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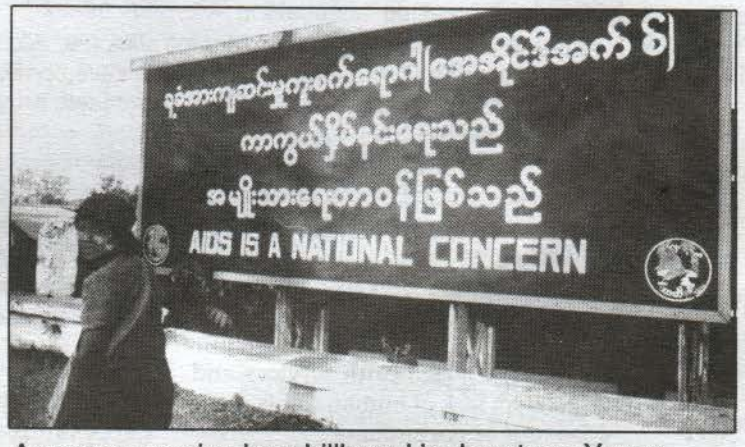
Much more than information



Nancy-Amelia Collins

A woman passing by a billboard in downtown Yango (Rangoon)- In spite of the billboards, there is little AIDS awareness or education in Burma.

All too often, HIV prevention programmes focus on providing information, and encouraging individuals to change their behaviour. But just knowing the facts is not enough. Like all human behaviour, what people do sexually (and why, where, and with whom) is influenced by a large number of factors:

- what people know or don't know (knowledge)
- what they think or feel, and what they feel able to do (beliefs, attitudes and self-esteem)
- what they know how to do (skills)
- how other people in the community behave, think and feel (peer pressure and social influences)
- the wider environment (culture, religion, economic opportunities, health policies, legislation, and service provision).

People's age and sex also affect what they do. For example, men and women are expected to act in very different ways. Both sexes are influenced by very strong and widely held beliefs about appropriate male and female behaviour.

All these factors influence how people behave and their health. This means that programmes working with people to help make their sexual lives safer (and reduce their risk of HIV/STDs) need to explore how these issues affect what people do, and consider how to address them (see pages 6 and 7).

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

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

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

Participation is key

The authors of the case study on page 11 explain how they have begun to broaden the focus of an HIV prevention campaign with sex workers in rural India to make changes in their wider social and economic environment. The article on page 3 describes how programmes are working with key influential individuals to generate shifts in social influences and local policy. The case studies illustrate the importance of enabling people to identify their own priorities, and to respond in an appropriate way. Health and education programmes can never do this for people, but can only work with them to help with the process. As one trainer asks: "Do you agree or disagree with the statement: it is very difficult to change people's sexual behaviour." Usually, everyone agrees except for the trainer herself. She responds: "I disagree, because it's not just difficult, it's impossible!" Participants usually laugh in agreement, and go on to discuss why.

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Fulfilling individual needs

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

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

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

Making environments supportive

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

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

Social and cultural influences

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

Policies and legislation

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

Economic opportunities

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

Condom supply and health services

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

Open environment

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

With thanks to Nancy Fee and Rakesh Rajani.

Global AIDS News, no 1, 1995 (from GPA/WHO).

Training activity: education strategies

This training activity aims to help participants to think about health education techniques. Teaching a child about teeth brushing is used as an example of behaviour change. Although teaching children is very different from working with adults, using this simple example helps to highlight the main principles before beginning to discuss more complex issues of sexual behaviour. Participants are asked to name different methods they would use to encourage a child to brush their teeth. These are written on a board or paper:

- describing what could happen if teeth are not cleaned (i.e.understanding risk)
- involving the child's older brother or sister (i.e. positive peer pressure)
- saying that everyone else does it (i.e. norms)
- encouraging the child to feel good about having clean teeth (i.e. increasing self-esteem)
- providing a toothbrush or cleaning stick (i.e. access to materials)
- demonstrating and helping (i.e. skills development)
- building on what the child thinks about teeth brushing (i.e. increasing knowledge).

By identifying these different elements, participants realised that they had themselves used all the different strategies, and also that health education is not a top down or one-off activity. In further sessions, participants begin applying these ideas to participatory AIDS education. Working in small groups, they discuss how to work with people's specific perspectives and needs.

Peter Barker/Panos Pictures

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

Talking about tradition

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

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

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

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

One practice that could lead to HIV/STD transmission is the custom of male circumcision at puberty. After the circumcision has been done by traditional practitioners, young men are required to have sexual intercourse with two to four different women.

People also discussed issues such as multiple sexual partners, abortion, teenage pregnancy, family planning (including access to condoms), and young people leaving the area. The study findings were presented to officials at district level, who agreed to support an HIV/STD education programme. The programme began in co-operation with the health service, churches, schools and government.

Discussing sexuality

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

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

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

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

Continuing discussion

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

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

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

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

Irko Zuurmont/Yayasan Haumeni

Drawing 'maps' of male and female bodies promotes open discussion.

Guidelines for Effective Educational Materials

When do HIV/AIDS information materials cross the line between being educational and being pornographic?

In 1994, controversy arose in the Philippines over HIV/AIDS materials produced by two non-government organisations (NGOs). The materials were a brochure and poster, and a series of comic books. These had been developed for specific audiences, namely sex workers and men who have sex with men. When the materials reached the general public, the influential Catholic Church hierarchy as well as other sectors were in an uproar. The visuals and text of the materials were considered "offensive" and "pornographic", and not appropriate for the general public. Conservative sectors called for censorship of HIV/AIDS educational materials.

The controversy was addressed by the Philippine National AIDS Council (PNAC), a multi-sectoral body composed of national government agencies and NGOs working with different sectors of the population. The NGOs in the PNAC advocated for guidelines on the development and distribution of materials. The idea was not for censorship but for constructive inputs on how to produce materials which are effective and appropriate.

The process of drawing up IEC (information/education/communication) guidelines involved consultations with different organisations producing HIV/AIDS educational materials. Existing materials were reviewed to derive a picture of the current standard of IEC materials. The draft guidelines were also reviewed at meetings of the PNAC.

The resulting documents were the IEC Guidelines, which provides inputs on how to develop and disseminate materials, and the IEC Checklist, which is designed to help evaluate the quality of an IEC material.

Although the PNAC developed and endorsed the Guidelines and Checklist, it does not review IEC materials produced by the different sectors. The PNAC believes that while organisations have the responsibility of developing quality materials, they also maintain their autonomy in carrying out HIV/AIDS prevention efforts.

The IEC Guidelines and Checklist, which were adopted by the PNAC in June 1995, are currently undergoing review and evaluation, after which the Guidelines/Checklist will be revised to be more responsive to the concerns of people and organisations involved in HIV/AIDS education and prevention.

The IEC Guidelines of the PNAC are reproduced below. Due to space limitations, the IEC checklist will be featured in the next issue of *Aids Action*.

Philippine National AIDS Council Guidelines on HIV/AIDS IEC Activities

1. The main objective of these Guidelines on IEC activities is to support and encourage efforts to minimize the spread of HIV and to reduce the impact of AIDS on the individual, the family, the community and society.
2. The Guidelines aim to ensure the quality of IEC activities on HIV/AIDS. The Guidelines would assist in the development of IEC activities, as well as in the evaluation of existing IEC activities related to HIV/AIDS.
3. The Guidelines are recommendatory in nature; they do not constitute legal obligations. The Guidelines are not for censorship purposes.
4. These Guidelines constitute general principles which could be adopted by individuals and organisations working on HIV/AIDS prevention efforts. All members of the PNAC, who will be signatory to this document, are expected to abide by these Guidelines.
5. The PNAC may also recommend the Guidelines to other organisations, and encourage them to consider the Guidelines in the development of their IEC activities. The Guidelines may apply to educational as well as promotional (advertising) activities. Other organisations which are encouraged to consider the Guidelines in their IEC activities are the government, non-government organisations, civic organisations, the private sector, producers of prophylactics and other products used in connection with HIV/AIDS, the promotions industry (advertising agencies, etc.), hospitals, health personnel, and all others involved in HIV/AIDS prevention efforts.
6. The Guidelines will apply to the following IEC activities:
   - print - newsletters, news reports, brochures, posters, leaflets, hand-outs, fliers, billboards, T-shirts, and others
   - electronic broadcast - radio, TV, film, and video
   - interpersonal communication - counselling, workshops, lectures, focus group discussions, etc.
7. The Guidelines operationally define "quality" of IEC activities as follows:
   - **Accurate** - Biomedical and technical information should be consistent with empirical evidence of the World Health Organisation, the Department of Health, or other recognized scientific bodies. The IEC activity may cite bibliographical references to establish accuracy of information presented.
   - **Clear** - the intended audience should be able to readily understand the content and message of the IEC activity.
   - **Appropriate** - To the target audience
   - **Acceptable** - The material/activity is not offensive or distasteful to the target audience.
8. The Guidelines further recommend that IEC activities be:
   - gender sensitive (non-homophobic and non-misogynist)
   - affirmative (non-alarmist, non-fear arousing, and non-coercive)
   - nonmoralist and non-condemnatory
   - non-pornographic

The following discussion provides a more detailed explanation:

Gender sensitive
IEC activities should not show sexual bias or discrimination based on gender. Since women are more often discriminated against than men, IEC activities should not be anti-women (misogynist). Anti-women attitudes are reflected in visuals (photos, illustrations) as well as in language. IEC activities should not portray women as being inferior to men, and women should not be portrayed as sex objects solely for the pleasure of men. The portrayal of women (whether directly or indirectly) as being the ones responsible for the spread of HIV is inaccurate, as well as being sexist. Also in line with gender sensitivity, IEC activities should not be anti-homosexual (homophobic), and should not portray homosexuality as abnormal behaviour.

Affirmative
It is recommended that IEC activities use affirmative approaches. Alarmist, fear-arousing and coercive messages have been proven to be counter-productive, as these do not contribute to an atmosphere conducive to a thorough discussion of HIV/AIDS.

Non-moralist and non-condemnatory
It is recommended that producers of IEC materials/activities do not impose their moral code on the target audience. It is also recommended that IEC activities do not condemn any individual or population group for attitudes or behavior which may differ from those of the IEC producers.

Non-pornographic
The aim of IEC activities is to inform and educate. In contrast, the aim of pornography is to titillate or arouse sexual desire. IEC activities should be non-pornographic – and their main purpose should be educational.

9. The distribution of materials is crucial in HIV/AIDS education activities. In line with the Guidelines' goal of "appropriateness," the organisation should undertake measures to ensure that its materials are distributed to the intended target audience.

The following measures are recommended:

a. A "protective clause" on the cover of the material may indicate the nature of the material. This will serve as a protection for the organisation as well as to the audience, who will be advised in advance of what the material contains. The protective clause may specify the objective of the material, its content, and the intended target audience.
b. Organisations are encouraged to keep a logbook to record where their materials have been distributed.

Provided that measures have been undertaken to ensure appropriate distribution, organisations will not be held liable for the second-hand or third-hand distribution of their materials.

10. In developing IEC materials, the Guidelines recommend the following:

a. Baseline research would help the organisation identify knowledge gaps and attitudes and behaviour which may increase the risk of HIV infection. The appropriate IEC materials could then be developed based on the research results.
b. The Guidelines strongly recommend that a pre-test be conducted with a group similar to the intended audience before the materials are finalized.
c. An organisation may also consider having a panel of "experts" review the material before it is finalized.
d. For materials which are to be translated into other languages, it is recommended that back translations be carried out to ensure that the translation is true to the original version.

Explanatory Note

Baseline research enables the researcher to draw up a profile of the target group. Baseline research usually determines the knowledge, attitudes and practices of the target population. These data can be generated either through quantitative methods (such as surveys) or through qualitative methods (focus group discussions, etc.). Results of the baseline research would point to areas of concern which need to be addressed by the IEC material/activity.

Pre-test of the material/activity is usually done with a group similar to the one the material/activity is intended for. Respondents from the target group are given a draft or a prototype of the material/activity for them to evaluate. A pre-test may use quantitative or qualitative methods. The pre-test will help ensure that a material/activity is effective, appropriate, and acceptable to the target audience. Depending on the pre-test results, the material/activity may need to be revised.

Panel review is similar to the pre-test, except that the ones reviewing the material/activity need not necessarily come from the intended target group. The panel is usually composed of people who have the experience and capability needed to objectively evaluate the material/activity.

Back translation is done when a material/activity is translated from one language to another. This process is conducted to ensure that the material/activity is not inadvertently misinterpreted or distorted in the process of translation.

After the original material has been prepared, the following steps should be undertaken:

a. The original document is translated into another language (e.g. from English to Tagalog)
b. The translated version (e.g. Tagalog) is translated back to the original language (e.g. English) by a person other than the one who did the original translation. The output of this step is the "back-translation".
c. The two versions (the original and the back-translation) are compared to determine if the back-translation is consistent with the original version. Although the actual text of the back-translation may differ from the original, the concepts discussed and the manner of presentation should be consistent with the original. If there are inconsistencies, the translated version needs to be revised.

Source: Charlotte Peden Johannesburg City Health AIDS Prevention Programme

This diagram divides the influences on individual behaviour into five key areas. The top levels represent the wider political, economic and social influences. The lower levels refer to individual attitudes, knowledge and skills.

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

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

Group activity

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

You will need:
3 large boards or sheets of paper

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

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

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

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

Possible barriers to HIV prevention

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

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

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

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

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

Society — *Community* — *Individual*

Ways to reduce risk

1. SUPPORTIVE ENVIRONMENT

Policy and laws/human rights
- legal access to condoms
- decriminalising same-sex relationships and sex work
- sex education in schools
- legal rights for women e.g. property and safety
- legal rights for people with HIV

Access to materials and services
- integration of HIV/STD programmes into primary health care services
- safe blood supply
- health services for young people
- access to clean injecting equipment
- collaboration between government, church and NGOs
- voluntary HIV testing and counselling
- affordable condoms

Economic opportunities
- employment for women and young people
- adequate income for men and women
- adequate alternatives to sex work
- employment for people with HIV

Open environment
- positive media images about people with HIV
- clear and frank messages about HIV
- condom advertising

2. HELPFUL SOCIAL AND CULTURAL INFLUENCES

- challenging early sexual activity
- challenging alcohol-related violence
- women have right to refuse sex or leave violent partners
- accepting abstinence, faithfulness, condom use as normal practice
- challenging traditions such as widow inheritance
- promoting practices and traditions that reduce risk
- support for opportunities for girls and women
- less stigma about STDs
- include people living with HIV in making decisions
- involve community and religious leaders
- men and women sharing sexual responsibility

3. POSITIVE ATTITUDES AND BELIEFS

- believing men and women are equal
- working with people as equals
- wanting to make sex safer and enjoyable
- accepting people's right to different ways of life and sexuality
- caring for others
- understanding personal risk
- accepting young people's rights
- personal motivation to reduce risk
- belief and confidence in yourself and abilities
- having respect for others including people with HIV
- seeking STD care if needed
- feeling able to be different e.g. postpone sex
- being involved in community activities

4. INCREASING KNOWLEDGE

- reproductive health
- facts about HIVand STDs
- enjoyable safer sex
- infection control
- how to care for sick people
- human sexual and emotional development
- safe injecting drug use

5. MORE SKILLS

- leadership
- participatory teaching
- counselling
- basic nursing and caring
- communication/ negotiation skills
- being able to use a condom
- income generation skills
- assertiveness for women and young people

Asian Women Facing Greater Risks

Two international conferences draw attention to the plight of women in the region.

ONCE at the sidelines of the HIV/AIDS pandemic, women are increasingly being sucked into the centre of the vortex of the deadly disease.

In many parts of the developing world, Asia included, AIDS is still viewed as a homosexual male and foreign affliction. But the World Health Organization (WHO) is sending out a grim, wake-up call: Women now make up half of all new HIV infections.

Every minute, two women are infected with the human immunodeficiency virus that causes AIDS. Every two minutes, one woman dies of AIDS.

In 1980, women were almost absent from the HIV/AIDS pandemic. But of the 18 million HIV positive adults in 1994, at least eight million women (a little over 44 percent) are of childbearing age.

Of this number, 5.5 million HIV-infected women live in Africa. As of 1994, 1.3 million of the estimated 3 million HIV-infected adults in South and South-East Asia were women.

Some 500,000 women died from AIDS in 1994 and one million new infections affect women each year. WHO projects that by the year 2000, 13 million women will be infected with HIV – equaling the number of men expected to be infected.

Women, especially adolescents and young girls, are today the group most swiftly being hit by the HIV crisis.

"Female vulnerability has become increasingly clear in Africa and Asia," says a 1995 report on "Facing the Challenges if HIV, AIDS and STDs: A Gender-Based Response", by the Royal Tropical Institute, the Southern Africa AIDS Information Dissemination Service and WHO.

This trend may well have implications not just for women's lives but for families, children, communities and economies.

"Women are dying needlessly. They are becoming infected with HIV, for the simple reason that we are not doing enough to stop it," Canada's Cindy Robbins of the International Community of Women Living with HIV/AIDS said at a packed seminar at the Fourth World Conference on Women in Beijing in September.

Five HIV-positive women had gone to Beijing to drum up awareness of unique ways that HIV/AIDS affects women. One day, September 5, was designated "Women and AIDS Day", along with World Health Day.

Women are more vulnerable to physical, emotional and social pressures that come with the disease, for which the prospect of a cure or vaccine is unlikely over the next decade.

First, women are biologically more susceptible to contracting HIV, so that male-female transmission is up to four times as efficient as the reverse. Women have higher rates of sexually transmitted diseases, which aids HIV transmission.

Socio-cultural and economic factors ranging from poverty, lower status compared to men and lack of control over sexual relations and behaviour ease HIV transmission and make them less able to protect themselves against infection.

In some places, women are unable to say no to husbands who they know have HIV. When they get sick, women can pass on the virus to their babies through delivery or breast-feeding. Often they are expected to provide care for husbands or relatives who fall ill, but may not get the same care themselves.

Experts are asking Asia to heed the warning signs now prevalent in sub-Saharan Africa. Expert projections say that by 1996, more Asians will be infected with HIV every year than in Africa. From the current 3 million, WHO says

HIV-infected Asians will number 10 million in five years.

Worrisome trends are already emerging for Asia, the world's most populous continent that experts say will be the locus of AIDS' spread by the century's end. Thailand, Burma and India are among the hardest hit by the pandemic in Asia.

Asia is already vulnerable to AIDS due to its commercial sex industry, intravenous drug use and intra-regional mobility. But the face of AIDS has been changing over the years, one trend being the emergence of heterosexual transmission as a main mode of infection.

"It is a fact not repeated enough that 90 percent of women who have been infected with HIV have only ever slept with one man in their lives, their husbands," said Marina Mahathir, daughter of Malaysian premier Mahathir Mohamad and head of the Malaysian Council of NGOs on AIDS.

Yet if a woman tests positive for HIV, "she is assumed to have had multiple sex partners," she said in a conference on AIDS in Manila last year.

In a position paper for Beijing, WHO says studies in some countries show up to 30 percent of HIV infections are taking place in women "whose only risk behaviour is sexual intercourse with a single male partner who in turn has had, or is continuing to have, unprotected sex with other partners."

The Association of South-East Asian Nations Task Force on AIDS, meeting in Manila in October, said over 70 percent of recorded HIV transmissions occur through unprotected sex.

The changing face of AIDS requires that AIDS programmes focus not just on sexual behaviour but tread on more sensitive ground such as cultural practices, male-female relations and women's economic dependence on men.

At the Third International Conference on AIDS in the Asia-Pacific in Chiang Mai, Thailand in September, experts said many Asian programmes still target mainly "high risk" groups such as drug users, commercial sex workers despite the fact that heterosexual sex has become a main mode of infection.

A common perception is that women, especially sex workers, are disease "carriers" and thus bear responsibility for being "clean", with little thought for the male clients who go to them. Men who seek out younger girls think they are safer, but this puts the girls at even greater risk.

"For too long, male promiscuity, including paying for sex with prostitutes, has been tolerated and accepted," says a WHO report on a February 1995 consultation on AIDS in Geneva.

Using a condom is still among the most effective preventive measures around, but this has run into other problems.

In some countries women find it hard to negotiate with sexual partners on condom use. Others, as a Thai study showed , shy away from discussions on condoms because it is "men's business". Those carrying condoms are seen as promiscuous and wives who suggest their use are accused of mistrusting husbands or shirking marital duties.

Anti-AIDS campaigns can become quite complicated. A study conducted in Palembang, Indonesia, found that married women as associating AIDS with "loose women, rather than believing themselves to be at risk".

The local women believe AIDS was contracted through "sexual contact with the lower class of commercial sex workers" and that the higher class had usually been protected from STDs. AIDS, they concluded, comes from "promiscuous women and multiple partners".

Sex workers are at times unable or unwilling to impose condom use on customers, though fully aware of the dangers of unprotected sex, because they cause customer discomfort or dissatisfaction.

Still, frank anti-AIDS campaigns are emerging even in more conservative societies like Malaysia. Even in the Philippines, the government's promotion of condoms has met with objections from Roman Catholic Church, which equates it with promiscuity.

"The question of Asian values is often used to prevent discussion on why people are vulnerable to the disease, "said Dennis Altman, an Australian health activist at the Chiang Mai conference. "But how can you empower people when you can't even discuss something as basic as sex or drug use ?"

And even as another front opens in the AIDS battle, experts worry about the danger of donor fatigue for AIDS programmes due to the failure to come up with a vaccine. They warn that AIDS may one day be viewed as just another developing-world problem.

Though 90 percent of HIV infections occur in developing countries, Western NGOs say only 13 percent of the 1.5 billion dollars spent globally a year to fight AIDS goes to the South.

Meantime, AIDS activists find that the campaign to equip people with the right information about the disease remains an uphill effort. A survey of 1,200 Filipino males showed many misconceptions about AIDS, including the belief that antibiotics and keeping healthy and fit can stop AIDS.

And at an October conference in Manila, listeners sat up in surprise when the editor of a provincial paper proposed that the Philippines turn away rice shipments due from Thailand because they could be contaminated with AIDS.

Johanna Son is the Manila-based regional correspondent of Inter Press Service.

Strategic Objectives from the Beijing Platform of Action

Women and poverty
- Review, adopt and maintain macroeconomic policies and development strategies that address the needs and efforts of women in poverty;
- Revise laws and administrative practices to ensure women's equal rights and access to economic resources;
- Provide women with access to savings and credit mechanisms and institutions;
- Develop gender-based methodologies and conduct research to address the feminization of poverty;

Education and training of women
- Ensure equal access to education;
- Eradicate illiteracy among women;
- Improve women's access to vocational training, science and technology, and continuing education;
- Develop non-discriminatory education and training;
- Allocate sufficient resources for and monitor the implementation of educational reforms;
- Promote lifelong education and training for girls and women;

Women and health
- Increase women's access throughout the life cycle to appropriate affordable and quality health care, information and related services;
- Strengthen preventive programmes that promote women's health;
- Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual reproductive health issues;
- Promote research and disseminate information on women's health;
- Increase resources and monitor follow-up for women's health;

Violence against women
- Take integrated measures to prevent and eliminate violence against women;
- Study the causes and consequences of violence against women and the effectiveness of preventive measures;
- Eliminate trafficking in women and assist victims of violence due to prostitution and trafficking;

Women and armed conflict
- Increase the participation of women in conflict resolution at decision making levels and protect women living in situations of armed conflicts or under foreign occupation;
- Reduce excessive military expenditures and control the availability of armaments;
- Promote non-violent forms of conflict resolution and reduce the incidence of human rights abuse in conflict situations;
- Promote women's contribution to fostering a culture of peace;
- Provide protection, assistance and training to refugee women in need of international protection and internally displaced women;
- Provide assistance to the women of the colonies and non-self-governing territories;

Women and economy
- Promote women's economic rights and independence, including access to employment and appropriate working conditions and control over economic resources;
- Facilitate women's equal access to resources, employment, markets and trade;
- Provide business services, training and access to markets, information and technology, particularly to low-income women;
- Strengthen women's economic capacity and commercial networks;
- Eliminate occupational and all forms of employment discrimination;
- Promote harmonization of work and family responsibilities for women and men;

Women in power and decision making
- Take measures to ensure women's equal access to and full participation in power structures and decision making;
- Increase women's capacity to participate in decision making and leadership;

Institutional mechanisms for the advancement of women
- Create or strengthen national machineries and other governmental bodies;
- Integrate gender perspectives in legislation, public policies, programmes and projects;
- Generate and disseminate gender-disaggregated data and information for planning and evaluation;

Human rights of women
- Promote and protect the human rights of women, through the full implementation of all human rights instruments, especially the Convention on the Elimination of All Forms of Discrimination Against Women;
- Ensure equality and non-discrimination under the law and in practice;
- Achieve legal literacy;

Women and the media
- Increase the participation and access of women to expression and decision making in and through the media and new technologies of communication;
- Promote a balanced and non-stereotyped portrayal of women in the media;

Women and the environment
- Involve women actively in environmental decision making at all levels;
- Integrate gender concerns and perspectives in policies and programmes for sustainable development;
- Strengthen or establish mechanisms at the national, regional and international levels to assess the impact of development and environmental policies on women;

The girl child
- Eliminate all forms of discrimination against the girl child;
- Eliminate negative cultural attitudes and practices against girls;
- Promote and protect the rights of the girl child and increase awareness of her needs and potential;
- Eliminate discrimination against girls in education, skills development and training;
- Eliminate discrimination against girls in health and nutrition;
- Eliminate the economic exploitation of child labour and protect young girls at work;
- Eradicate violence against the girl child;
- Promote the girl child's awareness of and participation in social, economic and political life;
- Strengthen the role of the family in improving status of the girl child.

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"Dirty water kills us, not AIDS!"

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

During our work with rural villages we were told about communities where the women have traditionally worked as sex workers for generations. Isolated because of discrimination, most of these women are non-literate, and very few have access to services. In 1991 we started an AIDS education programme with people from both the sex worker communities and local villages, where the clients live. Knowledge about HIV was very limited and there was no access to condoms. We planned an HIV prevention campaign with one-day "training camps" and designed leaflets, a traditional puppet show and a video with basic HIV information.

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

Listening to the women

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

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

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

Challenging attitudes

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

As well as improving conditions in the sex worker communities it was essential to challenge the attitudes of the local communities. We had meetings with village groups such as young people, heads of villages and local government workers.

We talked about how HIV spreads, showing that clients can be responsible for transmitting HIV. This challenges the assumption that sex workers are the "cause" of HIV. GBS workers who are well respected willingly work in the sex worker villages now and that has helped many local people to change their attitudes.

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

More important than learning about condoms, the women became actively involved in improving their working and living conditions.

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

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

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

ANNOUNCEMENT

HIV/AIDS ENQUIRY SERVICES FOR THE ASIA-PACIFIC

Health Action Information Network (HAIN) is now responding to requests for information from *AIDS Action* readers in the Asia-Pacific region.

The HAIN Resource Center maintains a collection of HIV/AIDS-STDs materials focusing on prevention, counselling, care, and treatment. We provide bibliographic information services through an annotated data base, annual acquisitions list, resource list, and publishers' catalogues.

How to request for information

1. You may request for information through telephone, e-mail, post, or fax. Personal visits to the Resource Center are also welcome.
2. Photocopies of articles are given free of charge for up to ten pages (back-to-back). Requests entailing more than 50 pages will be referred to the author/publisher.
3. Requests for information which HAIN cannot respond to will be referred to other organizations.
4. Materials cited in *AIDS Action* should be requested directly from the publisher.

For more information, contact:
HIV/AIDS Inquiry Services
AIDS Action Asia-Pacific
9 Cabanatuan Road
Philam Homes, Quezon City 1104
Philippines
Telephone: (632) 927-6760 or 929-8805
Fax: (632) 927-6760
e-mail HAIN@Phil.gn.apc.org

RESOURCES

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

Community action on HIV: a resource manual for HIV prevention and care provides clear and relevant information on HIV infection, and relates the HIV epidemic to wider development issues. Copies are available from HIDNA c/o ACFOA, Private Bag 3, Deakin ACT 2600, Australia. E-mail: ACFOA@peg.apc.org

Gays and Lesbians in Asia and the Pacific: social and human services consolidates existing research and writing on homosexuality in the region. For copies, contact Haworth Document Delivery Service, The Haworth Press, Inc. 10 Alice Street, Binghamton, NY 13904-1580, USA.

Targeting young men: audience-centered communication for AIDS prevention in Vietnam shares insights on the audience-centered communication strategy for HIV/AIDS prevention. Copies are available in Vietnamese and English from CARE International in Vietnam, c/o UNDP/Hanoi, PO Box 618, Bangkok, Thailand.

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

Videos

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

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

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

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AIDS action

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