"You can persuade your men to use condoms 100% of the time: " Transferring HIV/AIDS prevention programs across cultural boundaries. *

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Workshop objectives

The 2-hour workshop aimed to provide participants with the principles in planning and transferring HIV/AIDS prevention programs across cultural boundaries. It traced the development (2000-2003) of a community-based, Participatory Action Research [PAR] approach to pyramidal peer-education training to offer behaviour change techniques and strategies for non-literate groups at risk for HIV/AIDS. The staff, volunteers and international supporters of the Siem Reap Citizens for Health, Educational and Social Issues (SiRCHESI), a local NGO, adapted materials and best practices previously found highly effective in Singapore. Beyond this experience, we suggest that further adaptations of these practices are possible for other localities in Cambodia and elsewhere.

The HIV/AIDS/STI situation in Siem Reap, Cambodia

Cambodia has one the highest HIV prevalence rates in Asia, with an adult prevalence of about 4 per 100 persons in 2000. The rapid spread of HIV/AIDS/STIs is attributed to extensive solicitation of sex workers not only by international tourists, but by local Cambodian men. Cambodia implemented the national 100% condom use program for entertainment establishments in 1998, and this has increased condom use among direct sex workers from 53% in 1998 to 78% in 1999, with a concomitant significant decline in HIV. Despite this success, there is a need to increase condom use to a higher level, particularly in Siem Reap, site of the Angkor Wat temples. Here, a massive expansion in tourism combines with the high HIV prevalence of 43% and 16% respectively among direct and indirect sex workers (beer promotion women) in 2000. Our survey on sex workers in Siem Reap in 2001 showed that almost all (>90%) of them were aware of the effectiveness of condom use and non-curability of AIDS, but only 78% used condoms consistently with their clients. Their main reason for not using condoms was not being able to persuade their clients (66.7%). Multivariate analysis found a significant association of inconsistent condom use with low income and lack of negotiation skills.

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The above findings were very similar to those among brothel-based sex workers in Singapore. In 1994, Singapore implemented a condom promotion program among sex workers; condom use for vaginal sex increased significantly from less than 45.0% before 1995 (pre-intervention period) to 95.1% in 2002, with a corresponding decline in cervical gonorrhoea incidence from more than 30 to 2 per 1000 person-months. Consistent oral condom use increased significantly from less than 50% before 1996 to 97.2% in 2002, with a corresponding decline in pharyngeal gonorrhoea from more than 12 to 4.7 per 1000 person-months. After a first series of in-depth interviews in Siem Reap were conducted in 2000 with men and women, including medical personnel, it appeared to

us that some of the problems related to condom use among the sex workers in Siem Reap were rather similar to that in Singapore, and elsewhere. Peer education programs in a number of different cultures have shown that increasing knowledge about HIV/AIDS and STIs is not sufficient to reduce transmission rates in a community; rather what must be taught are new behaviours and negotiation strategies. We decided, therefore, to work as a team to culturally adapt the successful program in Singapore to the situation in Siem Reap, and to monitor this adaptation along the way.

The condom promotion program for sex workers in Singapore

The program's objectives had been to (i) motivate sex workers to use condoms by relating safe sex to what they most valued, which was being able to work and support their family; (ii) develop their condom use negotiation skills and increase their self-efficacy to always refuse sex without a condom if the negotiation fails; and (iii) provide support to them by getting brothel owners to display posters and talk to clients on condom use. Health staff from the public STI clinic followed up on the brothels' compliance. Three main strategies were used: skills development and heath education targeting sex workers; administrative measures targeting brothel management to support 100% condom use, and activities targeting health staff to monitor and continually improve program activities.

Sex workers participated in two 2-hour small group sessions on condom negotiation skills after receiving talks on STIs and AIDS. Instructional methods during the first session included video presentations which featured local sex workers demonstrating techniques to negotiate condom use; there were also role-play and peer group discussion sessions. The video presentations focused on specific strategies to negotiate condom use with different clients; alternatives to take in the event of client refusals, and the importance of peer co-operation so that none of them would lose their clients to others. During the second session, health facilitators and peer educators led the group to discuss problems in persuading clients to use condoms arising from their self-monitoring of condom use. Experienced peers shared their personal experiences in handling difficult clients and non-supportive brothel owners. Sex workers were also given free condoms and stickers (depicting "100%: condoms must be used here") for display in their brothel-rooms to facilitate their negotiation task. Comic books designed in an entertaining format were also distributed to the sex workers. Focusing on common problems encountered with clients and their solutions, the comic books were meant to reinforce the video clips as sex workers might not recall certain workable approaches. Posters on 100% condom use were distributed to all brothels and health staff checked on the brothels' compliance to ensure that the posters were displayed prominently in the brothels. Brothel managers who did not display posters or were found to be recommending clients to sex workers who did not use condoms were given warnings, and those brothels with high gonorrhea incidence rates of more than 10% were temporarily suspended from business.

Quality improvement activities were incorporated into the maintenance phase to monitor progress, identify problems and respond promptly to them. A booster session for sex workers was held three months after the initial program activities to reinforce messages on condom use and discuss problems encountered by them. Three booster sessions were subsequently held 6 months to a year apart over the two-year intervention period.

Trans-cultural adaptation to Cambodia—Focus groups and Community consultations

In February 2001, the intervention strategies and educational materials of the Singapore program were first used in focus groups in Siem Reap, Cambodia, where further cultural and local adaptations were proposed by "indirect sex workers". These "beer promotion women" sometimes accepted propositions from restaurant clients for paid sex, because of insufficient salary from the

international beer companies whose products they exclusively sold. These women viewed all the materials and commented upon each scene or page, often offering concrete suggestions for what "worked" and "didn't work" in their community. It also became evident in our focus groups, and in discussions of behavioural survey results and local epidemiological findings that HIV was not just being transmitted from ex-tourists to direct and indirect sex workers, but had now bridged to the community at large, as local men, married and single, frequented the same sex workers and then had unprotected sex with their wives, girlfriends, etc. (AIDS orphans and mother-child transmission also became community issues. The targeting of the "beer girls" would complement the government's ongoing program of client education, 100% condom policy and brothel administrative measures already being directed towards "direct sex workers". We felt that before developing workshops for men, we could first target married women with the same educational materials developed for the "beer girls", stressing the common strategies needed by women in the community to be safe from HIV/AIDS. Once local women in Siem Reap and our medical colleagues had given their input—additional ideas also came from Khmer men and women living abroad in Singapore and Australia—we prepared a series of workshops to train, pyramid–style, a series of peer-educator trainers in Siem Reap, who in turn would train other women, and also train other peer-educators to "fan out" into the community with what were, we believed, effective locally-adapted methods for obtaining behaviour change, that would eliminate risk of HIV transmission.

Separate day-and-a-half long peer educator training workshops on condom negotiation skills and behavioral strategies for avoiding HIV infection were separately conducted—at their request-- for 25 indirect sex workers and 25 married women—for the most part, without reading skills. In addition, a shorter half-day summary workshop was given for various literate outreach health workers from government agencies, hospitals, and non-governmental organizations. These peer educators and health staff would in turn train other sex workers and married women to use condoms. Health education materials from the intervention programs in Singapore such as the comic book and video clips demonstrating condom negotiation strategies were adapted to the cultural setting in Siem Reap, using the participatory action research approach, as with the earlier focus groups. In fact, based upon the reaction of the "beer girls" to the original Khmer version of the video tape – they were unfamiliar with television and learning from a small screen-- we relied instead on "audio-cassettes" of the Khmer soundtrack from the video. This could be replayed on simple Walkmen players and successful negotiation strategies memorized. During these sessions, we monitored the role-playing and discussion groups for additional successful strategies, to be incorporated in the next sets of workshops and materials. We also continue to gather in-depth behavioural information about local risk-taking and condom use practices from women and men coming to the Mondol Moi Health Centre for voluntary and free HIV/AIDS testing and counseling.

Local Lessons, Stubborn Particulars, and Cultural and Technology Transfers

Each program will learn important lessons about the fit between behaviour change strategies and local cultural practices, beliefs and resistances. Significant modifications occurred between the Singapore and Siem Reap workshops, as, we expect, will occur when the methods are exported elsewhere. Our cartoon booklets were redrawn by a graphic artist in France to better reflect the Siem Reap context and characters. First-draft translations of some materials were made in the Australian Khmer community. First versions of the audio-tape were produced by Khmer students in Singapore.

The effectiveness of the peer-education workshops are currently being evaluated in Siem Reap in 3 month, 6-month and 12-month follow-ups with some of the workshop participants. Initial 6-month results from small numbers of women indicated that while consistent condom use was now practiced with clients at about 94%, husbands of married women and boyfriends or sweethearts of "beer girls" still were not consistently reducing the risk of HIV transmission through 100%

condom use,. Therefore, these groups of men are being targeted in 2003-4. Of the original 50 women "at risk" who were trained in the two main workshops in May 2002, a number voluntarily continued in the pyramid training model…. In the 12 months following the workshops, over 1100 additional persons were trained about HIV/AIDS prevention. Surprisingly, about 15% of them were men, and our most active peer educators suggested they could also comfortably teach men about HIV prevention. Although the married women were not comfortable about sharing a workshop with the "beer girls" they suspect might "steal their husbands", in an experiment, three "beer girls" came to one of the married women's session. One was trying to support two children, and one had "been a married woman, like you" for 8 years; only when the latter's husband left her and 4 children, had she become a beer girl just a few weeks earlier. She challenged the married women to think "about what will you do, if you cannot read, and you must support your children, if tomorrow, your husband suddenly leaves the family household." In one workshop, we challenged the married women to begin openly discussing with their husbands their own sexual behaviours and how they might be at risk for HIV/AIDS; they were given a box of condoms to take home and suggest to their husband they try it that night! About 25% reported success and a positive response from their husband.

Many of the women, who have had limited or no education, could not understand our references to "statistics", such as: " 40% of Direct Sex workers have HIV/AIDS". We therefore developed visual numeracy techniques using beer-cans and cola-cans. Ten women who volunteered to stand at the front of the room were randomly, and secretly assigned, behind their backs, one of 6 "safe" beer cans and 4 cola cans representing "AIDS". Then 10 men, also with their randomly assigned cans hidden behind their backs also come forward. Some have been given a condom in their other hand, according to the known proportion of use. Random pairings of men and women are then created, and each "couple" then reveals to the audience the cans they each have behind their back ("seropositivity state"). When one partner has AIDS and there is no condom, the audience calls out "AIDS". Since transmission has taken place, the beer-can of the other temporary partner is exchanged for a new cola can. Both randomly selected persons return to the line-up, eligible for future pairings. The community bridging of HIV/AIDS and its spread from tourists to sex-workers and/or "beer girls" to both married men and boyfriends and then to married women (and newborns) can thus be dramatically played out with audience participation as the pandemic graphically spreads. By the time the men "go home to their wives" and additional "AIDS" infection occurs, the ideas of risk are clearer for most persons.

We blended into our workshops a blend of activities, many of which encouraged the women's active participation, while there were traditional "illustrated lectures", e.g., about reproductive health and HIV/AIDS transmission. Here, graphic flip charts and a "trainers manual" are used, There were also role-playing sessions where women creatively generate innovative responses to husbands (or other men) who at first seem to resist their suggestions to reduce risk of HIV/AIDS. Often the women, in each others' supportive presence, added humour and subtle shared insights into the psychology of local men, even though they might not normally express this directly to their male partner. (On one occassion, out of such role-playing "fun" came a quite serious group discussion of why men don't stay at home, but rather go out "with the boys" to drink beer and have paid sex.)

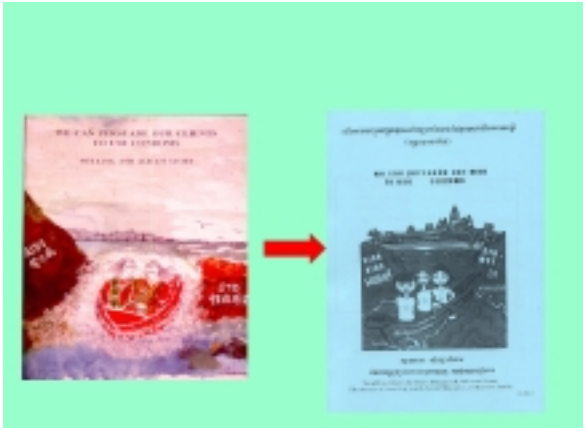
All women were given a hands-on experience of placing a condom on a model wooden penis. For those for did not want to use the model penis, due to religious symbolic significance, a water-bottle was used to allow the experience of unwrapping a condom and "correctly fitting it". (Female condoms were relatively unknown, still too expensive and not as readily available in Siem Reap). To learn new strategies of negotiating 100% condom use, the cartoon booklet was worked through along with the cassette. Buzz groups allow small group discussion and brainstorming and presenting shared experiences to the whole workshop with a degree of anonymity and a short "process evaluation" of the workshop elements is offered, using "happy face" "sad face" graphics at various points on a ten point scale. At the end of the workshop, a "Peer educator" certificate is given to each person, along with a kit for training others– cassettes, booklets, a training diary and a peer-educator tee shirt. A peer-educator coordinator follows up with monthly

meetings about ongoing pyramidal training, and collects outreach statistics for the project manager.

Each community and each “at-risk” group will have their own particularities; working sensitively through PAR with the ideas and suggestions of the persons at risk, themselves, and with medical and other outreach workers, can greatly facilitate the importation and adaptation of successful programs between cultures.

The final Khmer version of the cartoon booklet for women, after focus group changes.

The SiRCHESI peer-educator tee shirt, with its powerful graphic message, was chosen by the local women to create attention to the issues



The evolution of one pro-condom poster through three cultures