Prevention

AIDS prevention with local implementors – overcoming obstacles

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Observations made in the United Republic of Tanzania indicate that programmes for long-term AIDS prevention can only achieve their potential if local circumstances are taken fully into account.

Prevention programmes have contributed significantly to widespread public awareness of AIDS in East Africa, but the extent to which the disease has actually been prevented by national and international interventions remains unclear. In many sub-Saharan countries the prevalence of HIV infection and AIDS will continue to increase for many years. The main weapons against the epidemic will continue to be prevention through education and the fostering of social conditions in which individuals have the ability to translate knowledge into protective action. Given this scenario, any persistent obstacle to prevention education must be dealt with.

This article discusses some conceptual and structural impediments to effective prevention efforts which were observed during anthropological fieldwork conducted in the early 1990s in the vicinity of Moshi town in the United Republic of Tanzania’s Kilimanjaro Region (1). In this piece I do not offer an evaluation of local AIDS education and prevention, but put forward a critical discussion focused on a topic which is often neglected: the structural and conceptual relationship of AIDS educators and the communities they attempt to serve.

Four AIDS service organizations operated in the region. The largest was a joint project of the Tanzanian Ministry of Health and the Norwegian government. The others included a community-based AIDS service organization (the Kilimanjaro Women’s Group Against AIDS) and programmes run by the Lutheran and Catholic churches. All these groups were engaged in AIDS prevention, but the differing backgrounds of their staff, as well as their widely disparate objectives and resources, produced variation in the way they carried out their activities, how their audiences were defined, which issues were stressed, and what moral messages were conveyed. However, these groups also faced some common obstacles in conveying their prevention messages. Impediments stemmed from the fact that many of those who became involved in the local fight against AIDS belonged to relatively

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World Health Forum • Volume 18 • 1997
privileged and well-educated groups (such as nurses, pastors and teachers), whereas those who were seen to be most at risk belonged to the most disenfranchised groups (such as petty traders, “bar-girls”, sex workers, students and female farmers with migrant husbands).

**Perceptions matter**

From the perspective of urban young people, a key target audience for AIDS prevention, the biggest obstacle for the success of the joint Tanzania–Norway educational activities was one of credibility. Most of the local staff employed by this group were medical staff from the best area hospitals. Young people who were interviewed about public AIDS education seminars and speeches expressed the cynical view that those from the formal health care sector who found employment as AIDS educators and counsellors were mainly motivated by the opportunity to earn extra money. Tanzanians involved in AIDS-prevention work often had to contend with suspicion deriving from young people’s previous experience of corruption and insensitivity among medical personnel – particularly in encounters with those providing reproductive health services. Young men and women doubted the sincerity of the concern expressed by these same individuals who were now providing public education.

For their part, many Tanzanians working in the health sector regarded the opportunity of employment in an externally funded project as a welcome chance to augment their very poor salaries while performing a service of great value to their communities. When it came to communication about AIDS, however, educators often expressed their health messages in highly moralistic terms. This contributed to the perception of young audiences that their behaviour and lifestyles were being denigrated by people who saw themselves as morally and socially superior. I observed examples of this problem in several AIDS-prevention talks given to female secondary school students. The talks seldom had any educational value, and the students, many of whom were in their late teens or early twenties, were subjected to harangues about the dangers of birth control, premarital pregnancy, and the importance of working hard at school – all by way of AIDS education.

Young Tanzanians not in school have had to face the menace of AIDS at a time of increasing social instability, changing sexual mores and deteriorating economic conditions. Itinerant, survival-oriented lifestyles that began to emerge among young adults in the 1980s have placed them in a difficult position. Their enforced mobility contributes to instability in relationships and having multiple partners, and thus they are at increased risk for sexually transmitted infections, including HIV/AIDS. AIDS educators tend to speak of this lifestyle as the outcome of moral laxity rather than of social hardship. This is another way in which the structural differences between educators and audiences influence the transmission of prevention messages.
The point of these examples is to illuminate some very common features of AIDS education as it was practised in its local context. The local personnel of AIDS service organizations were not only vehicles for health information; as individuals they were also long-standing members of the community, and had cross-cutting social and class interests. Local conditions can have a major influence on the outcome of AIDS prevention programmes, and the vision and social status of implementors are much more significant in this connection than the perspectives of policymakers and evaluators.

**Support for local groups is critical**

Ultimately, the most effective interventions may not come from agencies or governments, since global and regional approaches cannot take into account all the issues that providers and users of services have to confront in particular locations. As funds for AIDS-related work in sub-Saharan Africa decline, local organizations dedicated to prevention should be strengthened, and policies giving some power and stability to the people most at risk should be given more support. There is a clear need to go beyond the channels of the formal health care sector in order to develop new approaches. In Uganda, for example, the highly successful group called “The AIDS Support Organisation” (TASO) grew out of the efforts of Ugandans who had requirements not only for prevention but also for training in the support and care of HIV-positive persons.

The execution of many programmes eventually becomes the responsibility of local personnel, and this calls for the development of creative, decentralized AIDS service organizations that draw on community participation at an early stage. It should be possible for programmes to adapt their organizational structures and specific services to local conditions while maintaining their global purpose of empowering and improving the lives of the people who are at greatest risk of HIV infection and ensuring the dignity and human rights of those already affected. These goals will be difficult to achieve, however, unless there is a frank appraisal of local conditions and the structural and cultural impediments that might be harming prevention work.

**Reference**


**Acknowledgments**

This article is based on research approved by the Tanzania National AIDS Control Programme (NACP) and the Tanzania Commission for Science and Technology (COSTECH). Valuable guidance was given by Dr M.T. Leshebari, Dr Eustace Muhondwa and Dr George Lwihula of the Muhimbili University College of Health Sciences, Dar es Salaam. Assistance was also received from the Kilimanjaro Regional AIDS Control Programme, the Kilimanjaro Women’s Group Against AIDS, the Tanzania-Norway AIDS Project, the Health Education Programme of the ELCT Northern Diocese, the Rainbow Centre of the Moshi Catholic Diocese, and Dr B.J. Singano, Medical Officer for the Kilimanjaro Region. Fieldwork was supported by grants from the Joint Committee on African Studies of the Social Science Research Council and the American Council of Learned Societies with funds provided by the Rockefeller Foundations and from Health in Housing, a WHO Collaborating Centre at the State University of New York at Buffalo.