Special series

HIV/AIDS Prevention and Care:
A Cultural Approach

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

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

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

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

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

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

The nine country reports and the proceedings of the workshops have been published within the Special Series of Studies and Reports of the Culture and Development Unit. The handbooks are being published within the present Methodological Handbooks Series of the Division of Cultural Policies.
A CULTURAL APPROACH TO HIV/AIDS PREVENTION AND CARE

UNESCO/UNAIDS RESEARCH PROJECT

HANDBOOK FOR PROJECT DESIGN

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

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

Each specific handbook deals with two major topics:

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

The present handbook comprises two major divisions: situation analysis and project design and includes cross-references to the other three handbooks. Numerous UNAIDS documents were consulted during the elaboration of this work, footnotes reference those quoted directly.
The Joint UNESCO/UNAIDS Project “A Cultural Approach to HIV/AIDS Prevention and Care” was launched in mid-1998, in relation to the new approach to HIV/AIDS prevention and care inaugurated by UNAIDS. The UNAIDS strategy emphasizes the necessity of giving priority to the multi-dimensional configuration of the issue and to the diversity of its environment, in order to build comprehensive and adaptable strategies and policies.

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

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

This handbook is specifically devoted to presenting methods for building culturally-appropriate programmes and projects. After recalling the key assumptions, objectives and methodological implications of the cultural approach, it defines the overall terms of reference for assessment/review of the current programmes and projects in relation to field realities.

Moreover, it describes the methodological tools necessary for building a culturally-appropriate response to the major challenges as identified by UNAIDS: risk, vulnerability, prevention, care, support and impact reduction. It also points to the main action priorities in this respect, with special emphasis on renewed preventive education and training/sensitizing/capacity-building.
1- THE CULTURAL APPROACH: A REMINDER

1.1- ASSUMPTIONS

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

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

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

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

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

These evolutions can result in destabilizing situations if these processes are not monitored and mastered. HIV/AIDS prevention and care policies and methods will be improved and made more efficient by making them culturally-appropriate (acceptable and relevant), fully understood and highly valued (culturally integrated) among given groups and persons, according to their priorities. This will enhance a new awareness of responsibility and motivate a subsequent willingness for mobilization against the expansion of the epidemic.
Over the last 15 years, many different approaches have been adopted in an attempt to curb the expansion of HIV and minimize its negative effects on individuals, families, and society. It is now clear that there is no simple formula that works for all countries. The most effective national responses are those designed to meet the specific needs of the country. They address the specific situations that make people vulnerable to HIV and its effects, and make use of the particular strengths of the country’s people and institutions. These practices are outlined in the UNAIDS Guide to the Strategic Planning Process for a National Response to HIV/AIDS (1998-1999) and the UNAIDS Methodological Review (1999).

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

1.2- OBJECTIVES AND IMPLICATIONS

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

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

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

Taking a cultural approach to HIV/AIDS prevention and care

In terms of HIV/AIDS prevention and care, adopting a cultural approach means that any given population's cultural references and resources (ways of life, value systems, traditions and beliefs, and the fundamental human rights) will be considered as key references in building a framework for strategies and project planning. These key references will also serve as the resources and basis for building a relevant response and sustainable action in prevention and care, as well as in impact reduction. This is an indispensable condition in order to achieve in-depth and long-term changes in people's behaviour and to give full consistency to medical and sanitary strategies and projects.
As emphasized by UNAIDS, building a response to HIV/AIDS at all levels requires a preliminary
 diagnosis in clear terms. Risk in itself, and vulnerability as its environment, are two major challenges
to be faced in all their facets before attempting to find reliable solutions. Developing relevant
 prevention and support systems in order to alleviate the impact of the epidemic represent a key issue
in strategy building, policy-making, project design and field work. This is why these different
questions are identified as the four major challenges of HIV/AIDS.

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

2.1- RISK

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

- The main cause of infection is sexual relations, whether heterosexual, as in Africa and in
other regions, and/or bi-sexual or homosexual, as recognized in the Caribbean, Latin America
and South-East Asia. The risk is aggravated by certain sexual practices such as having
multiple sexual partners, casual sexual relations, violent sexual intercourse and prostitution.
It is also related to other STDs, past, co-existing or confused with HIV/AIDS.

- Mother-to-child transmission of HIV/AIDS appears as another major cause, either during
pregnancy, at birth, or during breastfeeding. The latter represents half of this type of
infection, especially for women who have numerous children and breastfeed. This practice
is often maintained because safer alternatives, such as hygienically safe milk for babies,
are not available to them.

- The growing use of intravenous drugs with infected needles and the simultaneous
consumption of drugs and alcohol are also causes of infection, more specifically in eastern
Europe and central Asia.

- The transfusion of contaminated blood is estimated to be the cause of 10% of the HIV/AIDS
infections in sub-Saharan Africa. Contamination can also occur during sexual intercourse
when the reproductive organs of one partner are bleeding. It can also occur through rituals
of blood exchange in certain initiation ceremonies involving young men, unhygienic excision
or circumcision operations, tattooing and skin piercing. However, recent research in certain
African countries tends to show that male circumcision may entail a lower sexual
contamination risk. Factual evidence corroborates that violent fighting can also
result in contamination through bleeding wounds.
Despite this factual evidence, identifying these various high-risk situations raises two questions that go beyond the epidemiological approach, and are of an obviously more societal and cultural nature:

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

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

**2.2- VULNERABILITY**

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

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


**2.2.1- SOCIO-ECONOMIC CONDITIONS**

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

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

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

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

2.2.3- SOCIAL/POLITICAL ENVIRONMENT: HISTORICAL AND PRESENT SITUATIONS

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

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

2.2.4- IDENTIFICATION OF VULNERABLE GROUPS

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

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<tr>
<th>Underprivileged populations:</th>
<th>Culturally-destabilized groups:</th>
<th>Specific risk groups:</th>
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<tr>
<td>The poor</td>
<td>Disintegrated families</td>
<td>Segregated groups and communities</td>
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<tr>
<td>Young people</td>
<td>Unemployed persons</td>
<td>Homosexuals</td>
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<td>Women and girls</td>
<td>Refugees and displaced people</td>
<td>Prostitutes</td>
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<td>Uneducated people</td>
<td>Domestic and international migrants</td>
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<td>(out-of-school children and the illiterate)</td>
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2.3- PREVENTION AND SUPPORT

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

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

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

- International cooperation institutions;
- International and national NGOs.

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

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

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

2.4- IMPACT REDUCTION

2.4.1- ECONOMIC IMPACT

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

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

2.4.2- SOCIAL IMPACT

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

2.4.3- SOCIETAL AND CULTURAL IMPACT

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

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

HIV/AIDS and the private sector

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

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

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

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

The first rule to be observed when designing or assessing prevention and care projects is to evaluate their response to the four major challenges stated above: risk, vulnerability, prevention, care/support and impact reduction. These four facets have to be dealt with in any relevant project. This leads to further questions concerning projects content and involved stakeholders.

As regards project content, no consistent and appropriate prevention and care action can be designed and implemented without contextualizing it in its economic, social and cultural environment. The project must specify its level of action: from national strategies and policies through to field situations and work. Such a project would be considered as an example of best practices and should be highlighted accordingly. Only through reviewing administrative and technical documents elaborated by institutions for planning, implementing and evaluating their programmes and projects, will it be possible to construct a realistic view of the current working habits in this field.

More specifically, prevailing trends in project design and implementation are still characterized by limitations in the action taken and lack of communication between the different actors involved.

3.1- LIMITATIONS OF THE ACTION TAKEN

Limitations can be observed concerning risk, vulnerability, prevention, care, support and impact reduction. From the purely medical and sanitary point of view, geographical and social coverage is far from being comprehensive as regards detection and subsequent information about the spread of the epidemic, medical treatment and follow-up.

The current effort made by various developing countries to produce generic drugs has drawn the attention of the international community. However, material and social access to medication is still seriously limited by the monopoly of drug production by major international pharmaceutical firms and by the excessive cost of making medical services generally available in poor countries.

Another serious deficiency of the actions taken to date is their purely sanitary and cognitive approach to preventive action, which too often remains limited to “preaching” faithfulness, abstinence and condom use. Faithfulness in couples and sexual abstinence are advocated without consideration for the reasons of their non-observance in most people’s daily lives of many. For example: extreme poverty, total deprivation of basic subsistence facilities, family disintegration linked to economic migrations, wars, women’s exposure to mere survival threats and extreme dangers including personal or collective sexual violence, children’s abandonment, malnutrition, trafficking.

No consistent analysis has been made of these constraints nor of the possibilities offered by a different approach in preventive education. Similarly, condom use is imposed as the obvious alternative solution, mostly to men but also to women, whose life conditions are far from hygienic in all other aspects of daily life. The feeling of helplessness with respect to their actual situation gives way to an over-valuation of sexuality.
Thus, a serious deficiency in current projects is their lack of perspective on HIV/AIDS in terms of socio-economic disparities. This results from a lack of consideration for the human consequences of development, even though some of these are obvious and repeatedly emphasized in documents dealing with development.

3.2- LACK OF CONSIDERATION OF PEOPLE’S CULTURE

The largest breach between existing programmes and projects and field realities is due to the almost complete absence of consideration of people’s cultural references, except as obstacles to a logically built prevention and care action. As a consequence, these obstacles are to be eradicated by all means, including so-called frank and open public discussions, and are not used as resources for people’s understanding and mobilization. This approach appears to completely disregard problems of basic human rights, family and community rules, and the tragic situation of the infected person.

In the analysis of the role of culture in fighting HIV/AIDS, it must be recognized that cultural references and resources are closely interrelated. However, it is necessary to differentiate between them for an in-depth examination of their role in various possible situations. References should not be considered obstacles to preventive education, but rather as linked to other fundamental concerns in relation to the epidemic. Besides, these references evolve with time, within the framework acknowledged by various communities. At the same time, it must be borne in mind that, beyond keeping traditions as immutable assets, power conflicts take place within these communities.

On the other hand, certain cultural references can be considered as resources, as they encourage self-respect, respect for others, commitment to the improvement of life conditions, and compassion for the poor, destitute and sick. These resources are closely connected to ethical systems and spiritual values.

3.3- LACK OF COMMUNICATION ON THE ISSUE

Most current strategies on prevention and care are not conducive to initiating communication processes between the institutions and professionals involved and the populations. In fact, communication obviously offers new opportunities in the continuous educative process. It can also provide policy and project designers with richer, more adequate and accurate information on renewed preventive education.

Another serious lack of communication can be observed in certain countries both at the level of public authorities and of the population itself. At the level of public administration, this can result in the denial of serious problems with respect to HIV/AIDS. Populations themselves may have the same attitude of denial and responsibility may be placed on external influences or interference. This type of reaction can be explained by the silence enjoined in relation to taboo-rules and moral decency principles, both of which enforced are by certain opinion leaders. As a result, public stigmatization may be voiced against infected, or even people suspected of being HIV positive, who may in turn feel ashamed and guilty. Moreover, there may be significant misunderstanding due to semantic
interrogation in matters of sexuality, especially with regards to women. External prevention and care agents frequently consider that the latter are ignorant of their physiological functions, while the real situation may be different.

3.4- INVOLVED STAKEHOLDERS

It is impossible to elaborate and develop coherent prevention and care action without mobilizing all the categories of stakeholders. This condition is not met in most existing projects. Some of these projects are mainly designed and implemented, directly or indirectly, by public institutions, at international or national level, and consequently considered as the operational follow-up of previously decided strategies and policies.

3.4.1- THE PUBLIC SECTOR

In order to counter-balance this type of institutional rationale and technical administrative modes of action, it would be necessary to involve, on an equal footing, other categories of stakeholders: NGOs, representatives of the civil society, traditional and spiritual leaders.

3.4.2- NGOs

Besides decentralization efforts, institutions may develop new modes of action by including NGOs in their activities. Their simpler organizational structures and more direct contact with communities are reputed to be unique assets in securing a project’s continuing success.

However, a distinction must be made between large and locally based organizations. If the NGO in question is large, its size and resources may have a negative influence on the operational validity of the activities undertaken. In addition, a creative-paternalistic attitude, religious proselytism and the support of influential countries should not influence their role in prevention and care.

On the other hand, small grassroots NGOs are better equipped to meet the needs of the population and enlist their participation, precisely because of their smaller size and local rooting. Their multiplicity may, however, be counter-productive.

Direct government action

Despite the wide recognition that a multisectoral approach is necessary to tackle HIV/AIDS effectively, in many instances the only significant involvement of the public sector is in the health sector. Furthermore, administrative regulations and procedures hamper the flow of resources, particularly financial, but also of human resources (i.e. from central to provincial or district levels) and this may occasionally plague the government. It may also be difficult or delicate for the government to allocate resources to, or be directly associated with, certain HIV prevention activities, such as those targeting illegal behaviour, for example drug use or commercial sex work.

In all cases, it is essential to find a new balance between the roles assigned to the major institutions, NGOs and the local stakeholders. The prevailing current situation shows that external actors and their representatives speak and act too frequently in the place of populations. This practice is based on the belief that external experts have a better understanding of the needs and of the problems than the population they are meant to assist.

### 3.4.3- SOCIETY AND COMMUNITIES

Given the limits of purely institutional strategies, societies need to have recourse to their own cultural references and resources, before modelling their response to external pressures to change their behaviour. A viable response will be built on group and personal consensus, acceptance, conviction, motivation. More precisely, it will be based on cultural references and resources. It will also allow the development of new cultural practices in response to the constraints and evolution of the socio-economic environment.

This is why community-based projects have to be built on a fully participatory basis, with local leaders, informants and families, including the HIV-positive and even sick persons. People will feel mobilized only if they are reached where they are, and on an equal footing.

In matters of mobilization, the role of religious communities, social movements (women, youth, sports associations, etc.), trade and business unions may be essential. This potential has not been sufficiently explored so far. These groups would consider HIV/AIDS prevention and care activities in relation with their own value systems and mandates, whether practical, social, ethical or spiritual.

### NGOs potential and weaknesses

The proliferation of HIV/AIDS-specific NGOs has sometimes been at the expense of quality and accountability, through ill-designed or inappropriate projects absorbing scarce resources and failing to have any significant impact. Other areas of concern include:

- Mutual government/NGOs distrust;
- Weak management structures;
- Specific priorities of some NGOs may not always match those of national programmes.

In spite of these deficiencies, innumerable AIDS-specific NGOs, national and international, intervene and provide services across the whole range of prevention and care strategies and activities. They play a vital role and make significant contributions to successful national responses. They present some unique advantages:

- Their relevance and responsiveness to community and grassroots needs;
- The committed and motivated human resources of the smaller national NGOs;
- The ability, unlike the government sector, to work with marginalized populations such as drug users or sex workers.

NGOs are usually also more willing or can afford to take risks, such as allocating resources for untested strategies, or starting up pilot projects in new geographical and thematic areas. International NGOs also provide links to wide networks and are therefore sources of substantial technical and financial support.

Traditional cultural leaders, especially traditional healers, may also be consulted to facilitate cooperation between themselves and modern medical and educational systems. They are often consulted as medical, social and psychological advisers in health issues, especially when HIV is suspected or confirmed.

As regards individuals, advocating abstinence, faithfulness in couples and condom use raises complex practical and moral issues. Moreover, traditional family rules can impose silence on the subject, but also provide material and human support to the infected or sick person.

Lastly, considering risk groups or culturally and endangered societal groups in particular, it is obvious that socio-economic, educational and cultural factors interact dramatically with medical and health issues. These groups are endangered by various types of difficulties at the same time, all of them with seriously destabilizing and segregating effects: massive unemployment, poor housing or lack of shelter, economic distress, lack of education.

These factors are aggravated by societal/cultural destabilization, such as: migrations, rural decline, instability in certain countries and regions, prominence of short-term economic strategies in production activities and rapid urbanization – as opposed to the much lower pace needed for cultures and societies to build new configurations responding to change.

In this context, unsafe practices, such as: refusing condoms, drug abuse and smuggling, alcoholism, sexual or all forms of violence, prostitution and procuring are all aspects of emerging sub-cultures. These are linked to issues of mere survival in a world of brutal power and materialistic interests, and may create serious obstacles to HIV/AIDS prevention and care. Subsequently, these issues must also be addressed in order to reach significant results in fighting the epidemic.
4.1- SYNOPSIS

The first section of this handbook was devoted to a review of the current methods used for designing and implementing prevention and care programmes and projects. This second section describes ways and means for building, implementing and evaluating culturally-appropriate projects. After reviewing the project’s specific position between strategies and field work, it describes the basic concepts and instrumental choices to be made in the preparation, implementation and evaluation of projects using the cultural approach.

The description of appropriate ways and means in designing programmes and projects focuses on the main priorities. First, it points to the need for joint mobilization of the institutional network and civil society, with special emphasis on the importance of building a community-based response and subsequently redefining the specific responsibilities of the institutions. Then, it presents the conditions for culturally-appropriate communication, via the media, education system and live dialogue likely to result in behaviour change. It describes, in more detail, preventive education in this renewed perspective. Finally, an improved methodology is proposed, as regards training/sensitizing/capacity-building and new types of projects and programmes.

4.2- BETWEEN STRATEGY AND FIELD WORK: THE PROJECT

All prevention and care projects prepared in collaboration with institutions and donors must take into account trans-sectoral or sector strategies. In this sense, they must be linked to the major goals put forward by institutions and included in their planning documents: UNAIDS medium-term plans, biennial programmes and budgets.

They must also make sure that the validity of the project has been checked with the responsible authorities and that clear reports are accessible on a periodical basis on the use of budgetary, technical and human resources.

They should also fit in with the inter-sectoral and inter-institutional approach indispensable to fight HIV/AIDS (links

What is a project?

It should be recalled that programmes and projects are a planned series of actions or activities established within a framework of a given budget and time frame in order to reach one or more objectives. In terms of basic methodology, there is little significant difference between a project and a programme. A project is a planned intervention designed to achieve one or several specific objectives. A programme is a group of project or related services designed to achieve a certain number of generally complementary or inter-dependent objectives.

between the specific fields of implementation and other sectors: health, education, employment, housing, rural and urban development). They should be elaborated, as a medium-term set of actions in a long-term perspective (taking into account the existing situation and the previous history of the society and community involved, in order to gain sustainability and long-term impact on behaviour change in a given society).

On the other hand, no project can be successful without direct and indirect feedback on the situation in the field and the project environment, i.e. the existing natural and human context in which the project is to be implemented. Thus, a well-designed project is the result of a coherent combination of two types of needs: institutional logic and the limits imposed by the reality of the epidemic. It must create or reinforce a continuing communication process between the field and institutions, so as to be clearly understood by both stakeholders.

Interactions between the project and the local cultural and social context (men/women, children and youth/adults, employers/employees, people with or without authority, etc.) requires that the project be reformulated and adapted whenever necessary. Finally, a project could be considered as complete from the moment external intervention is no longer justified. In other words, when the local actors can take over full responsibility for the follow-up in prevention and care. Moreover, in the case of HIV/AIDS the actions undertaken as part of the project do not end there. The changes, initiated as a result of the project, continue thanks to the impetus brought about by external intervention. At this stage, the project may be considered as successful.

Projects must respond to the major HIV/AIDS challenges as defined by UNAIDS: risk, vulnerability, prevention, care and support and impact reduction. These must be clearly reflected in the major components of any project.

4.3- INTERACTING FACTORS, ACTORS AND FIELD ASSESSMENT

As explained above, full understanding of the epidemic cannot go without an in-depth examination of multiple interacting elements such as: informal economic systems, historical process, cultural diversities. On the other hand, the interweaving and frequent overlapping of actors, factors and domains involved in a prevention and care action are also necessary.

Given the coexistence and complexity of these interactions, anyone wishing to adopt a cultural approach to the epidemic’s prevention and care must first ask a series of questions, which can be summarized in a checklist and may be used as terms of reference for preliminary evaluation.

4.3.1- PREREQUISITES

These issues may be addressed using the following guidelines for preliminary evaluation, and for the whole process of strategy, project design and implementation.
### 4.3.2- TERMS OF REFERENCE FOR PRELIMINARY EVALUATION

This evaluation should be carried out along the same lines as the terms of reference described in section 2.2 in order to:

- Analyse current interactions between the evolution of the HIV/AIDS epidemic, and the socio-economic development processes;
- Identify cultural features, references and resources;
- Identify specific needs of economically-socially-culturally underprivileged risk groups.

### 4.4- IN-DEPTH FIELD INVESTIGATION

#### 4.4.1- EVALUATIONS ITEMS

Today, the lack of motivation behind the much discussed behaviour change is the major obstacle to be overcome, in order to develop pilot projects and sustainable information/education/communication activities accordingly.

This is why there is a need for an in-depth analysis of people’s formal cultural references. As a result country- and people-centred response methods will have a greater opportunity to evolve and be integrated in people’s norms in the prevention of infection and the spread of infection.

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<table>
<thead>
<tr>
<th>Determinants of the current situation</th>
<th>Expected Outputs</th>
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<tbody>
<tr>
<td>• What are the underlying social, economic and cultural factors in the overall HIV/AIDS situation?</td>
<td>Identifying socio-economic and cultural conditions for reaching significant changes in behaviour concerning risk vulnerability, care and support.</td>
</tr>
<tr>
<td>• What is the social, economic and cultural context of the epidemic in the given project area?</td>
<td>Developing prevention and care action in the framework of the overall development project.</td>
</tr>
<tr>
<td>• What types of risk groups or behaviour are vulnerable to the infection or result in the development of the disease?</td>
<td>Developing appropriate information among population groups, whether so-called risk groups, young people, poor populations, women and girls, migrants and mobile professions.</td>
</tr>
<tr>
<td>• How and why?</td>
<td>Building partnerships across the public sector (trans-sectoral approach), the private sector and with NGOs and community organizations.</td>
</tr>
<tr>
<td>Which factors impact on the spread of the disease and the support to HIV-infected persons and their families?</td>
<td>Repertory possible motivations which can mobilize a wide range of people, their skills and resources for a joint effort in combatting HIV/AIDS.</td>
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</table>
Similarly, new attitudes and behaviour towards infected and sick people will have to be developed. This is necessary in order to reintegrate them into the community and give them human support at the final stage of the development of the disease.

4.4.2- WHICH INSTRUMENTS CAN BE USED?

Specific case studies must be conducted in clearly differentiated situations (suburban districts, rural areas, diverse ethno-cultural groups, migrants, refugees, etc.). In all cases, the specific situation of girls, women, young people and children, especially orphans must be given due attention. These methods can also be employed in other issues and with different populations.

GENERAL SURVEY

This type of survey can be carried out through semi-open questionnaires, used as guidelines in group discussions by investigating teams. It is limited to identifying similar features among groups. It can, however, represent the only possible form of investigation in countries where it is impossible to reach all categories of people for instance in conflict or war areas.

However, it does not use in-depth investigation material, which would be indispensable for carrying out a full size national survey based on the cultural approach. For instance, using questionnaires for group discussions can only be relevant for collecting information from an educated population sample. Thus, it is almost impossible to find information concerning out-of-school and illiterate groups, which may form the majority of the population exposed to the virus. Therefore it is crucial but extremely difficult to sample representative and clearly defined areas from which nationwide conclusions can be extrapolated.

CASE STUDIES AND INTERVIEWS

An in-depth understanding of specific groups (i.e. segregated young people in extreme poverty, in difficult housing and survival conditions) may necessitate intermediary contacts between them and the investigators. For instance, an in-depth analysis of the situation of rural populations living in remote areas may require a long period of field work.

Similarly in-depth investigation among a segregated group in suburban area will need time to build trust and cooperation between data collectors and group members whose situation and needs cultural references and resources have to be assessed. In fact the latter are often critical of outside interveners who are supposed to propose appropriate prevention, care and support activities If more general analytical criteria are used during the investigation, this analysis may be conducted in a shorter period of time.
Data collection in a suburban environment (shanty towns around big cities)

Populations living in poor suburban areas, slums and shantytowns are often very suspicious of any kind of social inquiry, which they associate with police investigation. Moreover, many of them are in a situation of frequent mobility, for economic or personal reasons. Thus, methods of contact must be carefully designed and implemented.

In this context, different methods can be used:

- Semi-structured interviews with young people (15 to 24), boys and girls, belonging to the poorest or marginal (informal) economic sectors, considered to be highly vulnerable to infection due to the various ways they may be linked to the sex industry;
- Survey of HIV-positive persons: questionnaires on demographic and socio-economic factors and social/family relations;
- Community interviews with the most directly concerned persons, of which a typology (sampling) can be built, for instance highly differentiated sub-groups, in order to accurately depict their specific situation as regards the risk itself, its determinants and effects.

In order to interview these various persons, common guidelines should be prepared, so that answers to the following items can be compared: personal data, sexual initiation and orientation, attitude towards sexual workers and various sexual orientations, perception of HIV/AIDS, children’s information on the disease and, in relevant cases, their most dramatic direct or indirect experience. More specifically oriented interviews should be conducted in sub-groups and even with individuals belonging to the group.

This type of interview necessitates confidentiality and empathy between the interviewers and those interviewed. In the case of the Dominican Republic, after an appropriate training session, members of the local network of people living with HIV/AIDS, collected data in the field, through interviews with HIV-positive persons, their families and young people belonging to the poorest social groups. They also participated in forums of discussion and in the analysis of the results.

Case study in rural areas

In the case of rural populations, real in-depth investigation would require several months in order to build contacts and exchanges on the basis of mutual trust. In order to carry out a relevant investigation in a limited period of time, the following more general methodological headings can be used:

- Choice of the area to be investigated: visible and specific interfaces between culture, development and HIV/AIDS;
- Major investigation headings: demographic data, available health services, knowledge, attitudes and beliefs about HIV/AIDS, sexual and non-sexual practices related to AIDS, migratory patterns and gender issues.

Research findings through in-depth case investigations will provide data for building more efficient, relevant and sustainable prevention and care action on the following issues:

- The HIV/AIDS crisis, sexual work and the informal economy in the context of the overall socio-economic development crisis, poverty, unemployment and societal/cultural disintegration;
- Cultural references and resources in relation to HIV/AIDS and their possible role in securing the efficiency, relevance and sustainability of prevention and care: religious beliefs, chieftaincy, traditional healing, loyalty and condom use, linguistic and semantic shortcomings, hiding or notifying one's infection;
- Marginalized groups' specific risk situation, discrimination at work or legal protection, specific cultural and educational needs of groups living in extreme poverty, complex situations requiring further research;
- Specific gender issues, polygamy, concubinage, early marriage, widow inheritance, early and/or unwanted pregnancy, poor education;
- Prostitution for survival, prostitution opportunities linked to trade centres, transportation rest houses, men-only collective hostels, army camps, construction sites, modern production farms and plantations, border zones, tourist resorts.

4.5- CULTURALLY-APPROPRIATE PROJECTS: A STEP BY STEP APPROACH

Designing culturally-based projects for HIV/AIDS prevention and care for populations at large, especially among the poorest and less developed countries, is a priority. Such an approach is meant to help people become fully aware of the challenge and to mobilize their energy in prevention and care, appropriating the issue in accordance with their societal/cultural references and resources. For this reason a more detailed analysis of project preparation, implementation and evaluation is presented in the following pages.

This analysis, founded on a step by step approach, will be of particular relevance when working on issues to be tackled in the field, rather than at a purely institutional level. However, it should present in mind that in reality, action, analysis and the critical evaluation of action are interdependent and thus should not be considered as unrelated phases in the project development but as key elements which should be implemented as a whole.

In all cases, field action will be the most important type of intervention for prevention and care, as long as new medical and pharmaceutical treatments have not been found and made accessible to all, including the poorest, most isolated and remote populations. Even with full accessibility to medication, as long as living conditions are not improved substantially, an educational and cultural apprenticeship is needed, in order to secure sustainable behaviour patterns and practices.

4.5.1- BASIC CONCEPTS: PEOPLE-ORIENTED PROJECT

The basic concepts for developing prevention and care projects through a cultural approach can be summarized as follows:

- They should be elaborated, implemented, evaluated and redirected in a holistic and cultural approach, taking into account people’s own rationality, cultural references and resources;

- People, should be fully persuaded that they have to change their sexual behaviour and rethink their representations of sexuality, body physiology, and their body/mind relationship;

- Only this condition makes it possible for them to appropriate external information and rethink it in their own concepts, value systems and terminology.

Such a process of change is subject to two conditions:

- The continuous communication-participation dialogue and co-active process which gives priority to community-based and field projects;

- A significant improvement in people’s life conditions, especially in less developed countries, so that they may work towards a better future, including HIV/AIDS prevention and care.
4.5.2- INSTRUMENTAL CHOICES

A COORDINATED APPROACH:

Coordination is the indispensable condition for an efficient action and an overall response to situations and issues relating to HIV/AIDS. Therefore, HIV/AIDS prevention and care strategies and campaigns should take into account their interactions with other sectors or global development strategies. This requires the design and practice of inter-institutional cooperation at all levels in order to guarantee harmonized action and to avoid overlapping.

POPULATION/INSTITUTIONS CONSENSUS

Community-based projects or regional (sub-national) projects may be considered as the most adapted to the epidemiological situation. They have to be clear and understandable for both institutions and local populations, in order to involve and mobilize people’s participation for common goals.

Consequently, the definition of objectives, means and results must always be fully and clearly articulated for both parties. To this effect, project design involves a two-way communication process, between the target population and the institutions at the following levels and related to the following operational issues:

Concrete action:

In practical terms action will be determined along the following questions to/from populations themselves:

- Which issues do they want to solve?
- What do they plan to do?
- What are their resources?
- What external resources do they anticipate?

Budgets and programmes (objectives/activities/ways and means):

Institutions should take into account the results of these discussions in the technical drawing up of their budgets and programmes. In this respect, they should successively do the following:

- Identification, definition of tasks, and evaluation of means, through the exchange of information, discussion, negotiation, compromise and agreement, are the main tasks to be carried out;

- Project finalization in technical terms as a result of this two-way communication process (developed on the basis of preparatory guidelines).

EXPECTED RESULTS AND EFFECTS (INDICATORS)

The projects are expected to bring about significant and sustainable behaviour changes in sexual practices. These changes will be secured under the following conditions:
• Community or individual acceptation and appropriation of information and medical care, which will be remodelled in order to become more interactive;

• Conviction that prevention and care are priorities and can result in significant effects;

• Launching of sustainable initiatives by a community or group on a voluntary basis with the cooperation of national institutions, IGOs and NGOs at the field level;

• Decrease of infection rate in the long term (mortality decrease) and curbing of the spread of the epidemic (more people tested, more controlled HIV-negative).

4.5.3- PREPARATION: CONTEXTUALIZING THE NEEDS

GENERAL REQUIREMENTS

• Links between institutional strategies, medium-term plans/programmes/projects/field actions should be strengthened, as emphasized in the new UNAIDS Strategy for 2000-2001;

• In this respect, it is indispensable to have an inter-sector and inter-institutional approach, in order to address the global situation, especially as regards risk, vulnerability, prevention, care, support and impact reduction.

• The long-term perspective necessitates an appraisal and assessment of previous situations or actions, and of the long ranging effects and sustainability of the new proposals. This will result in a complete account of the shortcomings and obstacles met in previous UNAIDS actions (beyond lack of medical data, information on people's overall situation, and the lack of communication between the project and the involved population);

• Abundant, detailed and updated information on the natural/societal/cultural environment of the epidemic is indispensable for improving the relevance and efficiency of the proposed project;

• The proposed action may require subdivision due to its geographical, human scope as well as the complexity of the interactions within it. The project could then remain continuously adaptable to the diversity of the cultural and societal environment, while keeping sizeable and manageable proportions;

• Project terms of reference, objectives and implementation conditions should remain acceptable and understandable for both institutions and populations at all stages of its development;

• From the outset, it is necessary to programme the project follow-up, and the hand-over of the initiatives and responsibilities to local agents, in order to achieve sustainability in the long term.
Bearing in mind these requirements, the major tasks for project preparation are as follows:

**PROBLEM IDENTIFICATION**

- The first task is to analyse the *regional, national or local specificity of the HIV/AIDS situation* and actions already undertaken or completed (if any). This analysis can also take into account previous project evaluation documents, follow-up of field reports as well as general information on the situation or the urgent needs to be addressed (the epidemic being aggravated by famine, violent conflict, genocide, etc.);

- **Identified problems and needs**, different views and opinions expressed by the population should be discussed and compared;

- **Prevention and care problems should be “contextualized”**, so that they may be better understood in their interactions with culture and development;

- Problem identification should begin with the **common understanding of needs** by institutions and the community. Due attention should be paid to the implicit or explicit rationale, rooted in culture, used by the various actors at both the institutional and community level.

**MOBILIZING ACTORS**

- **Donors and implementing institutions, decision-makers and technical agents** should be reminded of the importance of the cultural approach in securing the efficiency of the overall strategy advocated by UNAIDS;

- **Research centres and academic institutions** active in the cultural and social science fields should be more closely associated with the planning and implementation of HIV/AIDS prevention and care projects. Their network should be improved, with an emphasis on using research conducted in “southern” countries;

- The experience of **international, national and local NGOs** should be considered as an important resource, because they work in direct contact with the populations and have a better understanding of their behaviour and needs. On the other hand, they have to be more sensitized to the cultural approach;

- **Associations, social organizations, trade-unions, business unions, private corporations**, major local actors, and representatives of populations and communities have to be associated with preventive action and information, whether in the work-place, market place, social events and functions, or in formal or informal leisure time activities, in so far as they provide opportunities for socializing;

- **Traditional leaders and religious communities** can also play a crucial role in this respect, in connection with their spiritual and ethical influence;

- Traditional medicine experts and midwives, who are respected and trusted by the population at large can act as advisers, counsellors and provide moral support to infected or sick people and their family.
IDENTIFICATION OF VULNERABLE GROUPS

**Checking the project’s acceptability/receivability** is a key factor in the process of refining the project design and of adapting it to people’s situations and cultures, in other words to vulnerable groups, as defined by UNAIDS terminology.

Thus, the so called “target groups” or “beneficiary” populations – the main partners in fighting the epidemic – are in fact also the vulnerable groups among which some sub-groups are specially at risk. A list of the various categories of vulnerable groups, as defined by UNAIDS, and sometimes referred to as target population, can be found in section 2.2 of this document. Their active participation in the planning and implementation process is a prerequisite for the success of any project.

Lastly, it must be emphasized that no project should make abstraction from the broader national economic, societal and cultural environment.

AVAILABLE OFFICIAL DOCUMENTS FOR EFFICIENT COMMUNICATION

Communication between institutional agents, field workers and population representatives should be the basis of any efficient and sustainable local prevention and care project. This two way bilateral communication requires that official documents be accessible for the community representatives, especially when discussing joint action for fighting the epidemic. Therefore, discussing with populations should not be limited by the use of exclusively epidemiological or administrative documents.

Moreover, the terms of the documents should always be “reversible”: for large programmes and projects, anticipated steps and activities are bound to be expressed in technical terms for the institutional agents, especially planners, budgetary and administrative officers, senior- and medium-level staff.

However, discussions and consultations with national public authorities and representatives of civil society are indispensable. Projects must be explained accordingly and project objectives made clear and concrete for local partners.

OUTLINING THE PROJECT

Having identified the main characteristics and critical features of the existing situation, it is necessary to make an initial estimate of the feasibility of addressing the problems that have come to light. This first outline of the project is simply an “open” and totally transparent document, whose components may be changed, if necessary. It must be comprehensible to all partners, and should not indirectly impose options or constraints that they are not fully aware of. If this condition is not met, understanding and subsequent mobilization of partners can be compromised or even destroyed.

BOTTOM-UP PLANNING

In order to ensure that the methodological proposals are in line with the cultural approach, projects should be the result of a continuous process of exchange and mutual information between planning offices and field units. Therefore the viability of response is tested against the daily reality of the infection and epidemic in real time and space.
Thus, medical, demographic, socio-economic, societal and cultural information from the field should be collected, processed, summarized and transmitted at the most appropriate level.

The conditions to be met to this effect are as follows:

- An open and flexible attitude from large institutions, including decentralized units. Such flexibility is needed, on one hand, to balance the usual pre-eminence of central services, and the too formal division of institutional work, and on the other hand, to build a better partnership with the population;

- Explanatory sessions concerning this new approach should be organized for public authorities and local populations.

As regards NGO projects, a distinction should be made between large institutions and field NGOs. For the latter, the institutional breach between the field and the decision-making centres is much smaller and consequently does not entail the same shortcomings and technical corrective measures as in some large international NGOs.

**DRAWING UP OBJECTIVES**

This part of the work has to be carried out in association with beneficiary communities and the different stakeholders, once the problems at field level have been identified (bottom-up collecting and processing of information). It must be implemented with an integrated and coordinated approach, as repeatedly advocated by UNAIDS (trans-sectoral objectives can be attained by solving sectoral problems).

An evaluation of the means and time necessary for the project, as well as the relevance of modalities for an effective and efficient action must be established in a flexible way at the stage of planning.

**General objectives (linked to major institutional strategies)**

In the case of the UNAIDS strategy and derived projects, the major objectives are:

- To check the expansion of the virus in terms of direct risk and vulnerability leading to risk situations through prevention education and the improvement of socio-economic conditions;

- To encourage a more supportive environment for people with AIDS (PWA) and reduce the economic, social and cultural impact of the disease.

In order to secure their coherence with the overall United Nations effort towards human development, it is necessary to ensure that the relationship between these objectives and those of sustainable development – peace, human rights, gender equity and the eradication of poverty – are compatible.

These overall objectives have to be broken down into:

- Major policy objectives (strategies and policies at the national level);
- Operational objectives (programmes or project clusters);
- Action oriented objectives (projects).
In this process the cultural relevance and mobilizing power of each plan has to be checked at all levels.

Giving priority to the definition of operational objectives may lead to an underestimation of the concrete interactions between different problems, situations and human development objectives. Thus, it may hinder the adoption of culturally relevant prevention and care projects, in which the link between the infection and its environment is the key to any efficient action.

CHOOSING CULTURALLY-APPROPRIATE TOOLS

Consequently, the choice of technical tools, as described in the following paragraphs, can positively or negatively affect the feasibility of a cultural approach, particularly necessary for the complex and crucial implementation of prevention and care action, with a reasonable expectation for sustainability.

Useful tools currently in use

For Preliminary studies, certain new methods are considered as quicker, more reliable and efficient. For example:

- **Rapid rural appraisal** originally meant to facilitate the identification of elements likely to favour rural development projects in conjunction with local populations. This method could be transposed on the initial evaluation of HIV/AIDS field situations and possible means of action, provided the given situation is already well known;

- **Beneficiary assessment** methods can be used to make a project “palatable” to the local population, in order to secure its approval and cooperation with respect to the external preventive and medical action.

Receivability/acceptability inquiries can also be of help for assessing the given populations attitudes towards the project:

- **Receivability analysis** assesses the interest shown on the part of the population and/or institutional partners, in relation with their cultural habits regarding discussions on sexuality and behaviour when meeting external visitors.

- **Acceptability analysis** can establish the relevance of a prevention and care project in relation to:
  - Local situation analysis, risk awareness and perception of ensuing needs;
  - Probability of mobilizing a population for its implementation (felt needs, interests, motivations);
  - Balance between external and local know-how, resources and medical technologies, which have to be acknowledge and used, as much as possible, bearing in mind the need to directly involve the vulnerable or infected groups.

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Limitations of these tools:

- Rapid evaluation methods are likely to produce side effects such as: the instrumentalization of people’s culture; partial, reluctant or non-sustainable participation; and lack of a properly strategic perspective, though this is closely linked to the slow evolution of the infection;

- The use of written investigation guidelines or questionnaires is limited by the level of literacy, especially in areas where illiteracy is still widespread, and the relation between the risk, vulnerability and insufficient or absent education, especially among girls and women is underestimated.

Culturally-balanced methods adaptable to preventive action projects

Social soundness analysis helps to highlight the compatibility between the project and the local context, possible multiplying effects, and the social and cultural impact.

Participatory rural appraisal is based on behaviour, exchange of knowledge and shared experience. This method, however, is frequently curtailed resulting in rapid rural appraisal with its potentialities and limits.

The best procedure, by far, remains participation (Canadian International Development Agency) which helps to achieve the following results:

- Mobilizing the capacity of action of the population and vulnerable groups;
- Joint implementation, with genuinely endogenous dynamics;
- Ensuring continuity in the reflection/action process;
- Local prevention and care staff training;
- Cross-evaluation by the institution/population of the progress made in prevention, care, support and impact reduction.

Funding may appear as an aspect that has nothing to do with culture. However, cultural interactions can result from the choice in financing modalities, a crucial question when considering that behaviour changes are the key to relevant and sustainable solutions.

When discussing financing modalities, attention should be paid to the fact that it can produce negative societal and cultural effects.

Technical means and issues:

- For practical and cultural reasons local materials and know-how should be used as much as possible including traditional medicinal expertise, practical services;

- Sophisticated medical facilities are sometimes fragile and may raise problems of sustainability, maintenance and lead to dependence on external intervention;

- Where new technologies are employed for blood testing and medical follow-up, especially of pregnant women, local staff should be trained and given jobs for the fitting and maintenance of facilities using new information technologies; voluntary cooperation should not be underestimated (for instance, women and unemployed young people).
DECISION-MAKING IN A CULTURAL APPROACH

- Due attention should be paid to the data collected by field workers, in view of securing the relevance of the project, especially with respect to local realities and capacities for taking initiative;
- Expected results and the time frame for the projects should be defined with flexibility, since the evolution of the infection can be quicker and take unforeseen routes.

4.5.4- IMPLEMENTATION: CO-ACTION BETWEEN INSTITUTIONS AND POPULATIONS

At the level of implementation, taking a cultural approach means:

- Discussing the cost/advantage of a centralized or decentralized approach in carrying out the project activities, given the complexity of certain epidemiological and medical issues;
- Tracking the development of these activities as compared with defined objectives and means;
- Using a distinctive but compatible checklist for institutions and populations, in order to achieve a joint action, indispensable for significant behaviour change.

CENTRALIZATION VERSUS DECENTRALIZATION

In order to be compatible with the cultural approach, decentralized programmes and projects need to be complemented by the following activities:

- Participatory approach and partnership;
- Flexibility (time and means);
- Devolution of responsibility to local partners and stakeholders, in matter of financing, equipment, facilities and staff.

However, it should be borne in mind that decentralization has its advantages and limitations. On one hand, action is closer to the field and easier to translate into concrete terms, and the administrative structure is lighter and information more direct. On the other hand, counter-productive effects can develop, due to several factors:

- Excessive weight of local cultures and power structures;
- Difficulty in coordinating and maintaining contacts between headquarters and the field;
- Controlling running costs.

MONITORING AND THE CULTURAL APPROACH OF HIV/AIDS

In the context of the seemingly unrestrained spread of the epidemic in many parts of the world, it is crucial to secure a reliable follow-up and monitoring system of the considerable means invested at the international and national level. This should be done without hindering the necessary adaptation to cultural relevance, thus, the sustainability of the action taken. The evolution of the action carried out should be carefully observed, with special focus on the following aspects:
• Responsibilities taken on by the institutions involved (use of administrative or project financial documents);

• Problems addressed: balance between the involvement and contribution of external contributors/local agents;

• Concrete results, sizeable changes, feasibility and efficiency, institutional and local dysfunction, use of available means;

• Maintaining the bottom-up flow of economic, social and cultural information (control board);

• Corrections required to the modalities, means and even objectives of the project.

This follow-up must be ensured at all levels of responsibility, through the following measures:

• Joint management integrating all levels;
• Combining technical, financial and “substantial” follow-up (in cooperation with local actors).

However monitoring activities regarding HIV/AIDS prevention and care raises difficult methodological issues. In spite of efforts made to-date, there is still a significant lack of exhaustive evaluation data, because no thorough testing has been carried out in the most seriously hit countries. There is also ambiguity in the concept of visibility, since it may refer to the action taken by institutions or to a significant decrease in infection rates (which will only be noticeable in the middle to long term). Both issues make it difficult to consider that a fully satisfactory monitoring system is already available.

Moreover, it should always be kept in mind that institutions and their partners do not focus their attention on the same questions, as demonstrated by the summary of their current respective checklists.

**For institutions, the regular checklist is as follows:**

- Which stage has been reached in implementation?
- Which results have not been achieved?
- What is the contribution of the achieved results to the overall objective of the project?
- What is the partner’s role?

**For partners, the checklist is as follows:**

- What is the difference between promised and effective contribution?
- What part does this effective contribution play in the activities in progress?
- What is the relationship between the problems to be tackled and the improvements achieved or likely to follow?
- Should efforts be measured as a function of the expected improvement, or would a redefinition of the expected results at a lower level be justifiable?
The necessary observation tools for appropriate monitoring are the following:

- Result indicators;
- Feed-back from partners;
- Possible alternative solutions;
- Assessment of constraints and dynamic aspects of the situation;
- Improvement or deterioration of communication between external actors and the local population.

At the decision-making level, taking into consideration the cultural references and resources of the populations involved in a project could lead to:

- Readjusting the objectives and expected results;
- Remodelling ways and means;
- Revising the budgetary and time frame of the project.

EVALUATION: RESULTS OR EFFECTS

In the cultural approach method, the evaluation exercise should be carried out at two levels:

- **Technical level** (comparison of objectives/means/results, explanation of differences);
- **Comprehensive level** (socio-economic sector and inter-sector effects, both direct and indirect, which would allow an in-depth evaluation of the present methods used for HIV/AIDS prevention and care policies and projects).

In terms of a cultural approach, the evaluation should not be limited to economic (effective use of goods and services produced) and social (solutions to difficulties encountered by groups who asked for external support) considerations. For an in-depth understanding of the situation and subsequent redirection of the project, a proper cultural evaluation would include the following components: cultural cost/benefit analysis, re-evaluation of cultural resources, balance between external and local commitment, loss or restoration of self-confidence. These are all essential elements in the effort towards changing ways of thinking, behaviour norms and practices, and in building efficient prevention and care projects.

**Critical evaluation** should be an continuous process throughout the project life, and should be permanently reflected in the implementation of the project and redesigning of its technical documents.

METHODOLOGICAL CHOICES

In a cultural approach, systematic assessment at all stages of a project in relation to the population’s cultural references and resources, should be a basic requirement. These generally include preliminary evaluations and periodic evaluations. At project take-off: technical checking and confirmation of agreement on external intervention with population. Mid-term evaluations can be made earlier if necessary, especially if the project seems to be “fragile” (as are most HIV/AIDS projects) in order to:

- Redirect or re-frame the project or to give it new impetus;
- Measure its capacity for multiplier effects (indirect effects, parallel actions).
Final evaluation: a crucial stage

The differences or similarities between the purely institutional views and those of the involved populations will come to light in the final evaluation, as summarized in the current practice:

For institutions

The most important points are the actual results (direct effects) showing to what extent the objectives of the project were met (fully, partially, not at all)?

Results are classified using the following criteria to determine success or failure:

- Output of activities undertaken to reach the specific objectives of the project, before attaining “cruising speed” (i.e. maintaining/consolidating the produced outputs);
- In case of partial or total failure, an independent evaluation should be carried out (at the end of the project, and even 5 to 10 years later bearing in mind the time factor in HIV/AIDS epidemiological evolution);
- Specific points to be analysed can be expressed in terms of ratios: planned activities versus implemented activities expected results versus achieved results.

Indirect effects can be evaluated, if necessary, but at a later stage. Technical criteria point to mainly the short-term projection in the use of external contributions (for institutions), rather than the sustainable relevance to beneficiaries. While the evaluation of indirect effects is recognized as crucial for sustainable improvement of HIV/AIDS prevention and care, it is not current practice, as it needs a much longer period to be completely evaluated. The prevailing time limits for institutions, programmes and projects are: two years for short term planning and five to six years for medium term strategies. These limitations make it impossible for institutions to plan their activities and subsequent effects in connection with slower rhythms.

BEYOND EVALUATION

Conclusions should form the basis of future projects (or the next phase in a medium-term project). These conclusions cannot, however, integrate secondary effects external to the given field and are only understandable in the long-term perspective.

Certain conclusions can be transposed and used to conceptualize and carry out other projects in related or different areas (replicability).

<table>
<thead>
<tr>
<th>Conditions for success</th>
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<tr>
<td>(basic institutional point of view)</td>
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<tr>
<td>• Good planning;</td>
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<tr>
<td>• Competent and committed team;</td>
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<tr>
<td>• Sufficient organizational capacity;</td>
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<tr>
<td>• Real issues addressed through the project;</td>
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<td>• Obligations respected by all partners.</td>
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Reasons for failure

Technical reasons

• Poor definition of objectives;
• Inadequate viability;
• Poor use of teams;
• Lapse of local partners;

Relational reasons

• Lack of consensus;
• Irrelevant distribution of tasks;
• Insufficient motivation of partners.
Improved evaluation tools
The purpose of refining evaluation methods is to fully account in the projects for the diversities of situations, tailor the ways and means of their implementation, and change their rhythm accordingly. Even previously agreed upon project objectives may be redefined.

Interests analysis method

- There are similarities and differences in external/internal development, actors’ value systems and interests. In any action for prevention and care, people judge the proposed action in terms of their value systems and concrete interests;

- However, there are both similarities and differences in people’s cost/benefit perspectives (“price” to pay, “benefits” in terms of economic or symbolic return and power);

- The rationale and cost changes through negotiation and in the long-term perspective: its modes and conditions of evolution can provide key information on the development of culturally-appropriate prevention and care action.

Evaluation methods for populations
Result-oriented evaluation methods should cover problems that are of interest to the population. For example:

- Use of external input by local people (i.e. condoms and counselling);
- Modalities and content of information activities, their periodicity and relevance in relation to people’s cultural and societal habits;
- Account taken of cultural (local cultures/ideology of development) and inter-sector interactions (i.e. agriculture, education, employment, rural/urban development);
- Intra-administrative trend towards conformity in comparing expected and actual results;
- Dysfunctions in the agenda: incompatibility between “planners’ time” and “population’s time” (and HIV/AIDS time).

Cultural cost/benefit analysis
This analysis requires more focused attention from researchers. It would mainly deal with the positive and negative impact of HIV/AIDS and changing life conditions in:

- Identity, system of meaning, awareness of belonging to a given community;

- Aspirations, needs and a demand for societal change or continuity;

- Behaviour change in matters of sexual behaviour, but also in production and exchange activities, communal and family life, distribution of power, spiritual, ethical and cultural structures.

N.B.: Cultural cost/benefit analysis cannot be carried out without establishing the fundamental indicators and behaviour patterns of a given culture. It would be particularly useful to define such indicators in order to promote and evaluate the role and importance of the cultural approach, in order to significantly improve HIV/AIDS prevention and care action.
Continuous evaluation process: for a new partnership

As described earlier, this process is the most relevant as far as a cultural approach to HIV/AIDS prevention and care is concerned. It can be developed along the following guidelines:

- Simultaneous evaluation: testing the concepts and methods currently used in order to run and monitor projects, thus allowing the readjustment of activities, the redirection of overall orientations and, in the long-term, redesigning concepts and tools;

- Main mechanism: action/reflection/evaluation/readjustment;

- In a cultural approach, the major points to be verified for successful prevention and care are:
  - Correspondence between objectives and problems (felt needs);
  - Relevance of means to the problems and local situations;
  - The results and effects expected from the project (by institutions/by populations).

Continuous revision and adjustment will be based on the answers to the points listed above.

- “Beneficiaries” should be involved in all activities: data collection and processing, joint implementation, joint “scanning” and conclusions;

- This should help to identify qualitative data, which is of key importance in focusing efforts towards behaviour change: population’s expectations and fears, self-confidence or discouragement. These are crucial in securing an efficient and sustainable effort in prevention activities, as well as in humanizing care to the sick people and developing a more supportive environment for the affected and infected persons.

Ex-post evaluation:

- Sustainable effects, positive or negative, in medical and educational actions and in other related fields: economic, environmental, social, cultural;

- Specific, non-medical and sanitary consequences of HIV/AIDS actions;

- Desired and undesired effects: possibility of failure in rooting prevention and care action in people’s ways of thinking and behaviour norms; development of passive attitudes in the case of exclusively external actions.

4.6- PRIORITIES FOR ACTION

As a follow-up to building appropriate new strategies and policies for prevention, support and reduction of the social, economic and cultural impact of the epidemic, priorities have to be defined. These priorities are urgent key action programmes designed to achieve significant changes at all levels (national to local) and develop joint action between institutions and society.
More specifically these priorities are:

4.6.1- JOINT MOBILIZATION OF THE INSTITUTIONAL NETWORK AND CIVIL SOCIETY

Community-based prevention and care projects can only be designed, carried out and evaluated successfully through a continuous exchange process with the target populations, whether non-infected, HIV-positive or sick. This is necessary in order to fully understand their concerns, priorities, and make full use of their own cultural resources and capacity for mobilization. Effective partnerships can, thus, be built between the institutions, networks and society.

4.6.2- BUILDING A COMMUNITY-BASED RESPONSE

Involving people in the campaign against the epidemic is of vital importance. In other words, building an appropriate and sustainable response to HIV/AIDS means that people have to be personally involved: at home, in their neighbourhood and at their work place. Each individual, family and community can become “AIDS-competent” by assessing how AIDS affects various aspects of their lives and by taking concrete measures to minimize its impact at the local level.

In order to change their behaviour, people need support from their human environment. Developing partnerships at a local level can improve the effectiveness of their response. Thus, a well-supported mobilization process should result in numerous local initiatives. Sustained behavioural change can result from common social reaction and a clear understanding that disease and death are the direct consequences of HIV/AIDS for one’s self and family.

As a consequence, it should be emphasized that interventions proposed by experts and planners have to be appropriated and implemented as much as possible by people and communities. In this process, sociocultural determinants may greatly influence the assessment and reaction of the community to HIV/AIDS issues. Thus, it is indispensable to learn and understand, at the local level, how the various actors have handled the assessment and response process. Experts and planners must, therefore, change their action modalities in order to influence rather than supervise the action.

4.6.3- SPECIFIC RESPONSIBILITY OF INSTITUTIONS

Regarding government strategy and policy, key elements for mitigating the impact of the disease on infected and affected people include the following measures.

3. Barrière Constantin, Luc (UNAIDS) Key concepts of the local response agenda. Presentation of the local responses team during the Kampala subregional workshop on “Cultural Approach to HIV/AIDS Prevention and Care”.

Mitigating the impact on people infected by HIV/AIDS

- Credit programmes to mitigate the effects of HIV/AIDS on households through loans in order to maintain levels of household expenditure, school attendance, etc.;
- Benefit packages to mitigate the impact of HIV/AIDS on families and children, targeting children and families, including the provision of food (at school), school vouchers, and school uniforms;
- Legal reforms or aid for vulnerable groups, such as the windows and children of those who have died from HIV/AIDS, who often risk losing property or autonomy due to existing inheritance laws or traditions;
- Workplace interventions to maximize continued labour force participation;
- Home-based care in households in order to enhance the quality of life of people living with HIV/AIDS;
- Community-based self-help groups for individual and family support, to ensure the continued participation of children in school, to maintain household expenditure patterns, and to promote savings.

Key interventions in reducing vulnerability of specific population groups

- Legal review and reforms aimed at changing laws and government policies, which make it difficult for vulnerable groups to protect themselves. For instance, laws which make sex work illegal, especially if applied aggressively, may discourage sex workers from seeking help;
- HIV/AIDS education campaigns in schools and in the workplace;
- Better accessibility to education for youth, especially girls;
- Military programmes undertaken by the armed forces, specifically targeting their personnel, who are both highly vulnerable and receptive to HIV/AIDS prevention and education campaigns;
- Programmes targeting persons in jail or prison.

4.6.4- CULTURALLY-APPROPRIATE COMMUNICATION FOR BEHAVIOUR CHANGE

Elaborating culturally appropriate communication for behaviour change is instrumental in building a sustainable and appropriate response to the challenges of risk and vulnerability to HIV/AIDS.

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5. A detailed description of methods for cultural appropriate communication for behaviour change is given in the handbook specifically devoted to this question.
Fostering a better understanding of the HIV/AIDS related challenges facing populations should result in HIV/AIDS becoming a high priority for the populations themselves. This will result in the development of a sense of responsibility and on the focusing of energy towards mobilization on the part of the population.

This requires that the following activities to be carried out:

- **Methodological research to:**
  - Evaluate the cultural relevance of the current Information/Education/Communication (IEC) practices;
  - Understand people’s cultural references and resources;
  - Identify the societal/cultural conditions for people’s sensitization and mobilization.

- **Identify specific demands and needs of the target audiences**, regarding their relation to HIV/AIDS, their socio-economic situation, specific risk behaviour and relation to society at large;

- **Develop proposals for a cultural approach to appropriate IEC materials and processes for prevention and care** based on a combined elaboration and the delivery of relevant messages.

### 4.6.5- RENEWED PREVENTIVE EDUCATION: A VITAL ISSUE (RISK AND SOLIDARITY)

After a first phase of action focused on health and medical care, within the limits of the epidemiological approach, education (and to some extend media information) has become the second major instrument used to forestall the risk and to implement the practical protection measures risk implies.

However, its limited results have raised growing concerns as to the real efficiency of preventive education campaigns. It becomes more and more patent that in fact, even when preventive education messages are well received and intellectually assimilated, very frequently their content is not appropriated in practice by populations, especially children and adolescents, and thus does not entail behavioural changes and solidarity towards the infected and sick people.

The reasons for these poor results are probably linked to the lack of distinction between preventive education and school instruction. In addition, school instruction is too often limited to the one-way transmission of purely cognitive information. Thus, in spite of the unique and indispensable capacities of the school system, it remains that by definition, it does not reach children and adolescents who cannot attend school (up to 80% in certain countries). Moreover, illiteracy rates among young people and adults above fifteen, especially girls and women, are still very high in numerous countries (above 75% in some cases).

For these reasons and fundamental considerations, preventive education has to be envisaged through all its channels, including non-school educators such as social workers, NGOs, business men and entrepreneurs, associations and movements, sports groups, ethical, religious and traditional community educators.
From another point of view, educational material should not be “pre-cooked”, but should emerge from the educational process itself, based on empathic dialogue and on people’s societal and cultural values, behaviour norms and understanding capacities.

To this effect, preventive education will have to be remodelled in depth, in order to make it relevant to the forms of diversity in people’s representations and styles of life and also to their living conditions. Only through this approach will people accept to question their practices, traditions, customs, habits and motivations, thus giving genuine attention to new ways of considering their personal and collective priorities for the future, and changing their behaviour accordingly.

4.7- PROPOSED METHODOLOGICAL IMPROVEMENTS

In order to take into account cultural diversity and interactions between local cultures and development action, specific methodological tools are required, some of which are already being researched and tested. The first category of methodological requirements deals with systems and instruments for developing human resources through the cultural approach. The second major task is to focus on proposing new methods for project design in order to reform the planning process itself. Current experiments in this area must be evaluated and improved on.

4.7.1-TRAINING/SENSITIZING/CAPACITY-BUILDING

Training/sensitizing decision-makers in culturally-appropriate HIV/AIDS prevention and care strategies and policies means developing not only techniques, skills and know-how, but also changing attitudes and understanding capacities. Thus, allowing self-evaluation sessions on the compatibility and discrepancies between institutional cultures and local people’s cultural habits and ways of thinking as well as defining modes of convergence between institutional and public rationality.

This requires the elaboration, of research-development oriented training programmes aimed at helping decision-makers, project planners and managers to integrate cultural references into strategies, programmes and project design and implementation. As a general rule, this should be a two-way bilateral learning process, an exchange of experience between decision-makers and practitioners.

Like many other externally driven actions, the strategic planning approach has no chance of surviving in the long term unless national and local planners have internalized this method. Hence, the capacity-building of local staff is critical in order for the process to gain the necessary momentum to affect the national, regional and global response to HIV/AIDS. As stated above, the regional networks of technical support will be used for that purpose, but the best way of learning is active involvement in the real-life exercise.

Source: UNAIDS Guide to the strategic planning process for a national response to HIV/AIDS.
4.7.2- WHO SHOULD BE TRAINED/SENSITIZED?

High- and medium-level decision-makers

Planners, scientific and technical specialists, medical and health programme leaders, in national and international institutions:

- Theme groups;
- National health and HIV/AIDS planning and administrative committees;
- Educational and media specialists (see above).

Field-level actors

- Field workers;
- Local stakeholders: religious, spiritual and political (traditional chiefs).

CULTURALLY-APPROPRIATE TRAINING METHODS

First category: senior officers

- Pre-service training:
  Understanding and using the cultural approach should be part of the various training courses at post-graduate level. It should include academic material from the social and human sciences, supplemented by field sessions, for instance in the curriculum of high-level medical schools and universities; public administration institutes and specialized economic and social management training institutions. Another possibility would be to have senior officers go through a dual training system: medicine and anthropology.

- Sensitizing, updating seminars and retreats:
  As most high-level and medium-level decision-makers have had a specialized university and postgraduate education, short sensitizing and updating sessions could be useful to them. These could be organized as specialized in-service seminars and retreats, and/or brief and intensive courses.

Second category: Medium-level professionals

- Teachers, social and welfare workers;
- Medical and nursing staff when necessary;
- Press or media journalists.

Third category: Field workers:6 local staff and stakeholders (capacity-building sensitizing).

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6. The training of field workers will be described in detail in the handbook Field work and Building Local Response.
4.8- SUMMARY

As in strategy and policy building, project design, implementation and evaluation must respond to the major challenges in fighting HIV/AIDS: risk, vulnerability, prevention, care, support and impact reduction through a cultural approach. In this respect the modalities of current action show serious deficiencies: geographical, medical and even socio-economic limitations, combined with an insufficient consideration of people’s societal and cultural references and resources. Another serious deficiency is the lack of communication and the partial involvement of stakeholders, outside the public sector: NGOs, societies and communities.

Culturally-appropriate response, in terms of project building, should first deal with its specific level of action between strategies, policies and field work. Then, a preliminary evaluation must be done in order to identify the general determinants of the current situation and expected outputs of the project. However, in-depth field investigation is needed in order to fully understand the complexity of the interactions in terms of people’s concrete difficulties. Relevant methodological instruments must be used to this effect, for general survey, case studies, both in suburban environments or in remote rural areas, which will portray, in indisputable terms, the gravity and complexity of efficient prevention and care.

Then, the standard phases of project planning are described in a step-by-step approach: preparation, implementation and evaluation, bearing in mind that in reality they are constantly interwoven and should not be considered separately from each other. At the purely instrumental level, choices must facilitate coordination, population/institution consensus and the clear indication of expected results and effects. Preparation, problem identification, mobilization of actors and the definition of vulnerable groups are presented in turn. Additional conditions are then described: official document accessibility, bottom-up planning, the use or adaptation of current tools. Comparative advantages of centralization/decentralization, as well as the conditions for prevention and care project monitoring in the cultural approach, are then presented and summarized as checklists for institutions and populations. Finally, the impact of methodological choices in the evaluation exercise is discussed, in so far as it deals with results or effects.

On this basis the main priorities for action in project design/implementation/evaluation can be listed in order:

• Joint mobilization of the institutional network and the civil society;
• Building a community-based response;
• Subsequent redefinition of the institution’s responsibility;
• Culturally-appropriate communication for behaviour change;
• Subsequent renewed preventive education.

As a consequence, methodological improvements are proposed on two issues: training/sensitizing/capacity-building and new project design methods.
The basic prerequisite for project design, implementation and evaluation is its capacity to face risk, vulnerability, prevention, care and support in a given situation. This situation is characterized by its relative position by reference to overall strategies and policies on the one hand, and field factual issues on the other hand. Moreover, it should be contextualized in its economic, social and cultural environments. Technical concepts and tools should be readjusted accordingly.

In the present handbook, four major issues have been considered:

- Preliminary in-depth rethinking of current project design methods in relation to prevailing direct and indirect risk practices and field situations;
- Issuing new proposals for more efficient, relevant and sustainable prevention, care, support and impact reduction projects in a step-by-step approach;
- Proposing methodological improvements;
- More specifically, identification and implementation of the following priorities in action:
  - Joint mobilization of the institutional network and the civil society;
  - Building a community based response prior to defining the specific responsibility of the institutions;
  - Renewed preventive education concerning risk and solidarity, as a key aspect of culturally-appropriate communication for behaviour change;
  - Training/sensitizing/capacity-building at all levels: beyond technical scientific and administrative skills, opening a broader view of the societal and cultural environment of prevention and care among professionals involved in planning and implementing strategies and policies.

N.B.: As mentioned in the Foreword, three other practical handbooks will be devoted respectively to: strategy and policy building, field work and appropriate-communication for behaviour change.
List of Publications elaborated within the Project:

**A Cultural Approach to HIV/AIDS Prevention and Care**

**UNESCO/UNAIDS Research Project**

Studies and Reports, Special Series -

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

Methodological Handbooks-

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

All of these documents are available for consultation on Internet at:

http://www.unesco.org/culture/aids/