar owners of places where members of the target group 'hang out' on a regular basis. Restaurant owners may be approached to announce prevention activities such as health parties to gay men who visit their establishments. Other programmes have used these hang out places as distribution and dissemination points for health promotion materials. An intervention where the front of a shop was used as a distribution point for bleach kits and condoms to IDUs and their female partners reported significant increases in condom use and cleaning of injection equipment (Fishbein et al., 1996).

Another study identified African-American women as opinion leaders to form part of Women's Health Councils in their respective communities (Sikkemda, Kelly, Winett, Solomon, Cargill et al., 2000). An outstanding characteristic of these African-American communities was the high prevalence of single females being head of their households. The purpose of the Women's Health Councils was to assist in community events about AIDS awareness, to recruit participants for risk-reduction workshops and to conduct risk-reduction workshops themselves after receiving training for two months. The same study reported significant improvements in reported condom use among women in these communities. Another study (Lauby, Smith, Stark, Person & Adams, 2000) utilised female community volunteers to provide stories of how they overcame various obstacles in their lives as they went through different stages of dealing with their drug use problems, and to distribute these stories to others in their communities. The aim of this study was to motivate women at high risk of HIV infection (due to STI history and drug use), to find alternate ways of coping with the pressures of life and to progress to the next level of change in the same way that role models in the stories did.

Although the advantages of community participation are numerous in terms of sustainability and ownership of the intervention by the community, participation in

itself needs to be carefully negotiated and monitored to reach the above levels of success. The example of the Summertown projects shows the ‘danger’ of allowing the process to go unmonitored and letting community power dynamics bedevil initial benefits gained from the project (Campbell, 2003). Another danger is that of not involving all the major stakeholders (Naidoo, 2003). In interventions where public health intersects with community dynamics, it is important that these divergent viewpoints are represented by the consortium of stakeholders. Representation should then also be in such a way that voice is given to the traditionally and historically powerless. The example from Thailand has shown that government involvement in community mobilisation programmes could go a far way to deal with power and gender dynamics and to smooth conflicts that exist at community level (Elkins et al., 1996). It is essential that power be given to the community (people at grassroots level) who will eventually be the recipients of the intervention, so that they could engage in a meaningful way in the development of such intervention (Duongsa & Duangsa, 2004).

Theory-based approaches

Whereas participatory approaches work truly from the community level upwards, theory-based approaches use external ideas and explanations of behaviour, mostly from psychology and health promotion, to bring about behaviour change in the target populations.

Principles from social cognitive theory have been used to facilitate behaviour change towards safer sex, because it was reasoned that having improved social skills would enable individuals to make decisions regarding safe sex (Kalichman et al., 2000). One example is a study conducted in the USA by Kalichman, Rompa, Cage, DiFonzo, Simpson et al. (2000), which involved the teaching of coping and decision-making skills, as well as the promotion of safer sexual practices to people who were HIV positive, by using didactic and interactive methods. This intervention was based on the theoretical assumption that teaching coping skills to individuals might enable them to cope better with daily stress and resist pressures to engage in unprotected sex. The study reported significant improvement in self-reported condom use, but no significant improvement in incidents of refusing unsafe sex, disclosing HIV status, and reducing the number of partners or rates of sexual intercourse.

Some community-based programmes described earlier used the trans-theoretical model of behaviour change and the diffusion of innovation theory respectively as a basis for the development of the intervention and to facilitate behaviour change

(Corby et al., 1996; Lauby et al., 2000). The trans-theoretical model of change postulates that people are on different levels of change. Interventions, therefore, seek to identify the stage of awareness and change at which the individual is and, once this has been established, seek to move the individual to the next level of change and awareness. In the first part of the programme a photo-novella was designed, which depicted stories from various role models about how they overcame barriers to move from one stage of awareness to another (Corby et al., 1996). In the second part, community volunteers used the tailored messages from the photo-novella to promote condom use among women who were at high risk of HIV infection (Lauby et al., 2000). These volunteers were chosen because they were regarded as opinion leaders to the women targeted in the intervention. According to the diffusion of innovation theory, health messages could be spread through a community by targeting selected people in that group who would influence the rest (Rebchook & Kegeles, 2004). The photo-novella was used as a stimulus to get members of the community or target group to talk about the characters in the stories and relate their (the characters') stories to their own life situations. This idea of using stories to educate people on how to deal with certain life problems has also been used successfully in mass media programmes like *Soul City* (Social Surveys, 2002) and health outreach programmes for tuberculosis (Dick, 1994). Lauby et al. reported that community volunteers were well received, and that greater agency was achieved among participants to negotiate condom use with male partners.

Researchers who follow this approach argue that the characteristics of the target community need to be thoroughly researched by means of ethnographic methods (Higgins et al., 1996). The intervention needs to be grounded in the emerging findings of this research and built around its emerging hypotheses. This view is strongly advocated by the Federal Agency in the USA, who developed the AIDS Community Demonstration Project as a blueprint for funding community HIV prevention programmes (Dearing, Larson, Randall & Pope, 1998). In developing countries, however, the necessary funding to conduct focused or applied ethnographic studies in target communities or population groups is often lacking. Petersen and Bhana (2004) suggested doing rapid focused ethnographies as a quick way to gain information about the research community, and building interventions from this information base. However, even this approach may be too complicated for community-based organisations that tend to have little research expertise and may have to rely on technical assistance for this (Gibbs, Napp, Jolly, Westover & Uhl, 2002).

There are few reports of programmes driven by behavioural or cognitive theories having been successful when implemented in community contexts in developing countries. This might be related to the fact that individual decisions are more often influenced by broader societal and community enabling factors (Campbell & Williams, 1999; DiClemente & Wingood, 2004; Ellison, Parker & Campbell, 2004). It has been argued that community-oriented theories might be more useful in developing HIV prevention programmes for developing country contexts (Campbell & Cornish, 2003; Visser & Schoeman, 2004). Campbell (2003) extended the conceptualising of the health-enabling community with the notion of *social capital*. She distinguished between two types of social capital, namely bonding social capital and bridging social capital. Bonding social capital refers to the trust, mutual support and common positive identity that exist in relationships within homogenous groups or communities. Peer educator programmes typically seek to use these features in social groups to promote HIV prevention behaviours. An explorative study in rural Zimbabwe, for example, suggested that young women who were satisfied with the performance of the group to which they belonged were more likely to engage in HIV protection behaviours (Gregson, Terceira, Mushati, Nyamukapa & Campbell, 2003). Another study in Ghana found that there was a link between religious affiliation and AIDS knowledge among women (Takyi, 2003).

Bridging social capital refers to networks and links between diverse groups with various levels of access to material wealth and power on the basis of some overlapping mutual interest (Campbell, 2003). Community mobilisation programmes (cf. Ainsworth et al., 2002; Duongsa & Duangsa, 2004; Elkins et al., 1996) seek to utilise both bridging and bonding social capital by drawing on stakeholder participation in and around the community as a means of overcoming health and social inequities, as well as gender and racial inequalities within target communities or population groups (Gilbert & Walker, 2002). The process evaluation of the Summertown project (Campbell, 2003) illustrated the complexities involved in combining bridging and bonding capital in the development and implementation of community programmes. The need to incorporate an understanding of the cultural values of the target population in the development of community prevention programmes have been stressed by many social scientists and should only be ignored at the peril of implementing non-effectual programmes (Airhihenbuwa & Webster, 2004; Gausset, 2001; Van Dyk, 2001). The vulnerable position of women in sub-Saharan Africa with respect to risk of HIV infection has been singled out as the target for future HIV prevention programmes (UNAIDS, UNFPA & UNIFEM, 2004). The high prevalence of HIV/AIDS among women and the fact that girls get infected

at a younger age (compared to boys) place the imperative on HIV prevention programmes to build social capital as part of their strategy to reach out to communities (Gilbert & Walker, 2002).

Institution-based community prevention programmes

A common mistake committed by many who conduct community-based programmes is not defining *who* the community is who is to be reached with the intervention programme (Campbell, 2003). It is imperative that community-based organisations, HIV activists and researchers recognise institutions in and around the geographic community that influence behaviours within the community in various ways. These institutions may play a crucial role in promoting or inhibiting the efficacy of intervention programmes in the community (cf. Campbell & Williams, 1999). In this section we discuss programmes that have been implemented in three types of institutions existing in most communities, namely health services, schools and places of work or employment.

Health services-based prevention programmes

Health services-based interventions for the prevention of HIV/AIDS in community settings are normally extensions of the clinic's antenatal, family planning and sexually transmitted infections treatment and prevention services (Kalichman et al., 2000). These include intervention activities such as voluntary counselling and testing (VCT), condom promotion and distribution, STI screening and treatment, and prevention of mother-to-child transmission (PMTCT) programmes. The last activity is strictly a biomedical or clinical intervention, and thus also goes beyond the scope of this discussion and review. An exploratory study in Swaziland revealed that adolescents prefer to receive sexual risk behaviour information from health workers, which suggests that the latter could play a greater role in HIV education (Buseh, Glass, McElmurry, Mkhabela & Sukati, 2002).

Condom promotion and distribution

Condom promotion and distribution strategies have shown promise for improving HIV prevention behaviours. Promotion of male condoms was an integral component of the highly successful programmes conducted in Thailand (Ainsworth et al., 2002) and Uganda (Blum, 2004). In both these countries male condoms were available at public health institutions at no cost, and the health system played a definite supporting role in reaching out to the community to promote condoms, being

accessible to potential users and having a ready supply of condoms available on request. Arguably the most successful condom promotion programme to date, the '100% Condoms' campaign in Thailand, demonstrated that, when targeted at high-risk groups, condom promotion strategies would be more effective than universal condom promotion programmes. In contrast, a condom promotion and distribution and awareness campaign utilising health workers and teachers in Zambia did not report successes in improving abstinence, condom use or reduction in casual sex among several targeted groups (Hughes-d'Aeth, 2002). The reason for this reported outcome may be that the campaign targeted diverse at-risk groups and did not acknowledge the dimensions of difference that exist between these groups or their influence on sexual behaviour and their attitudes towards HIV protection.

The female condom was introduced to selected audiences in reproductive health facilities and through public and private outlets in Brazil, Ghana, South Africa and Zimbabwe (Warren & Philpott, 2003). This intervention focused on training health workers and other providers on how to use female condoms. The various outlets also reported that demand for female condoms was favourable. The authors estimated that manufacturing costs for female condoms could be reduced to as little as US\$ 0.57, if governments were willing to commit to buying in bulk. They argued that, although somewhat costly for resource-poor countries, this would present a possible cost benefit when compared to the public health costs saved from STI and HIV diagnosis and treatment. Since female condoms are reusable, cost to consumers or clients is also somewhat reduced. Other advantages of the female condom are that it is effective, easy to learn to use, has no side effects and is not tied to sophisticated medical facilities (Kaler, 2001). Many feminists and health activists view female condoms as a means of empowering women to take charge of their own reproductive health by giving them control over their bodies and autonomy from other individuals, institutions and belief systems. Secondly, it is believed that female condoms could protect women from the dangers of heterosexuality by allowing them to insert the condom up to eight hours before sex, doing so secretly without having to discuss this with the partner and being protected from men who deliberately damage male condoms when forced to use them. Being able to insert a female condom in beforehand was seen by participants as a means to protect women from coercive sexual encounters and rape. A randomised controlled trial in rural Kenya showed that STI education, the promotion of both male and female condoms and case management contributed to decreases in STI prevalence (Feldblum, Kuyoh, Bwayo, Omari, Wong et al., 2001).

The female condom does have some drawbacks. Since Warren and Philpott's (2003) multi-country study was implemented with the buy-in from national health departments, questions remain about the sustainability of female condom promotion and distribution, both of which rely heavily on government supply or subsidies. The issue of costs remains pertinent with female condoms costing up to ten times more than male condoms (Kaler, 2001). Another factor that impeded implementation was that female condoms were new to the consumers and not widely in use. However, Kaler's (2001) observations in South Africa and Kenya suggested that utilising community-based distributors and outreach workers might go a long way to bridging community resistance to new technology. Though female condoms have been hailed as a marker for women's empowerment, the fact remains that they are not entirely invisible, and still continue to draw resistance from male partners (Feldblum et al., 2001). In this regard, anti-HIV microbicides may provide a better option and should be further developed and tested. Although the trial by Feldblum and others showed good effect in reducing STI incidence, it was not clear whether this was the result of the female condom distribution strategy, other components of the intervention or a combination of some. Thus, the effectiveness of female condom distribution in reducing STI/HIV infection still needs to be determined.

In summary, male condom promotion should include both a general awareness component as well as targeted interventions to specific groups that are known to be high-risk for HIV infection. In the latter case, interventions must be tailored to this group (or groups), taking into consideration the context in which sexual behaviours take place. Female condoms may present a case for women empowerment by virtue of leaving the decision about condom use in the hands of women rather than men. Resistance by community members in general and men specifically, as well as lack of availability and cost, remains a barrier to the use of female condoms as a protective mechanism for HIV prevention for women. The role of health services in condom promotion strategies is essential as distribution points, but needs to be supported by community outreach workers and public and private outlets to allow for maximum distribution in the population.

Syndromic STI management

It has been clinically proven that people presenting with STIs have greater risk of becoming infected with HIV. This is also true because people who have a history of STI episodes are more prone to engage in unsafe sexual behaviour. Two studies conducted in Uganda, however, have shown varied results. Wawer, Sewankambo, Serwadda, Quinn, Paxton et al. (1999) reported that a home-based

mass treatment of STI for adults in a rural district every 10 months over three years significantly reduced the prevalence of certain STIs. However, this study reported no improvement (decrease) in HIV infection rates. In another study (Kamali, Quigley, Nakiyingi, Kinsman, Kengeya-Kayondo et al., 2003) the syndromic management of STIs was combined with an IEC component to see if the management of STIs made a difference in infection rates. This study found no improvement in HIV infection rates. However, the study reported significant improvement in reported condom use. Kamali et al. (2003) argue that the specific STIs targeted in their intervention did not allow for greater sensitivity in picking up the more serious STIs and those more commonly associated with HIV infection. In the study by Wawer et al. (1999) the high STD prevalence and high HIV infection rate could have influenced the results of the study markedly. It is suggested that at the peak of a pandemic the infection rates tend to taper off, irrespective of whether the intervention is successful or not, because the number of people at risk is saturated. This means that people are getting re-infected. They also argued that when interventions target specific segments of the population that are more at risk, this could lead to increases in the HIV infection rates, as measures to detect infection and reporting are improved in the process of conducting the study.

Another potential intervention that may be rolled out by health services to the community is VCT for couples (Painter, 2001). Thus far VCT centres have been operating mainly from existing PHC facilities and as separate entities. Since the spread of HIV infection has been carried by heterosexual encounters, it makes sense to increase coverage to address couples as well. To date no evaluations have been conducted of community VCT programmes. It is suggested that promotion of VCT services to communities be undertaken to address general resistance against knowing one's HIV status (Van Dyk & Van Dyk, 2003).

School-based prevention programmes

The school is often used by peer educators as a base for reaching out to youth with HIV prevention information and activities aimed at promoting healthy sexual behaviour. However, programmes that target only in-school youth (Campbell & MacPhail, 2002) tend to have less success than those with a greater community focus (Reijer, Chalimba & Nakwagala, 2002). As mentioned earlier, the Summertown project's school-based peer educator programme was blocked by the highly regulated and rigid school system. Although this programme sought to embed the peer education programme in the school within a health-enabling community, the latter

was not successfully established. The fact that the programme was solely based within and dependent on the cooperation of the school system contributed to the lack of success in implementing the intervention. Another example of a programme that failed to bring about changes in sexual behaviour due to the strictly regulatory environment in the school, is the guardian programme for schoolgirls in Tanzania (Mgalla, Schapink & Boerma, 1998). In the guardian programme female teachers were used to act as guardians to schoolgirls, so that the latter would be encouraged and feel comfortable to take issues pertaining to sexuality to their guardian to discuss openly and without judgement. The rationale for the programme was to protect young girls from coercive and other sexual relations with older men especially, by creating channels for communication about sex-related issues. This programme failed, because the school system had a rigid policy of dealing with sexual offenders, by expelling pregnant girls from school and handing out corporal punishment to learners caught having sex, and teachers only advising learners to abstain from sex. A review of school-based prevention programmes for African youth showed that these programmes only succeeded in changing sexual behaviour among younger learners in primary and early secondary school (Gallant & Maticka-Tyndale, 2004).

In Namibia the notion of health-promoting environments has been raised, which points to a possible role that schools could play in educating the broader community about HIV/AIDS and sexual risk behaviour where understanding of these are lacking (Campbell & Lubben, 2003). Reijer et al. (2002) reported increases in HIV/AIDS awareness among youth, decreases in teenage pregnancies, as well as a high demand for AIDS clubs in the community as a result of the programme. The programme included Life Skills education in the school, anti-AIDS clubs based at the school, skills clubs for in- and out-of-school youth, as well as innovative mass media campaigns to promote awareness of the programme through advertisements, radio, music, soap opera and print. In Zimbabwe Community Project Clubs were established at a number of farm schools to equip children with skills and to create awareness about HIV/AIDS in the schools and in the surrounding communities (Fox, Oyosi & Parker, 2002). Activities of the clubs include drama performances based on HIV/AIDS issues and gardening projects in which vegetables are grown and sold and the profits from sales are used to meet material needs of orphans at the school. The link between the school and the community is a powerful component of a school's health-promoting environment (Campbell & Lubben, 2003). Where awareness of HIV/AIDS is lacking in the community, learners and teachers could play an important role in reaching out to other members of the community. This is

important so that what is taught in schools in sex education is understood in the community.

In summary, indications are that school-based prevention programmes that focus exclusively on learners within the school tend to be subject to control by the school system (Campbell, 2003). It is suggested that in order to minimise this control, prevention programmes use the school only as a base to reach out to youth in the community (out-of-school), as well as learners within the school and other schools in the environment (Fox et al., 2002). Furthermore, school-based prevention programmes must be endorsed and supported by the broader community to make sure that what young people receive from the school-based programme is reinforced at home and by religious and other institutions (Lopez et al., 2004; Kleintjes, Peltzer, Shishana, Niang, Seager et al., 2004).

Examples of programmes that took place outside of the school setting but also focused on life skills development are the Masiye Camp in Zimbabwe and the Humuliza project in Tanzania (Fox et al., 2002). Both programmes focused on children affected by HIV/AIDS. The Masiye Camp taught children life skills through outdoor recreational activities, aerobics, counselling sessions, craft activities and traditional dancing. The goal of these activities was to help children overcome their fears, and become self-confident and strong in mind and body. Constant and long-term support was provided to the children after the camp through follow-ups in their own communities. The Humuliza project aimed to assist in the development of coping capacities of children and to preserve their capacity to act in order to influence a situation, and to create an understanding and competent social environment for them.

Workplace-based prevention programmes

Workplace-based prevention programmes have a special place in the discussion on community HIV prevention, because of the interaction between employees and other segments of the community (outside of the company), which may influence efforts to reduce HIV infection in the broader community. The example of Summertown shows that failure to involve the main employer in the township – the mine company – as a participating stakeholder hindered the effectiveness of outreach to CSWs (Campbell, 2003). Though primary prevention was targeted at CSWs through a community peer education programme, the largest proportion of the CSWs' clients were employed by the mining company and they did not receive any intervention in this regard (Campbell & Williams, 1999). It has been argued that protective behaviour such as

condom use in commercial sex has to be tackled both from the CSW's and the client's perspective (Ainsworth et al., 2002). Interventions should seek to reinforce consistent condom use and deal with power and gender dynamics within the community in a constructive way that would leave CSWs empowered to negotiate, and maybe even insist on, condom use with clients and others.

Factors that contribute to effective community interventions for HIV/STD prevention are the establishment of community, business and CBO partnerships; maintenance of the intervention post-research funding, and buy-in by the community or target group (Ross & Williams, 2002). Simon-Meyer and Odallo (2002) reported successes with involving people living with HIV/AIDS (PLWHA) in various interventions in communities and places of employment in South Africa to break the silence and stigma around HIV/AIDS. They showed that PLWHA were effective advocates in mobilising communities, setting up workplace programmes and creating general awareness of HIV/AIDS among CSWs around mines, the workplace and in the media. Social movements such as the Treatment Action Campaign (TAC) in South Africa and the Movement of Men Against AIDS in Kenya (MMAAK) reach out to workers who are HIV positive through networking and advocacy programmes (Mkala & Onyango, 2004). The Positive Workers Union has been set up in several companies in Kenya as part of MMAAK activities to support men.

The need to reach out to CSWs with prevention interventions has been mentioned before. Pathfinder International (2004) developed programmes that reach out to CSWs and their clients in India, Uganda, Tanzania, Nigeria, Brazil and Bangladesh with STI/HIV/AIDS prevention. These programmes seek to reach out to CSWs and their clients through comprehensive, participatory initiatives. These include dealing with underlying conditions that lead people into sex work and enlist the support of government, policy makers, brothel owners and community organisations to create a safer atmosphere for CSWs and their clients; STI and family planning services at free-standing clinics and in brothels; peer education; support and care for PLWHA; communication for behaviour change; activities and training for CSWs for income generation, and building institutional capacity for NGOs and CSW associations. The Targeted Interventions for Groups At Risk (TIGRIS) project in India target brothel-based and non-brothel-based sex workers and their clients through clinic and community-based STI diagnosis and treatment, HIV education and prevention, as well as behaviour change programmes. In Uganda, condoms, STI treatment and vocational skills are provided to young CSWs. In Brazil CSW associations have been formed for advocacy regarding the rights of CSWs.

In addition to CSWs, several other professions have been targeted for HIV prevention by community programmes as a result of their interaction with community members who may fuel the spread of the HIV pandemic. Hughes-d'Aeth (2002) reports that teachers, traditional birth attendants, traditional healers, health workers, police, businesses and trade union representatives could be trained to bring prevention messages to those with whom they interact while performing their professional duties. Pathfinder International (2004) implemented workplace programmes in Lesotho, Ethiopia and Bangladesh that involve training workplace promoters, youth peer educators and health service providers as counsellors and primary caretakers in the workplace. The programmes also include advocacy and sensitisation activities for the workplace, distributing educational material on STI/HIV/AIDS at bus, truck and train stations and establishing or providing clinic and community-based essential health services. In Nigeria specific programmes have been set up to reach out to army, navy, air force and police staff through various awareness-raising activities and reproductive health services. In Uganda BCC campaigns targeted young military staff to reduce casual sex and commercial sex encounters, which were known to fuel the spread of HIV in the country (Alonso, 2004).

Lessons learnt

Prevention programmes do not operate in a vacuum. The review of several community-wide prevention strategies highlighted the need to create an environment where people were at least aware of the dangers of HIV/AIDS and where AIDS is talked about openly without fear of discrimination and stigmatisation (Bessinger et al., 2004; Stadler & Hlongwa, 2002). The demonstration of political will – from government to local level – has been highlighted as one of the key components for effective national HIV prevention strategies (Ainsworth et al., 2002; Parkhurst & Lush, 2004). Several programmes (e.g. *loveLife*, *Soul City*) demonstrated that utilising mass media to educate communities can be effective as a first step towards behaviour change. However, it has been clearly articulated that raising awareness by giving information needs to be followed up with specific communications to promote and enable desired protective behaviours (Parker, 2004). The role of government sectors, again, is critical in ensuring availability of condoms and access to reproductive health services, for example (Blum, 2004).

The challenges and failures of general community-wide programmes to reach out-of-mainstream groups such as CSWs and out-of-school youth have been mentioned (Rakotonanahary et al., 2002; Ramirez et al., 2000). Two techniques that have been

implemented widely to reach out to these and other at-risk groups *within* communities were peer education and community mobilisation. These techniques were most successful when utilised in community-based interventions, where characteristics of the target groups could be researched and the intervention be tailored according to the community setting (Lopez et al., 2004). Failure of peer education and community mobilisation programmes has been linked to lack of social empowerment within communities (Beeker et al., 1998). The need to create a health-enabling environment has been stressed (Campbell & Lubben, 2003), and where this was not successfully established, it was clearly illustrated that potential positive effects of the intervention were diminished (Campbell, 2003). Social capital was introduced as a central concept linking HIV prevention with social development within community contexts. Utilising social capital, however, has proven to be much more complex at the level of programme implementation as very intricate community dynamics have to be traversed.

The essence and contributions of institutions and structures such as health services, schools and places of employment are essential for community-imbedded interventions (Campbell & Williams, 1999; Gallant & Maticka-Tyndale, 2004; Painter, 2001). These institutions provide valuable infrastructure and systems of communication to support community-based initiatives (Campbell, 2003). The latter systems may also provide bridging social capital to bring resources for HIV prevention to the community (e.g. Painter, 2001; Reijer et al., 2002). Failure to make resources available to the community, however, may cause division between the community and the institution, and hinder the institution in fulfilling its predefined community task (Naidoo, 2003). This relates to the already mentioned issue of an implementation approach to community interventions.

Some issues with respect to the implementation of community-based HIV prevention interventions need to be highlighted. These include characteristics of the environment that facilitate or inhibit the intervention, information about the organisations that implement community programmes with specific reference to funding and research sources, and issues of sustainability and transferability.

Environmental characteristics

Successes like those achieved by the ‘100% condoms’ programme in Thailand (Ainsworth et al., 2002) would not be possible or sustainable without adequate support from the health services sector. As reported elsewhere (Elkins et al., 1996) Thailand boasted a highly developed infrastructure for health, education and social welfare,

which facilitated the roll-out of the programme nationally. Another characteristic of the Thailand experience was that interventions to mobilise communities around HIV/AIDS awareness started during the early stages of the HIV pandemic. Thus, by the time the '100% condoms' programme was implemented, considerable activity regarding raising awareness within various communities has already been implemented or was still in progress. It has been argued elsewhere (Campbell, 2003) and demonstrated in Thailand (Aheto & Gbesemete, 2004) and Uganda (Parkhurst & Lush, 2004; Blum, 2004) that prevention efforts are more effective when they are backed by strong political leadership from national government with respect to HIV/AIDS.

The community-based prevention programmes described earlier provide proof that interventions need to be accompanied by support from government sectors, particularly the health services. In developing countries where poverty is pronounced among those communities with high vulnerability to HIV infection, the availability of free condoms is essential to effectively promoting safe sex among those who are sexually active (Bessinger et al., 2004). It has been demonstrated that a history of STI episodes increases the risk of HIV infection for that person (Hitchcock & Fransen, 1999). Although the effectiveness of community-based STI interventions is not conclusively proven (Kamali et al., 2003; Wawer et al., 1999), the availability and accessibility of clinics to provide STI and other reproductive health services enhance efforts at the community level to promote awareness about safe sex behaviours among those groups that run a high risk of HIV infection (Campbell, 2003).

Characteristics of community organisations

Studies in developed countries have shown that prevention programmes that took into consideration specific aspects of targeted communities and used people from those communities to deliver the intervention were more effective in reaching high-risk groups with health prevention messages (Kalichman et al., 2000). Community-based organisations and non-governmental organisations that used people from targeted communities in their prevention programmes as change agents found greater acceptability of the intervention by the broader community, and had a greater chance of success (Harper & Carver, 1999) and sustainability due to the inherent community empowerment component of such programmes (Kalichman et al., 2000).

Another issue relating to characteristics of organisations is that of collaboration between community organisations in developing countries and research and other organisations from developed countries (Harper & Carver, 1999). In developing

countries, accessing funds to deliver prevention programmes is critical for service providers (Magongo, Parker & Kelly, 2004). The pool of money available within their country (from national grants) is limited and often fiercely contested, leaving them with the only option of seeking funding from corporate companies and international funding agencies. Not only do such partnerships provide sufficient financial resources for implementation, but they also facilitate the transfer of technical support from partner organisations in developed countries to implement evidence-based interventions and to conduct evaluation research into programme effectiveness (Campbell, 2003). In some cases community programmes have been implemented by international organisations such as UNAIDS and WHO, through their local offices or branches within developing countries (UNICEF-Ghana, 2002). The advantages of multiple organisations and partners for implementing community-based prevention programmes are numerous. As already mentioned, it allows for sufficient funding to implement technically sophisticated programmes that often require additional infrastructure and staffing (Stadler & Hlongwa, 2002). International funding grants also include an allocation for thorough evaluation of programme outcomes (Social Surveys, 2002). These partnerships bring host country organisations (based in developing countries) into contact with 'experts' from developed countries, who could help with the development, implementation and evaluation of complex evidence-based interventions. Such partnership brings scientific evidence that is mostly inaccessible (only published in scientific journals and academic books) closer to community service providers. The partnership benefits members of local community service organisations who can gain experience in implementing science-based interventions as well as build capacity for conducting evaluation research.

However, despite these advantages several challenges remain for international partnerships. The issue of equal participation in the development of prevention programmes remains pertinent (Cain, 1997). Tensions between local priorities and scientific interests need to be negotiated in a democratic manner that does not leave the host partner disempowered (Naidoo, 2003). On the other hand, funding partners from developed countries would want to ensure and be assured of accountability with respect to the use of funds. The presence of locally based offices in the host country (as explained above) goes a long way to ensuring responsiveness to local priorities and that local cultural practices and values are respected (UNICEF-Ghana, 2002). In the case where local community organisations partner with research institutions in developed countries it may be advisable that a research institution in the host country be a partner as well. Participation of local researchers (based within the host country) in programme development could facilitate the reconciliation of scientific interests

and community priorities (Campbell, 2003; Wawer et al., 1999). In this way a diplomatic resolve could be reached where prevention science is made relevant, applicable and useful to the local community AND where intervening at community level contributes to the expansion of the scientific knowledge base. It is imperative that local researchers act as translator and interpreter in the dialogue between funding partner and community service provider, democratising the process of negotiations. A further advantage of involving local research organisations is that it could ease concerns that international funding partners might have about where their money goes.

Sustainability and transferability

Programmes that utilise members of the target community to deliver the intervention demonstrate a greater likelihood of sustainability. Interventions such as peer education and community mobilisation not only bring about a natural transference of knowledge and skills to members of the intervention team through training components, but also have a better prognosis of the intervention being sustainable beyond the duration of the study. Campbell (2003) showed that training community members to deliver the intervention is in itself not sufficient to ensure transferability of technology and sustainability. She argued that specific management skills are needed to ensure that implementation of the intervention is not side-tracked by various group dynamics within the intervention team as well as within the broader community. It may also be important that fidelity measures be taken to ensure that the intervention programme is implemented as initially planned. On the other hand, the sustainability of a programme may well be dependent on the ability to adapt to changing dynamics and situations within the intervention community.

Summary

In summary, the major requirements of community-based HIV prevention programmes, key barriers and some key strategies that have been and could be implemented for effective intervention are reviewed. Effective community-based prevention strategies require an environment that enables individuals to make decisions and change behaviours towards safe sex practices, whether abstaining completely, staying faithful to one partner or using condoms regularly (Blum, 2004). Creating a health-enabling environment often goes beyond the scope and exceeds the capacity of community organisations and research programmes (Campbell,

2003). The need for demonstrative political will in the fight against HIV/AIDS and effective community-wide (national) awareness programmes have been advocated as steps towards establishing a platform from which community-based prevention programmes could be built (Parkhurst & Lush, 2004). Committed resources (such as health services) to HIV prevention programmes go a long way toward fighting the pandemic (Ainsworth et al., 2002). In addition, community organisations would need knowledge about the community and dominant modes of HIV transmission in the community. Without such information, intervention programmes would not reach those who are most at risk for infection. Lastly, community organisations would benefit from a grounded knowledge and understanding of health promotion models in developing interventions that are tailored to community contexts.

Key barriers to implementing effective prevention programmes are the following: conflicting messages about HIV/AIDS being given to communities from government as well as local groups; lack of unification on community level; and resistance to health technologies. Despite widespread criticism of the ABC (Abstinence, Be faithful, and Condoms) approach to prevention, Uganda has used this strategy to great effect (Blum, 2004). The key to their success in lowering the rate of HIV infection lies in this message being consistently propagated at all levels – government, health services and communities/grassroots. When compared to the vast number of mass media programmes in South Africa, each with their own message, and government's flirtation with opposing ideas that HIV is not a necessary and sufficient cause for AIDS, it is understandable why community members are hesitant to believe what is being told to them through community-based HIV prevention programmes (Campbell, 2003). Conflicts and conflicting ideas within a community present another major barrier to effective prevention programmes as these [conflicts] divide the community, create an atmosphere of distrust and suspicion, and bedevil efforts to utilise resources (social capital) in the community. These conflicts are often rooted in the race, culture and economic make-up and resultant inequalities that exist within communities. The evidence of such conflicts can be seen in the existence of marginalised groups (e.g. out-of-school youth, CSWs and PLWHA) who are the victims of social and economic discrimination and exclusion. Lastly, within the African context of severe poverty it is often believed that community programmes should necessarily have a social development component (UNAIDS, 2004). Researchers and public health activists, who spend a lot of money and resources fighting an invisible disease, are often perceived as being oblivious to and unconcerned with the life struggles that the community face on a daily basis. Thus, when protective measures such as condoms are introduced to communities without addressing other

urgent community needs, these are almost always viewed with scepticism and distrust.

The most important strategy to overcoming barriers in the community towards prevention programmes is involving the community in aspects of development, implementation and even monitoring and evaluation. This has been done through peer education training, community mobilisation and stakeholder participation. However, before these techniques are implemented, community characteristics have to be explored and resultant reports verified by a selected number of community members (Corby et al., 1996; Fishbein et al., 1996; Higgins et al., 1996; Schnell et al., 1996; Simons, Rietmeijer, Kane, Guenther-Grey, Higgins et al., 1996; Valentine et al., 1996). Based on this report, members of the community could be approached to form part of stakeholder panels, planning councils or community forums that would be consulted throughout the process of development and implementation of the programme (Elkins et al., 1996). Care should be taken to include those community members most affected by AIDS (including those who are HIV positive) and to give them a voice in contributing to decision making. Where certain theoretical approaches are judged to be best suited to intervention in a particular setting, time should be taken to 'educate' community stakeholders about the rationale and benefits of such an approach so that they can make an informed decision about its implementation. Rules and protocol governing the [participatory] process should be clearly spelled out, to ensure that the project remains on track and that conflicts are handled in a forthright and transparent manner. The power of stakeholder participation (their commitment to the project) can be increased by involving their respective institutions (i.e. health services, schools and places of employment around the community) as platforms to launch aspects of the intervention. In this way the project would also benefit from existing infrastructure and systems of communication (bridging social capital). Drawing other community organisations in as stakeholders to the programme could ensure that the community does not receive conflicting messages around HIV, and that the message promoted by the intervention does not contravene prevailing (and acceptable) culture and norms of society (Airhihenbuwa & Webster, 2004; Naidoo, 2003).

Democratising discourse is central to fruitful participatory processes. Whereas the Thai culture could be characterised as one of submissiveness (Duongsaa & Duangsa, 2004; Elkins et al., 1996), the same would not be the case in many African countries where power dynamics are very pertinent (Campbell, 2003). Government could play a crucial role by setting appropriate policy and legislation-regulating interactions between international donors and local community organisations and, in doing this,

harmonising power imbalances between partners (Cain, 1997; Parker, 2003). Another way to deal with the imbalance of power between community organisations that provide the intervention and community recipients is by making learning the centrifugal force in participatory processes. Researchers could educate stakeholders about health promotion models and behavioural theories, while they themselves could learn from stakeholders about the community. Effective learning would ease concerns about acceptability, and once this group ‘owns’ the intervention, they could act as change agents in the community. A truly participatory process has the potential to create the platform to introduce specific issues within HIV prevention science that demand attention – i.e. the vulnerable position of women and girls, CSWs and other marginalised groups – and place these issues on the table for discussion (Ainsworth et al., 2002).

Another critical barrier to implementing effective prevention programmes is funding (De Cock, Mbori-Ngacha & Marum, 2002). The increasing number of partnerships between local community organisations and researchers on the one hand, and international funding agencies on the other hand, has led to the implementation of costly evidence-based HIV prevention programmes all across sub-Saharan Africa. Increased project budgets made it also possible for these programme implementers to employ community members in aspects of the intervention, which in a limited way could be perceived as them ‘seeing’ the community’s need and ploughing, in a symbolic sense, a portion of programme funds back into the community. The use of community members in programme implementation has also been found to improve acceptability of the intervention by community members.

Recommendations

Effective prevention at community level requires that intervention activities be aligned with overarching national strategies. Community-based organisations and researchers implementing prevention programmes should actively seek to promote the messages that are being proclaimed through IEC and BCC campaigns. In this way a united front would be presented to communities about the dangers of HIV/AIDS and what actions could be taken to prevent spread of the pandemic. Though awareness programmes seldom lead to behaviour change, the massive contribution that these programmes make in creating a platform (environment) for further and specific intervention should be acknowledged and supported (Parker, 2004). Nation-

wide awareness may also communicate a favourable message to donors that HIV/AIDS is being viewed nationally as a priority disease (d’Cruz-Grote, 1996).

At government level national frameworks should be developed to regulate community activities. All community organisations should be mandated to subscribe to these guidelines. At provincial or regional level a secretariat should be established to monitor and support community organisations in accordance with national frameworks. Part of this mandate should be to set up forums for dialogue and collaboration between various community organisations. The secretariat may also act in a guiding capacity, drawing attention to specific issues at community level that demand attention for intervention, such as youth, women’s rights and CSWs (UNAIDS, UNFPA & UNIFEM, 2004).

The national framework should develop frameworks for partnerships between local service providers and community organisations and international donors. Such a framework may serve as a means to hold community prevention programmes accountable to good practice and sustainability. Also, such a framework may ease concerns by NGOs and CBOs regarding funding, by setting up guidelines for exchange between these partners and creating capacity within smaller organisations to apply for funding grants. Currently this role is taken by grantmakers (e.g. Nelson Mandela Foundation in South Africa, FACT in Zimbabwe and Siselo Trust in Botswana), but governments should provide the administrative structure to generate a pool of resources that could be earmarked for community programmes.

Incentives should be given to academic institutions to strengthen and complement research capacity in community organisations for the implementation of evidence-based programmes and rigorous evaluation of interventions. In the same way that universities receive funding for publications in scientific journals, target measures could be set for departments to get involved in community-based work that would make them eligible for further government awards.

It is the authors’ recommendation that governments should explore ways to appropriately reward schools, health services and work places that are involved in HIV prevention programmes. Rewards for health services should go directly towards staff to motivate them to work with the community and do beyond what is merely expected in terms of job descriptions. Companies involved in community programmes should be given incentives such as tax deductions and favourable status inferred (such as when competing for government tenders and licencing).

It is strongly propagated that community programmes integrate both prevention and care programmes (Colfax & Dawson-Rose, 2004). Although it might fall outside the expertise and experience of certain organisations focusing on HIV prevention,

avenues could be explored to join their efforts with other community organisations that provide care and support in the community. HIV prevention programmes that target youth should also include a component that encourages those who are HIV positive to go for treatment (Amon, 2002). Knowledge that treatment for AIDS is available may help to reduce the stigma around being HIV positive, and encourage prevention behaviours. Also, the new information that AIDS drugs (ART) are available should be incorporated into prevention messages to ensure that people are fully informed about the nature and extent of treatment, and its implication for further health (De Cock, Marum & Mbori-Ngacha, 2003). Prevention activities and programmes should include those who are HIV positive to prevent re-infection (themselves) and further infection (of others).

The vulnerable position of women and girls has been emphasised throughout. This necessitates that HIV prevention programmes be complemented with social development programmes. Support programmes, such as those reviewed by Strebel (2004), should be incorporated alongside prevention and care programmes to provide a comprehensive response to HIV/AIDS on community level (Menting, 1999). It is thus recommended that various community organisations involved in the same community work together – complementing each other and communicating with each other – to maximise their effectiveness in their respective services (Kelly, 2000).

References

- Aheto, D.W. & Gbesemete, K.P. (2004). Rural perspectives on HIV/AIDS prevention: a comparative study of Thailand and Ghana. *Health Policy*. Retrieved November 11, 2004 from <http://www.sciencedirect.com.html>.
- Ainsworth, M., Beyrer, C. & Soucat, A. (2002). AIDS and public policy: the lessons and challenges of 'success' in Thailand. *Health Policy*, 64, 13-37.
- Airhihenbuwa, C.O. & Webster, J.D. (2004). Culture and African contexts of HIV/AIDS prevention, care and support. *Journal of Social Aspects of HIV/AIDS Research Alliance*, 1, 4-13.
- Alonso, A. (2004). Strategies in HIV prevention: the A-B-C approach [letter]. *The Lancet*, 364, 1033.
- Amon, J.J. (2002). Preventing HIV infections in children and adolescents in sub-Saharan Africa through integrated care and support activities: a review of the literature. *African Journal of AIDS Research*, 1, 143-149.
- Asthana, S. & Oostvogels, R. (1996). Community participation in HIV prevention: problems and prospects for community-based strategies among female sex workers in Madras. *Social Science and Medicine*, 43, 133-148.
- Baltazar, A., Fages, V., Nzima, M., Kironde, S., Mwachibuzi, H., Richardson, J. & Nfuko, M. (2004). Out-of-school youth as community mobilizers: an innovative method of involving orphans and vulnerable children in community communication in Muheza, Tanzania [poster]. Bangkok: *XV International AIDS Conference*.
- Beeker, C., Guenther-Grey, C. & Raj, A. (1998). Community empowerment paradigm drift and the primary prevention of HIV/AIDS. *Social Science and Medicine*, 46, 831-842.
- Bessinger, R., Katende, C. & Gupta, N. (2004). Multi-media campaign exposure effects on knowledge and use of condoms for STI and HIV/AIDS prevention in Uganda. *Evaluation and Program Planning*, 27, 397-407.
- Blum, R.W. (2004). Uganda AIDS prevention: A, B, C and Politics. *Journal of Adolescent Health*, 34, 428-432.
- Boadi, E. & Essandoh, E.K. (2004). Ensuring the meaningful involvement of youth in HIV prevention programs: lessons from Ghana [poster]. Bangkok: *XV International AIDS Conference*.

- Buseh, A.G., Glass, L.K., McElmurry, B.J., Mkhabela, M. & Sukati, N.A. (2002). Primary and preferred sources for HIV/AIDS and sexual risk behaviour information among adolescents in Swaziland, South Africa. *International Journal of Nursing Studies*, 39, 525-538.
- Cain, R. (1997). Environmental change and organizational evolution: reconsidering the niche of community-based AIDS organizations. *AIDS Care*, 9, 331-344.
- Cain, R.E., Schulze, R.W. & Preston, D.B. (2000). Developing a partnership for HIV primary prevention for men at high risk for HIV infection in rural communities. *Promotion and Education*, 75-78.
- Campbell, B. & Lubben, F. (2003). The provision of a health promoting environment for HIV/AIDS education: the case of Namibian senior secondary schools. *International Journal of Educational Development*, 23, 529-542.
- Campbell, C. (2003). *Letting them die: why HIV/AIDS intervention programmes fail*. Cape Town: Double Storey Books.
- Campbell, C. & Cornish, F. (2003). How has the HIV/AIDS pandemic contributed to our understanding of behaviour change and health promotion? In G. Ellison, M. Parker, & C. Campbell (Eds.), *Learning from HIV and AIDS* (pp. 148-177). Cape Town: Cambridge University Press.
- Campbell, C. & MacPhail, C. (2002). Peer education, gender and the development of critical consciousness: participatory HIV prevention. *Social Science and Medicine*, 55, 331-345.
- Campbell, C. & Williams, B. (1999). Beyond the biomedical and behavioural: towards an integrated approach to HIV prevention in the Southern African mining industry. *Social Science and Medicine*, 48, 1625-1639.
- Clacherty, G. (2003). *loveLife: promoting sexual health and healthy lifestyles*. Johannesburg: Clacherty and Associates.
- Colfax, G. & Dawson-Rose, C. (2004). Integrating HIV prevention into the care of people with HIV. *HIV InSite*, February.
- Corby, N.H., Enguidanos, S.M. & Kay, L.S. (1996). Development and use of role model stories in a community level HIV risk reduction intervention. *Public Health Reports*, 111, 54-58.
- d'Cruz-Grote, D. (1996). Prevention of HIV infection in developing countries. *The Lancet*, 348, 1071-1074.

- Dearing, J.W., Larson, R.S., Randall, L.M. & Pope, R.S. (1998). Local reinvention of the CDC HIV prevention community planning initiative. *Journal of Community Health*, 23, 113-126.
- De Cock, K.M., Marum, E. & Mbori-Ngacha, D. (2003). A serostatus-based approach to HIV/AIDS prevention and care in Africa. *The Lancet*, 362, 1847-1849.
- De Cock, K.M., Mbori-Ngacha, D., & Marum, E. (2002). Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century. *The Lancet*, 360, 67-72.
- Delate, R. (2001). *The struggle for meaning: a semiotic analysis of interpretations of the loveLife His&Hers billboard campaign*. Durban: University of Natal.
- Dick, J. (1994). *Adherence to anti-tuberculosis therapy in Cape Town*. Unpublished doctoral dissertation, University of Cape Town.
- DiClemente, R.J. & Wingood, G.M. (2004). Expanding the scope of HIV prevention for adolescents: beyond individual-level interventions. *Journal of Adolescent Health*, 26, 377-378.
- Duongsoo, U. & Duongsoo, D. (2004). Lessons learnt from promoting participatory learning from local responses to HIV/AIDS in Thailand. Bangkok: *XV International AIDS Conference*.
- Ellison, G.T.H., Parker, M. & Campbell, C. (2004). Introduction. Learning from HIV and AIDS: from multidisciplinary to interdisciplinarity. In G.T.H. Ellison, M. Parker & C. Campbell (eds), *Learning from HIV and AIDS*. Cambridge: University Press.
- Elkins, D.B., Kuyyakanood, T., Maticka-Tyndale, E., Rujkorakarn, D. & Haswell-Elkins, M. (1996). Multisectoral strategy for AIDS prevention at community level. *World Health Forum*, 17, 70-74.
- Feldblum, P.J., Kuyoh, M.A., Bwayo, J.J., Omari, M., Wong, E.L., Tweedy, K.G. & Welsh, M.J. (2001). Female condom introduction and sexually transmitted infection prevalence: results of a community intervention trial in Kenya. *AIDS*, 15 (8), 1037-1044.
- Finger, B., Lapetina, M. & Pribila, M. (2002). *Intervention strategies that work for youth* (Youth Issues Paper I). Family Health International, YouthNet Program.
- Fishbein, M., Guenther-Grey, C., Johnson, W.D., Wolitski, R.J., McAlister, A., Rietmeijer, C.A. & O'Reilly, K. (1996). Using a theory-based community intervention to reduce AIDS risk behaviours: the CDC's AIDS Community Demonstration Projects. In S. Oskamp & S.C. Thompson (eds), *Understanding and preventing HIV risk behaviour*. California: Sage Publications.

- Fox, S., Oyosi, S. & Parker, W. (2002). *Children, HIV/AIDS and communication in South Africa – A literature review*. Johannesburg: Centre for AIDS Development, Research and Evaluation.
- Gallant, M. & Maticka-Tyndale, E. (2004). School-based HIV prevention programmes for African youth. *Social Science and Medicine*, 58, 1337-1351.
- Gausset, Q. (2001). AIDS and cultural practices in Africa: the case of the Tonga (Zambia). *Social Science and Medicine*, 52, 509-518.
- Gibbs, D., Napp, D., Jolly, D., Westover, B. & Uhl, G. (2002). Increasing evaluation capacity within community-based HIV prevention programs. *Evaluation and Program Planning*, 25, 261-269.
- Gilbert, L. & Walker, L. (2002). Treading the path of least resistance: HIV/AIDS and social inequalities – a South African case study. *Social Science and Medicine*, 54, 1093-1110.
- Gregson, S., Terceira, N., Mushati, P., Nyamukapa, C. & Campbell, C. (2003). Community group participation: can it help young women to avoid HIV? An exploratory study of social capital and school education in rural Zimbabwe. *Social Science and Medicine*, 58, 2119-2132.
- Gruber, J. & Caffrey, M. (2004). HIV/AIDS and community conflict in Nigeria: implications and challenges. *Social Science and Medicine*, 60, 1209-1218.
- Hainsworth, G. (2002). *Providing sexual reproductive health and STI/HIV information and services to this generation – Insights from the Geração Biz Experience*. Watertown, MA: Pathfinder International.
- Hainsworth, G. (2004). *Preventing HIV/AIDS among youth*. Watertown, MA: Pathfinder International.
- Harper, G.W. & Carver, L.J. (1999). “Out-of-the-mainstream” youth as partners in collaborative research: exploring the benefits and challenges. *Health Education and Behaviour*, 26, 250-265.
- Higgins, D.L., O’Reilly, K., Tashima, N., Crain, C., Becker, C., Goldbaum, G., Elifson, C.S., Galavotti, C. & Guenther-Grey, C. (1996). Using formative research to lay the foundation for community level HIV prevention efforts: an example from the AIDS Community Demonstration Projects. *Public Health Reports*, 111, 28-35.
- Hitchcock, P. & Fransen, L. (1999). Preventing HIV infection: lessons from Mwanza and Rakai. *The Lancet*, 353, 513-515.

- Hughes-d'Aeth, A. (2002). Evaluation of HIV/AIDS peer education projects in Zambia. *Evaluation and Program Planning*, 25, 397-407.
- Ismail, Y., Watt, A., Allen, K. & Pepper, L. (2003). Providing HIV/AIDS care in Mbarara, Uganda. *The Lancet*, 3, 169-171.
- Kaler, A. (2001). "It's some kind of women's empowerment": the ambiguity of the female condom as a marker of female empowerment. *Social Science and Medicine*, 52, 783-796.
- Kalichman, S.C., Rompa, D., Cage, M., DiFonzo, K., Simpson, D., Austin, J., Luke, W., Buckles, J., Kyomugisha, F., Benotsch, E., Pinkerton, S. & Graham, J. (2000). Effectiveness on intervention to reduce HIV transmission risks in HIV-positive people. *American Journal of Preventive Medicine*, 21, 84-92.
- Kalichman, S.C., Somlai, A. & Sikkema, K. (2000). Community involvement in HIV/AIDS prevention. In N. Schneiderman, M.A. Speers, J.M. Silva, H. Tomes, and J.H. Gentry (eds.), *Integrating Behavioral and Social Sciences with Public Health*. Washington DC: American Psychological Association.
- Kamali, A., Quigley, M., Nakiyingi, J., Kinsman, J., Kengeya-Kayondo, J., Gopal, R., Ojwiya, A., Hughes, P., Carpenter, L.M. & Whitworth, J. (2003). Syndromic management of sexually-transmitted infections in behaviour change interventions on transmission of HIV-1 in rural Uganda: a community randomised trial. *The Lancet*, 361, 645-651.
- Kelly, K. (2000). *Communicating for Action – A contextual evaluation of youth responses to HIV/AIDS*. Beyond Awareness Campaign, HIV/AIDS and STD Directorate, and Department of Health.
- Kelly, K., Parker, W. & Oyosi, S. (2001). *Pathways to Action: HIV/AIDS prevention, children and young people in South Africa – A literature review*. Centre for AIDS Development, Research and Evaluation.
- Kelly, K. & Parker, W. (2002). *Communities of practice. Contextual mediators of youth response to HIV/AIDS* (Rep. No. Stage Two Report). Beyond Awareness Campaign, HIV/AIDS Directorate, and Department of Health.
- Kleintjies, S., Peltzer, K., Shishana, O., Niang, J., Seager, J. & Kaseje, D. (2004). Report and policy brief: 2nd Annual Conference on Social Aspects of HIV/AIDS Research, Cape Town, 9-12 March. *Journal of Social Aspects of HIV/AIDS*, 1(2), 62-77.
- Lauby, J.L., Smith, P.J., Stark, M., Person, B. & Adams, J. (2000). A community-level HIV prevention intervention for inner-city women: results of the Women and Infants Demonstration Projects. *American Journal of Public Health*, 90, 216-222.

- Lopez, S.I., Gomez, H., Baez, M. & Portes, C.R. (2004). *Systematization and documentation of best BCC practices to fight HIV/AIDS in youth aged 10-19*. Coalition of non-governmental organizations in the area of HIV/AIDS of the Dominican Republic.
- Low-Beer, D. & Stoneburner, R.L. (2004). *Social communications and AIDS population behaviour changes in Uganda compared to other countries*. Centre for AIDS Development, Research and Evaluation.
- Magongo, B., Parker, W. & Kelly, K. (2004). Addressing the challenges of funding local responses – case study from South Africa. Bangkok: *XV International AIDS Conference*.
- Menting, A. (1999). HIV prevention strategies in Africa. *Harvard AIDS review*.
- Mgalla, Z., Schapink, D. & Boerma, J.T. (1998). Protecting school girls against sexual exploitation: a guardian programme in Mwanza, Tanzania. *Reproductive Health Matters*, 6, 19-30.
- Mkala, Z. & Onyango, M. (2004). Involving men in HIV prevention, care and support in Kenya. Bangkok: *XV International AIDS Conference*.
- Naidoo, P. (2003). *Youth divided: a review of loveLife's Y-centre in Orange Farm, Gauteng*. Centre for AIDS Development, Research and Evaluation.
- Ntuli, A., Ijumba, P., McCoy, D., Padarath, A. & Berthiaume, L. (2003). *HIV/AIDS and health sector responses in South Africa. Treatment access and equity: balancing the act* (Discussion Paper Number 7). EQUINET.
- Painter, T. (2001). Voluntary counselling and testing for couples: a high-leverage intervention for HIV/AIDS in sub-Saharan Africa. *Social Science and Medicine*, 53, 1397-1411.
- Parker, W. (2003). Re-appraising youth prevention in South Africa. Durban: *South African AIDS Conference*.
- Parker, W. (2004). South Africa's Beyond Awareness Campaign: tools for action. Bangkok: *XV International AIDS Conference*.
- Parkhurst, J.O. & Lush, L. (2004). The political environment of HIV: lessons from a comparison of Uganda and South Africa. *Social Science and Medicine*, 59, 1924.
- Pathfinder International (2004). *STI/HIV/AIDS programs for commercial sex workers*. Watertown, MA: Pathfinder International.
- Patten, S. & Ibanez-Carrasco, F. (2004). Where to begin? Assessing research capacity in community-based HIV/AIDS organizations. Bangkok: *XV International AIDS Conference*.

- Pearlman, D.N., Camberg, L., Wallace, L.J., Symons, P. & Finison, L. (2002). Tapping youth as agents for change: evaluation of a peer leadership HIV/AIDS intervention. *Journal of Adolescent Health, 31*, 31-39.
- Petersen, I. & Bhana, A. (2004). Rapid focused ethnographic research methodology. Bangkok: *XV International AIDS Conference*.
- Petersen, I. & Swartz, L.P. (2002). Primary health care in the era of HIV/AIDS. Some implications for health systems reform. *Social Science & Medicine, 55*, 1005-1013.
- Pozo, G., Argandona, A. & Kane, M. (2004). HIV/AIDS prevention project among adolescents in La Paz, Bolivia. Bangkok: *XV International AIDS Conference*.
- Rakotonanahary, A., Rafransoa, Z. & Bensaid, K. (2002). Qualitative evaluation of HIV/AIDS IEC activities in Madagascar. *Evaluation and Program Planning, 25*, 341-345.
- Ramirez, J.I., Gosset, D.R., Ginsburg, K.R., Taylor, S.L. & Slap, G.B. (2000). Preventing HIV transmission: the perspective of inner-city Puerto Rican adolescents. *Journal of Adolescent Health, 258-267*.
- Rebchook, G. & Kegeles, S. (2004). Community-based organizations put prevention science into practice by adopting an evidence-based HIV prevention intervention. Bangkok: *XV International AIDS Conference*.
- Reijer, P., Chalimba, M. & Nakwagala, A.A. (2002). Malawi goes to scale with anti-AIDS clubs and popular media. *Evaluation and Program Planning, 25*, 357-363.
- Richter, L., Manegold, J. & Pather, R. (2004). *Family and community interventions for children affected by AIDS*. Cape Town, HSRC Publishers.
- Ross, M.W. & Williams, M.L. (2002). Effective targeted and community HIV/STD prevention programs. *Journal of Sex Research, 39*.
- Schnell, D., Galavotti, C., Fishbein, M. & Chan, D.K. (1996). Measuring the adoption of consistent use of condoms using the stages of change model. *Public Health Reports, 111*, 59-68.
- Senderowitz, J. (2004). *Partnering with African youth: Pathfinder International and the African Youth Alliance Experience*. Pathfinder International.
- Shisana, O., Hall, E., Maluleke, K.R., Stoker, D.J., Schwabe, C., Colvin, M. Chauveau, J., Botha, C., Gumede, T., Fomundam, H., Shaikh, N., Rehle, T., Udjo, E. & Grisselquist, D. (2002). *The impact of HIV/AIDS on the health sector: national survey of health personnel, ambulatory and hospitalised patients and health facilities, 2002*. Cape Town: Human Sciences Research Council.

- Sikkemda, K.J., Kelly, J.A., Winett, R.A., Solomon, L.J., Cargill, V.A., Roffman, R.A. et al. (2000). Outcomes of a randomized community-level HIV prevention intervention for women living in 18 low-income housing developments. *American Journal of Public Health, 90*, 57-63.
- Simon-Meyer, J. & Odallo, D. (2002). Greater involvement of people living with HIV/AIDS in South Africa. *Evaluation and Program Planning, 25*, 471-479.
- Simons, P.Z., Rietmeijer, C.A., Kane, M.S., Guenther-Grey, C., Higgins, D.L. & Cohn, D.L. (1996). Building a peer network for a community level HIV prevention program among injecting drug users in Denver. *Public Health Reports, 3*, 50-53.
- Skinner, D., Tsheko, N., Mtero-Munyati, S., Segwabe, M., Chibatamoto, P., Mfecane, S., Chandiwana, B., Nkomo, N., Tlou, S. & Chitiyo, G. (2004). *Defining orphaned and vulnerable children*. (Social Aspects of HIV/AIDS and Health Research Programme, Occasional paper no. 2). Cape Town: HSRC Publishers.
- Smith, M.U. & DiClemente, R.J. (2000). STAND: A peer educator training curriculum for sexual risk reduction in the rural South. *Preventive Medicine, 30*, 441-449.
- Social Surveys (2002). *Evaluation of Soul City Series 5*. Johannesburg: Soul City.
- Stadler, J. & Hlongwa, L. (2002). Monitoring and evaluation of *loveLife's* AIDS prevention and advocacy activities in South Africa, 1999-2001. *Evaluation and Program Planning, 25*, 365-376.
- Strebel, A. (2004). *A literature review of evidence-based interventions for home-based child-centred development*. Cape Town: HSRC Publishers.
- Takyi, R.K. (2003). Religion and women's health in Ghana: insights into HIV/AIDS preventive and protective behaviour. *Social Science and Medicine, 56*, 1221-1234.
- UNAIDS (2004). *2004 Global report on the HIV/AIDS epidemic*. Geneva: UNAIDS.
- UNICEF (2004). *Facing the future together. Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa*. New York: UNICEF.
- UNICEF-Ghana (2002). Evaluation of HIV/AIDS prevention through peer education, counselling, health care, training and urban refugees in Ghana. *Evaluation and Program Planning, 25*, 409-420.
- UNAIDS, UNFPA & UNIFEM (2004). *Women and AIDS: confronting the crisis*. Geneva: UNAIDS, UNFPA & UNIFEM.

- UNAIDS, UNICEF & USAID (2002). *Children on the brink 2002: a joint report on orphan estimates and program strategies*. Geneva: UNAIDS, UNICEF & USAID.
- Valentine, J. & Wright-De Aguero, L. (1996). Defining the components of street outreach for HIV prevention: the contact and the encounter. *Public Health Reports*, 111, 69-74.
- Van Dyk, A.C. (2001). Traditional African beliefs and customs: implications for AIDS education and prevention in Africa. *South African Journal of Psychology*, 31(2), 60-66.
- Van Dyk, A.C. & Van Dyk, P.J. (2003). "What is the point of knowing?": psychosocial barriers to HIV/AIDS Voluntary Counselling and Testing programmes in South Africa. *South African Journal of Psychology*, 33(2), 118-125.
- Van Wyk, B.E., Benjamin, E. & Sandenbergh, R. (2003). *Assessment of staff-support needs of facility managers in the Nyanga health district*. Cape Town: Medical Research Council.
- Visser, M.J. & Schoeman, J.B. (2004). Implementing a community intervention to reduce young people's risks for getting HIV: unravelling the complexities. *Journal of Community Psychology*, 32(2), 145-165.
- Walters, A.S. (1999). HIV prevention in street youth. *Journal of Adolescent Health*, 25, 187-198.
- Warren, M. & Philpott, A. (2003). Expanding safer sex options: introducing the female condom into National Programmes. *Reproductive Health Matters*, 11, 130-139.
- Wawer, M.J., Sewankambo, N.K., Serwadda, D., Quinn, T.C., Paxton, L.A., Kiwanuka, N., Wabwire-Mangen, F., Li, C., Lutalo, T., Nalugoda, F., Gaydos, C.A., Moulton, L.H., Meehan, M.O., Ahmed, S., Rakai Project Study Group & Gray, R.H. (1999). Control of sexually transmitted diseases for AIDS prevention in Uganda: a randomised controlled trial. *The Lancet*, 353, 525-535.

Social Aspects of HIV/AIDS and Health Research Programme



Occasional Papers from the HSRC Press

This informative series is a means of disseminating information on the organisation's research output. Through these papers, topical information can be disseminated as and when the debates rage and while topics are 'hot'! The papers are printed on demand and are also available for free download online at www.hsrcpress.ac.za. If you are interested in receiving information about existing and forthcoming Occasional Papers, please complete the form on the next page.

Subscriptions

www.hsrcpress.ac.za



Please mail or fax this form to the HSRC's sales agent:

For sales within Africa:

Blue Weaver Marketing,
PO Box 30370, Tokai 7966, South Africa.
Fax: +27-21-701-7302
or email: booksales@hsrc.ac.za

For sales in North America:

Independent Publishers Group
Fax: +1+312-337-5985
or email: frontdesk@ipgbook.com

Please advise me

by email by post

of details about:

- current and future Occasional Papers by the Social Aspects of HIV/AIDS and Health Research Programme of the HSRC;
- current and future Occasional Papers produced by the HSRC across all subject areas.

I understand that receiving this information places no obligation on me to purchase copies.

Name

Organisation

Designation/
Department

Postal address (if no email)

Postal code

Tel Fax

email

Date

- Chief Executive Officer HSRC: Dr Olive Shisana
- Chair of HSRC Council: Prof. Jakes Gerwel
- Publishing Director: Garry Rosenberg

