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Condom Social Marketing, Pentecostalism, and Structural Adjustment in Mozambique: A Clash of AIDS Prevention Messages

Despite significant debate about the efficacy, ideology, and ethics of the method, condom social marketing (CSM) has become the dominant approach to AIDS education in many sub-Saharan African countries. However, critics have charged that social marketing (SM) distracts from the structural determinants of health-related behavior and excludes genuine community participation. This article argues that the diffusion of SM techniques in Africa is not driven by demonstrated efficacy but is attributable to the promotion of privatization and free markets in the structural adjustment era across the region. The CSM experience in a central Mozambican community reveals the dangers of using the method at the expense of community dialogue and participation to confront the AIDS epidemic. The advertising campaign developed to sell condoms has clashed with Pentecostal and Independent Churches, now a majority of the population, that have expanded rapidly across the region spreading a contrasting message about sexuality and risky behavior. [social marketing, Pentecostal, African Independent Church, Mozambique, AIDS]

Over the last 20 years, "social marketing" has emerged as the dominant approach to health education and communication in the developing world, in many instances replacing community outreach, empowerment, and participation programs. The social marketing (SM) concept, which centers on the use of commercial advertising techniques and private-sector distribution of health products to promote "individual behavior change," has been institutionalized in many public health schools that now routinely train students in the "four Ps" of SM: product, price, place, and promotion (Walsh et al. 1993).

Condom social marketing (CSM) has become the centerpiece of AIDS education and prevention in many sub-Saharan African nations. However, this successful global diffusion of SM techniques for health promotion has not been driven by a thoroughly demonstrated efficacy in improving health by motivating behavior change. In fact, independent evaluations of SM campaigns are rare in the developing

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world; existing evaluations tend to focus narrowly on number of product units sold or self-reported change in knowledge and behavior (Price 2001). Rather, the widespread embrace of SM by many international nongovernmental organizations (NGOs) and ministries of health, especially in Africa, can be traced more directly to the promotion of privatization and free-market economics in the era of structural adjustment across the region.

The celebration of the private commercial sector, the commitment to promoting payment for health products, and the narrow focus on individual behavior change that define the SM approach provide a tight ideological fit with the broader economic adjustment reform packages promoted by the World Bank and International Monetary Fund (IMF) in Africa. Major bilateral and multilateral donors, including USAID and the World Bank, have increasingly channeled much of their public health funding into SM campaigns, usually managed by international NGOs. Donor literature extols the multiple virtues of the private sector's ability to reach target communities more efficiently than state services to change the presumably harmful health behaviors of the poor (USAID 2002a, 2003a; World Bank 1999). While medical anthropologists have been involved in the development of SM campaigns in the Third World, we have remained conspicuously and curiously silent about the broader impact of those campaigns on local communities, given how pervasive the approach has become.

SM has been controversial since its inception in the late 1960s, as critics charged that it distracted from the structural determinants and constraints on health-related behavior and excluded genuine community participation in tackling public health problems (Wallack et al. 1993). The use of commercial advertising techniques, the emphasis on collaboration with the commercial sector, and the stress on sales of health products rather than their free distribution in the public sector contrasted with the "Health-for-All" primary health care (PHC) ideals elaborated at Alma Ata in 1978. But the last two decades have seen a gradual and hastening rollback in public-sector PHC services led by structural adjustment programs (SAPs) that have generally reduced spending for government services and privatized local economies (Kim et al. 2000; Petersen and Swartz 2002; Poku 2002).

In Africa, this rollback in public services has coincided with the deepening AIDS crisis, placing local ministries of health in apparently insurmountable dilemmas (Turshen 1999). As Peter Piot, director of UNAIDS, has stated, "Structural adjustment raises particular problems for governments because most of the factors which fuel the AIDS pandemic are also those factors that seem to come into play in structural adjustment programs" (cited in Poku 2002:538). Social marketing, and its Western NGO and donor proponents, arrived with a prepackaged approach to AIDS prevention that could be easily integrated into ongoing economic reform programs that emphasized "cost-effectiveness" as the bottom line for priority setting in health. The SM concept is seductive, given its purported ability to harness the power of media and the private sector in a modernizing world to promote healthy behavior change. In societies increasingly awash in commercial media imagery (even in poor countries in recent years), the use of these media for social purposes appears to have an inexorable logic.

This article examines an eight-year-old national CSM project in Mozambique promoting a brand called "Jeito" that appears to have produced a troubling backlash

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in some communities; a reaction that underscores the shortcomings of SM approaches to complex community health problems such as AIDS prevention. The severity of the AIDS epidemic in Mozambique cannot be overstated. Over 20 percent of the adult population in several areas of the country are HIV-positive, and Mozambique remains one of the poorest countries in the world, with very low literacy levels, strikingly poor health outcomes generally, and few resources to confront the mounting crisis. The need to frankly assess interventions such as the Jeito campaign has taken on added urgency.

In the community described here, the CSM campaign implemented by the U.S.-based NGO Population Services International (PSI) encountered a society where deepening social inequality and economic insecurity produced by a SAP is believed by many to have heightened the reliance on sex work for survival among the poor. Not only have these structural determinants of risky behavior been ignored by the campaign designers, the advertising message that was developed to sell condoms has deeply angered many local sensibilities because communities were not substantively included in the campaign development. Over this same period, Pentecostal and African Independent Churches (AICs) also expanded rapidly across the region, spreading an entirely different message about sexuality and risky behavior that sought to address a growing "moral" panic around perceived promiscuous sexuality and deepened fears of AIDS transmission. Membership in these churches may now exceed 50 percent of the population in peri-urban areas in the center and south of the country, and the core message that they bring to their members centers on fidelity and the sanctity of family. According to research findings reported here, these churches frown on condoms because they believe their use promotes prostitution and immorality, which is not surprising given the history of similar faiths around the world.

The CSM campaign, on the other hand, has developed a central message that not only encourages condom use but is interpreted by many as endorsing "promiscuous" sexuality through its controversial images and suggestive slogans. Further, the campaign arrived in this region of Mozambique just when urban populations were coming to recognize and accept the existence of HIV/AIDS and its transmission through sexual activity. The preliminary research findings discussed here suggest that some, and perhaps many, in the community began to associate the promotion of condoms with HIV infection itself, because many believe that condom use promotes promiscuity and that promiscuity causes AIDS.

The churches, which have rapidly become the most dynamic social movements in the region, are delivering a message that directly contradicts the CSM campaign that lies at the center of Mozambique's national AIDS prevention strategy. Excluded from discussions on AIDS prevention within the international aid world, and left out of the planning process for condom promotion, church pastors in this research spoke angrily of the campaign that they believe has helped contribute to the AIDS crisis. This clash of messages illustrates how SM approaches to changing behaviors as complex and socially volatile as sexuality may not only be ineffective, but may actually be harmful, because genuine community participation, dialogue, and monitoring are excluded from the process, while structural determinants and social context of "high-risk" behavior are left unaddressed.

Given how widespread CSM campaigns have become, and how well known opposition to condom promotion is among diverse religious communities, there is

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an unusual gap in the literature that examines these conflicts in the developing world, especially Africa. Reports of significant clashes that can be heated and even violent are found in some agency documents (see Thompson and Bennett 1997), and scattered references to religious concerns with condom promotion and attitudes toward AIDS in the developing world can be found in some academic literature (see Black 1997; Da Silva and Guimaraes 2000; Freidman 1995; Garner 2000; Greeley 1991; Kagimu et al.1998; Lagarde et al. 2000; Solomon 1996; Spira et al. 2000; Takyi 2003), but little directly examines community responses to CSM campaigns. Clearly, the clash of messages between religious movements and condom social marketers in the developing world is not restricted to Mozambique, but it is widespread and understudied. The Mozambique experience described below not only suggests that CSM approaches need more careful evaluation in relationship to specific religious movements in Africa, but that such clashes expose the potentially high social costs of SM strategies that skirt community participation and dialogue.

The debate over the SM approach within the public health community has continued over several decades. But in the context of the AIDS pandemic, privatization, and growing inequality across Africa, the familiar dispute over SM takes on even greater importance. The now widespread diversion of scarce resources to SM as a central strategy for AIDS prevention in Africa requires that we revisit this discussion and begin to examine more closely the consequences of SM strategies on the ground. Medical anthropologists have an especially important role in moving the examination of SM beyond standardized knowledge, attitudes, and practices (KAP) surveys and measurements of product sales toward capturing complex local responses to the controversial images distributed in communities.

Methods

The critical appraisal of the Mozambique CSM campaign presented here is not the result of a formal evaluation of the program, but rather derives from a series of health-related studies and project experiences that produced a variety of data on community perceptions of the campaign. These findings come from nearly four years of fieldwork with a U.S.-based public health NGO in central Mozambique that included the periods 1993–95, 1998, five weeks in 2000, three months in 2002, and five weeks in 2003. During the first two periods, I was program coordinator and country representative for the NGO that worked closely with the Mozambique Ministry of Health on community health programs, and I worked together with PSI national staff on the initiation of the campaign in 1994.

Information on the church movements and their responses to CSM was gathered through participant observation in community projects from 1993–95 and 1998 and from two formal studies of churches and health in local communities I conducted. In 1998, the organization I was affiliated with conducted the first study, which centered on community leadership and public health in three communities (Chapman et al. 1999; Pfeiffer 2002). Formal interviews were conducted with 18 pastors, eight prophet healers, and five government officials, while 25 informal open-ended interviews with church and community members were completed. We also conducted focus group discussions with a range of community members, including three women's church associations, three youth groups, and two nonchurch women's focus groups.

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The second formal study, initiated in 2002, focused specifically on the expansion of Pentecostal and independent churches in the region. A survey of 616 individuals was conducted in three contiguous peri-urban *bairros* (or neighborhoods) in the city of Chimoio that were selected for their large populations that represent a broad socioeconomic range with demographic similarity to the rest of the city. The population of the three bairros together totals over 21,000 people (INE 1999). The survey used systematic random sampling and attempted to identify the range of churches in the community, estimate the level of participation in each faith, gather demographic information, and measure social attitudes. Likert-scale questions were used for attitude measurement to examine perceived change in social inequality, social well-being, occult practices, AIDS, and access to basic services since the end of Mozambique's civil war in 1992. The survey interviews each lasted about one hour. Eighty illness narrative interviews with recent church converts were conducted that ranged from 45 minutes to two hours. In this second study, 20 pastors were interviewed, while key informant interviews were also conducted with ten traditional healers, ten prophet healers, government representatives, 12 youth leaders, 30 nonchurch community members, and some NGO workers.

The constellation of data that has emerged from these various sources suggests a disturbing pattern of community responses to the Jeito promotion that have not been recognized or reported in the still scant literature on the Mozambique CSM campaign. These findings do not constitute a complete examination or evaluation of the CSM project impact on the entire community. However, they do provide compelling evidence that in at least some large and important segments of local society, the campaign has caused a hostile response that signals the critical need for more systematic qualitative/ethnographic evaluation combined with quantitative assessment of SM's impact on communities.

Social Marketing: Controversy, Commerce, and Clashes

The debate reviewed briefly here is well known to those involved in public health promotion projects, however, many medical anthropologists may be less familiar with the concept of SM and the criticisms that have been leveled against it. In 1952, G. D. Wiebe asked "Why can't you sell brotherhood and rational thinking like you sell soap?" in a seminal paper for *Public Opinion Quarterly* (quoted in Ling et al. 1992:342), and by the late 1960s and early 1970s, a number of early experiments in the marketing of public health in the developing world had been attempted. In 1971, Philip Kotler, a management professor at Northwestern University, first coined the term *social marketing* to propose that "well-honed and demonstrably effective techniques from the commercial business sector can successfully and efficiently be applied to advance social causes" (Walsh et al. 1993:107; see also Harvey 1999 for extensive discussion of SM).

"Exchange theory" is central to the SM conceptual framework (Lefebvre, Craig, and Flora 1988:302). It suggests that consumers "have resources that they want to exchange, or might conceivably exchange, for perceived benefits. . . . To be considered marketing transactions, ideas, products or services must be deliberately introduced into the transaction with a buy-and-sell intention." Embedded in this approach is the conversion of citizens into "consumers"; the SM literature emphasizes the primacy of identifying and targeting consumer needs. However,

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beyond meeting such needs, clever marketers can "create demand" for products by influencing and shaping beliefs and behavior (Manoff 1985:25–26). The science of marketing was born, and it would not be long before the public health community would take notice. "Creating demand" among "consumers" to become sufficiently "motivated" to purchase some health-related "product" revolutionized approaches to health education, behavior change, and disease prevention.

SM deploys a conceptual framework known in the field as the "four Ps": product, price, place, and promotion, which is repeated as a kind of industry mantra throughout the SM literature (Andreasen 1995; Goldberg et al. 1997; Ling et al. 1992; Manoff 1985; Walsh et al. 1993). As Walsh and her coauthors point out, the product can be a consumable object (such as a condom), a behavior, or even an abstract belief or practice. The techniques have taken on a standardized format that is as notable for what it includes as for what is left out (Ling et al. 1992:342). Audience analysis and segmentation is a critical early stage of research. The target audience must be defined, because all populations are heterogeneous and have varying needs and potential responses.

Further consumer research is performed through focus groups, surveys, and in-depth interviewing to identify perceived needs and potential barriers to product acceptance. Product development, packaging, and pricing are then done with the consumer research in mind so that the product correctly targets and motivates the audience segment. Prices are normally set so they provide some profit incentive for participating vendors but remain low enough for the target audience to purchase the product. An advertising message is developed and tested with the target audience, usually with carefully selected focus groups. Communities are systematically examined to identify the best channels for advertising (e.g., radio, billboards, television) and distribution of the product through private-sector vendors, shops, and other commercial outlets. The best "marketing mix" is achieved by finding the right balance among the four Ps tailored to the specific community (Smith 2000:15). Most SM campaigns mimic standard advertising campaigns for commercial products, using catchy packaging and clever slogans to promote strong "brand identification" in target audiences. SM is now extensively used across the Third World to promote condoms, other contraceptives, oral rehydration solution, mosquito nets, clean water kits, vitamins, antibiotics, and iodized salt.

As SM has become increasingly popular in health promotion both in the developed and developing world, dissenters in public health have challenged the fundamental assumptions behind SM and have raised ethical concerns (Buchanan et al. 1994; Minkler 1997; Musham and Trettin 2002; Rothschild 2000; Wallack et al. 1993; Wisner 1987). The literature on SM, and critical responses to it, is substantial; no attempt is made to review the extensive debate here, but key points are identified that help illuminate the problems encountered in the Mozambique experience.

Wisner (1987) criticized SM's focus on "product" rather than "process." He saw a one-way communication process, with little genuine community feedback other than focus groups, which provided a "quick fix" in contrast to process-oriented approaches that seek to establish dialogue with communities on health problems. He states, "Ministries [of health] that cut back expenditure in such participatory, empowering work because social marketing appears faster or more

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cost-effective cut the tap root of the newly sprouting community in the increasingly fragmented and class-polarized grassroots" (1987:179).

In a later critique, Buchanan and colleagues provided a more detailed assessment that tackled the underlying SM framework (Buchanan et al. 1994; also see response to this critique in Hastings and Haywood 1994). As they state,

> The first assumption here is that people become ill because they do not want (enough) to be healthy. The second assumption is that existing social conditions do not present serious (enough) barriers to attaining good health. People just need to get the right message at the right time in the right way and any obstacles can be overcome. . . . In lieu of addressing these factors, social marketing concentrates on communicating messages to individuals liberated from their social context by assumptions of the free market. [1994:52–53]

Wallack and colleagues have provided one of the most substantial critiques of social marketing in their promotion of an alternative approach they call "media advocacy" (Wallack 1994; Wallack and Dorfman 1996; Wallack et al. 1993). Wallack contrasts the "information gap" that social marketing seeks to fill with the "power gap" that underlies most health behavior problems (Wallack 1994:422). Wallack and coauthors state, "Social marketing tends to reduce serious health problems to individual risk factors and ignore the proven importance of the social and economic environment as major determinants of health" (Wallack et al. 1993:23). Again, echoing other critiques of SM, Wallack suggests that a two-way dialogue is essential to health promotion. He writes, "Traditional public health communication strategies [i.e., SM] tend to see individuals and groups as part of an audience to be addressed in a one-way communication. At best, if the 'audience' is included in the planning, it is after major boundaries of the issue have been set" (1994:425).

In spite of the considerable debate over the ethics and philosophy of SM in public health, and without clear evidence of its efficacy cross-culturally, SM has emerged at the beginning of a new century as the preferred health promotion technique in the developing world, especially for family planning and AIDS prevention. Given the elevated status of the approach and the enormous commitment of resources to it by major donors, a renewed skepticism and a reinvigorated debate about its efficacy is urgently needed. Skepticism begins with an exploration of why SM has been so widely promoted by key institutional actors in the world of international health, including USAID, the World Bank, and other major donors.

The Marketing of Social Marketing

Although at least 60 developing countries now have contraceptive marketing programs (Ainsworth 1998), this diffusion of SM approaches has been promoted by donors rather than aid recipients; the decisions to channel health funding into SM campaigns managed by international NGOs have been driven by broader ideological shifts toward free market promotion and contraction of state services, and have been advanced by a specific constellation of actors in international health dominated by USAID, the World Bank, and several U.S.-based NGOs with an extensive global reach (UNAIDS 2001). The World Bank, which recently became the lead global lender and policymaker in international health, has fully embraced

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SM as the primary method of AIDS education (Ainsworth 1998; World Bank 1999), while USAID has become the leader among bilaterals in promoting SM in its own funding priorities (USAID 2002a, 2002b). Other key multilaterals such as UNAIDS and the UNFPA have followed suit and embraced SM (UNAIDS 2001; UNFPA 2002).

Examination of the institutional literature and promotional material reveals the ideological signposts guiding SM promotion. One USAID-funded SM newsletter firmly embeds its promotion of SM within broader economic adjustment policy and the politics of heightened austerity that it generates:

> For public agencies, working with the private sector is a way to leverage increasingly scarce resources. In many countries, expanding private enterprise is a key component of more comprehensive economic reform or structural adjustment programs, which also include privatizing government-owned or controlled enterprises and generally reducing the government's role in the economy. The goal is to ensure that public spending increasingly targets the most needy, particularly as government budgets are reduced overall. [USAID 1998:1]

The newsletter also clarifies the benefits of SM to private sector partners: "The new emphasis [i.e., SM] on building commercially sustainable markets for key child-health related products requires more intimate and longer-term partnerships with private firms. This, in turn, represents an opportunity for these firms to develop new markets, expand existing markets, and reposition their products" (USAID 1998:1).

The rationale for channeling donor funds into SM parallels the logic used to justify health care privatization more broadly. As USAID's Global Health website states:

> Limited budgets in many developing countries can mean the curtailment or abandonment of publicly subsidized health care. . . . USAID's work in this area involves identifying existing or potential investment opportunities in health and family planning services and providing technical assistance to support the development of private sector interest and capacity to take advantage of these opportunities. [USAID 2003a]

An examination of PSI's own literature indicates the important ideological linkages between promotion of social marketing and broader processes of privatization. PSI's Biennial Report 2001–02 states succinctly that,

> In many developing countries, social marketing fills the critical gap between what over-stretched public sector facilities can provide to the poor and what the commercial sector can provide to a small upper class. In countries where PSI works, that gap is often quite large. . . . Social Marketing harnesses the can-do attitude and bottom-line focus of the commercial sector to improve the plight of the world's poor. [PSI 2002:4]

SM promoters must also justify to a skeptical public health audience why the sale of products is preferable to free provision, even for poor populations. It is presented as axiomatic, and repeated in document after document across agencies, that "When products are given away, the recipient often does not value them or even use them" (PSI 2003a). Nearly identical statements are found in UNAIDS, World Bank, DKT International, and USAID documents without cited evidence (UNAIDS

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2001:10; World Bank 1999; Harvey 2003; USAID 2003b). Although there may be research supporting the notion that free health products are often not valued or used by recipients in specific settings, the assumption is cast across a wide range of cultures and societies where it remains untested.[1]

Although major donors provide the financial support for SM campaigns, the administration of those activities and funds is nearly always allocated to a handful of well-connected NGOs that maintain close relationships with USAID and other key bilaterals. These include PSI, DKT International, International Planned Parenthood Federation, Marie Stopes International MSI in the United Kingdom, and PROFAMILIA (UNAIDS 2001:18), all of which began as population control or family-planning organizations. DKT and Marie Stopes have shared histories with PSI, interchanging executive board membership and receiving major funding from USAID.

PSI now operates in at least 45 nations in the developing world, usually in close association with USAID (PSI 2002) and has become the largest social marketer in Africa, emerging as a critical player in the swirl of health-related aid activity and funding generated to fight the AIDS pandemic. Having started out in the early 1970s with a focus on population control and provision of contraception, the refocus on AIDS prevention was a natural extension of their ongoing activities in reproductive health. To be sure, AIDS prevention efforts in most African countries, including Mozambique, use a blend of approaches that may include youth friendly services, voluntary counseling and testing facilities, school programs, and a variety of other community outreach programs. PSI has more recently branched out into other forms of AIDS prevention and education activities such as volunteer counseling and testing. However, SM approaches have increasingly become core educational and prevention strategies, superceding and often negating other community-based approaches. The Mozambique case illustrates PSI's approach to CSM in Africa and raises critical questions not only about campaign efficacy but also about process and unintended consequences of SM health promotion.

Social Marketing in Central Mozambique—The *Jeito* Campaign

Growing inequality and declining economic security over the last ten years have transformed the social environment and shaped community responses to the CSM campaign in central Mozambique. The city of Chimoio, the capital of Manica Province, lies along the Beira corridor, a well-traveled highway and railway line that links the Port of Beira to Zimbabwe. The city's population more than tripled since independence in 1975, from 50,000 to over 170,000, as many fled to Chimoio for safety during a protracted war with South Africa—backed rebels (known by their Portuguese acronym RENAMO) that finally ended in 1992. Central Mozambique has the highest HIV prevalence rates in Mozambique, estimated at nearly 20 percent of the reproductive age population (Agha et al. 2001; HAI 2001b), due perhaps in part to Zimbabwean troops who guarded the corridor for several years during the war; these troops were known for their high HIV prevalence rates. At the epicenter of the AIDS epidemic in Mozambique, the well-traveled corridor region became the focus of PSI's earliest condom SM effort.

Most Chimoio households combine cash-earning opportunities in the city with subsistence production on small parcels of land called *machambas* outside the

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city where they cultivate maize and sorghum. Portuguese is widely used by many residents, but Chimoio is a multilingual city, where Chiteve, a variant in the Shona-based family of languages that extends across most of Zimbabwe and central Mozambique, is spoken by a majority of people. In addition to the AIDS epidemic, there are under-five chronic malnutrition levels of over 40 percent, cumulative under-five mortality rates estimated at 25 percent, and maternal mortality estimated as high as 1,000–1,500 per 100,000 (Ministry of Health, 1997; Ulmera et al. 1994; UNDP 1998).

The National Health Service (NHS) provides biomedical care through the provincial hospital in Chimoio and at several health centers distributed in other parts of the city that offer basic primary health care services. A private health clinic opened in the city in the mid-1990s; it serves a small emerging elite that can afford the high fees, and by 2002 anti-retroviral drugs (ARVs) were available in the private clinic for about $1,000 per year. Voluntary counseling and testing and counseling centers were established by 2001, and pilot HIV/AIDS treatment programs have just been initiated along the corridor. Although many state services are still free or charge low fees, under-the-table payment demands worsened as health worker salaries dropped with economic adjustment (Cliff 1991).

After years of war with RENAMO that followed the struggle for independence, sweeping changes in social and economic life once again beset Mozambican society when a World Bank/IMF SAP was initiated in 1987, even as the war dragged on. Rapid class differentiation (in contrast to the postindependence socialist period), glaring economic disparities, and growing corruption emerged very quickly, as the SAP pressed for privatization of public services and industries, scaling back of social safety nets, and cutbacks in social services (Cliff 1991; Fauvet 2000; Hanlon 1996; Marshall 1990). These changes accelerated further after a ceasefire was initiated in 1992 and the country returned to life without war. Since then, Mozambique has been slowly rebuilding, and, by the end of the 1990s, it was hailed for its relatively robust economic growth (World Bank 2000; 2001). However, the national gross domestic product figures conceal the growing inequality that has left most Mozambicans mired in poverty (Hanlon 1996; INE 1998; Ministry of Planning and Finance 1998). Likert-scale data in the 616 person survey for this research revealed that over 80 percent of respondents either agreed somewhat or agreed strongly that since the war's end only a few had gotten wealthier, while most had gotten poorer. Nearly 45 percent of respondents felt that their own households had gotten poorer since the war's end, whereas only 30 percent felt that they had gotten wealthier.

The recent period of free market promotion and privatization also marks an especially intense and hastened commoditization of social life in which traditions of shared labor have been replaced by cash payment for work on machambas. Land now must often be purchased, fees (both legal and illegal) for health and education have been introduced, and bridewealth payments inflated so that cash income has become increasingly crucial to survival for the vulnerable, and social mobility for the ambitious (see Ministry of Planning and Finance [1998:312] for further evidence and discussion). In this environment, the desperate need for money among the poor majority has superceded and in some ways dissolved previous social obligations, family relationships, and other sources of reciprocity and support, according to many of those interviewed for this research.

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Unsurprisingly, this increased importance of cash to survival and social mobility has had gender-specific consequences. In the data reported here from the survey of 616 people, nearly 60 percent of women stated that they had earned no cash income at all in the previous month, in contrast to only 10 percent of men who earned none. Fifty-two percent of men earned over 500,000 meticais (24,000 meticais equaled one U.S. dollar) in the previous month, but only 13 percent of women earned in that range. According to informants, this lack of access to cash in an environment of deepened social inequality has further undermined economic security for many poor women and contributed to the expanded trade of sexual favors for money or goods. These activities range from full-time sex work around neighborhood bars to casual provision of sexual favors in exchange for cash or goods such as shoes or clothing.

Survey Likert-scale data indicated that over 80 percent of respondents believe prostitution and informal sex work has increased over the previous ten-year period; nearly 68 percent believed it had increased a great deal. The resulting pressure on intrahousehold relationships has reportedly produced greater distrust, allegations of adultery, and fear of the spread of sexually transmitted infections and, of course, AIDS. This ensuing moral panic in Chimoio has destabilized relationships, families, and households and has provided church movements with a thematic focus for their proselytizing and healing discourses. The simultaneous arrival of HIV/AIDS amid economic conditions that have driven many more girls and women into sex work has stimulated a variegated community discourse on the causes of AIDS, its relationship to sexual practices, and who or what is to blame. Into this volatile social and economic climate, the Jeito CSM campaign landed, dispersing its packaged set of controversial images, moral assumptions, innuendo, and suggestive slogans as it integrated into an expanding commercial world that has attracted some while alienating many others.

Church Expansion

At the same time that PSI's Jeito campaign was being established during this period of socioeconomic transformation, the region was also experiencing an extraordinary expansion of Pentecostal and Pentecostal-influenced AICs whose membership jumped from an estimated 10 percent of poor peri-urban populations to perhaps over 50 percent (see more detailed discussion in Pfeiffer 2002). Most of the AICs have roots in the Zimbabwean and South African "Zionist" and "Apostolic" movements that integrate local spiritual notions of illness causation with Pentecostal beliefs in the healing power of the "Holy Spirit" to recruit new members through treatment of illness (Cox 1995; Daneel 1988; Oosthuizen 1992; Sundkler 1961).

Mainstream international Pentecostals, such as the Assembly of God and the Apostolic Faith Mission, have had similar success attracting new members through healing and creating communities of mutual aid. According to the 1997 Mozambique census, the "Zion" churches alone have become the single largest church affiliation across the entire province, claiming about 30 percent of the total urban population, whereas the Catholic Church declined from 30 percent to about 20 percent (INE 1999). About 5 percent of the adult population in urban areas identified themselves as "Protestant/Evangelical," a category consisting mostly of Pentecostals.

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This proportion has certainly increased since 1997, according to the Department of Religious Affairs since the number of formally registered AICs and Pentecostals rose from 30 in the early 1990s to over 200 individual churches by 2003 in Chimoio.

The 616 person survey data reported here reveal even higher levels of participation, with about 45 percent of respondents belonging to churches described as Zionist, Apostolic, or Pentecostal (50 percent of women and 39 percent of men). About 12 percent identified as Zionist, 13 percent belonged to Apostolic churches that use prophetic healing, 20 percent were members of other Pentecostal churches, and Catholics accounted for about 23 percent of the total sample. The survey indicates that AIC and Pentecostal membership is over 50 percent among low-income respondents. Their current popularity in Manica Province certainly has many causes (for more detailed discussion, see Pfeiffer 2002), however, one key attraction for new recruits is church emphasis on the healing of social ruptures, especially intrahousehold discord and conflict with neighbors that has intensified as economic insecurity increased.

The 80 illness narratives that were collected for this research to elicit motivations for conversion suggested that spousal conflict, often centering on accusations of infidelity and prostitution, frequently underlies various experiences of affliction.Church prophet healers invoke the "Holy Spirit" to exorcise malevolent illness-causing spirits that are believed to emanate from these and other social conflicts. One activist with a local women's AIDS organization that focused on education of local sex workers asserted that many poor women in the community view the churches as refuges from accusations of adultery and prostitution. In addition to the healing services that the churches offer, well-developed systems of mutual aid provide special support for single women in house maintenance, provision of firewood and water, and even financial assistance for families during times of severe illness. In the midst of these burgeoning church movements, whose conservative vision of family and morality seems to resonate so strongly in poor communities scrambling for survival, the Jeito CSM campaign appeared, with a contrasting set of startling images and messages.

The Jeito Campaign: PSI and Condom Social Marketing in Chimoio

With encouragement from USAID, the Ministry of Health's National AIDS Control Program embraced the concept of CSM in 1994 promoted by the PSI, as a centerpiece of its AIDS education strategy nationally (Agha et al. 2001). USAID has become the lead donor in HIV/AIDS activities in Mozambique (USAID 2002b), so its prioritization of CSM has helped set the agenda for other agencies and donors. The campaign began in Manica and three other provinces where my organization was also enlisted to support the early development of the project and its messages. The project was eventually expanded throughout the country, and a variety of messages and slogans have been developed over an eight-year period. Through focus-group testing, the term "Jeito," which means "talent," "flair," or "style" in locally spoken Portuguese, was selected to become the condom brand name. The campaign initially developed a cartoon figure, with a baseball cap askew, who appeared on most of the advertising materials and was usually shown winking at the potential consumer. A question was normally placed over the cartoon figure,

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asking "Do you have Jeito?" (plus the wink), while a more recent slogan declares "Only with Jeito!" (PSI 2001). The campaign succeeded in tapping the term's powerful double entendre in Mozambique.

Early in its campaign, PSI also collaborated with a range of NGOs and other actors in "civil society," such as the local song and dance troupe initiated by my organization, to promote the product. Billboards, radio messages, TV spots, community theater, and vendors on bicycles continue to advertise and sell the condoms in local communities. Jeito condoms are sold in bars, nightspots, restaurants, hotels, and shops throughout the country, and the campaign has gained high visibility, as PSI's research suggests. The price has been kept quite low at 500 meticais (or about 8 cents), but the condoms are sold to vendors below cost to ensure profitability so as to keep commercial vendors interested in selling them. Jeito billboards are now ubiquitous in urban areas and on major highways, where they compete with beer, cigarette, and Coca Cola advertisements for attention in the postwar commercial landscape.

Defining and Measuring Impact

The literature produced by the SM industry tends to be triumphalist and relentlessly positive, providing or citing data that center on two major indicators: product sales and reported behavior change. But as Price has stated,

> It remains difficult to reach definitive conclusions about the extent to which CSMPs [contraceptive social marketing campaigns] meet the sexual health needs of the poor and vulnerable, due largely to reliance on sales data for CSMP monitoring and evaluation. CSMPs (like many health program strategies) have traditionally collected little information on client profiles, health-seeking behavior, condom use effectiveness, and supply-side issues. [2001:231]

Data on PSI's condom sales are gathered through vendors and outlets, while behavior change has been measured through KAP surveys. PSI's literature claims great success with the Jeito campaign, citing large sales increases from 2 million condoms in 1995 to 10 million in 1997 million (PSI 2001). PSI has also recently published studies in peer-reviewed public health journals including Agha et al.'s (2001) recent and thorough report on a KAP study that compares the Jeito campaign's efficacy across ten provinces by comparing length of exposure to the campaign's message with condom availability and use. Their data appear to show that in provinces where the Jeito campaign has been conducted for a longer period, there is greater awareness of the brand name and more condom use in nonregular partnerships. The authors confidently conclude, "Sofala and Manica provinces have above-average condom use, in part because of higher exposure to CSM communications and greater access to condoms" (Agha et al. 2001:150). According to the study, 46 percent (unadjusted) of respondents in Manica, 48 percent in Tete, and 39 percent in Sofala reported using condoms in their last sexual encounter with a nonregular partner; levels higher than in provinces where the campaign had started later. The researchers conclude that the campaign is responsible for increased condom use.

However, although sampling and statistical analysis are apparently sound in the PSI study, reported behavior is presented as actual behavior (see also Agha

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1998, 2002a, 2002b; Lagarde et al. 1996; Meekers 2001; Spira et al. 2000; Van Rossem and Meekers 2000 for similar reporting). The public health and anthropology literature abounds with concerns over the validity of responses to KAP questions about socially unacceptable behaviors such as alcohol use, risky sexual behaviors, and sanitary practices (see Lane 1997:175–176; Nations 1986; Stanton et al. 1987). The figures from the PSI Mozambique study are surprisingly high and leave ample room to doubt their validity. It is equally plausible that higher *reported* use of condoms in provinces with more exposure to the Jeito campaign reflects heightened awareness of the socially acceptable response to such questions.

Data from three other representative baseline surveys in Manica 1998, 2001, 2002 along the corridor area where the Jeito campaign had been active for over five years provide very different data on condom use. In the 1998 survey of 710 women, 85 percent indicated that they had never used a condom (HAI 1998), and in a 2001 survey of 2,700 women, only 2 percent stated that they *ever* had used a condom (HAI 2001a). In 2002, 85 percent indicated that they never use condoms, less than 10 percent indicated that they ever used condoms along a response format continuum of "rarely" to "always" (HAI 2002). Clearly, in these areas with years of exposure to the Jeito campaign, KAP survey responses vary widely, with some suggesting continued low condom use. In-depth ethnographic and qualitative research is necessary to provide better insights into actual responses and behavior change in order to adequately test the impact of the campaign on condom use.

Other aspects of the campaign have escaped critical scrutiny altogether, so that potentially negative or long-term consequences of the campaign have not been systematically assessed in the available literature. For example, given the strong opposition mounted by religious organizations to condom promotion in other parts of the world, it is curious that no systematic assessment has been conducted to determine how religious communities might view the campaign in Mozambique. The research findings reported here show that the community responses to the campaign are far more complex than PSI's own literature suggests, and that the campaign may, in fact, have been counterproductive in some communities.

Church Responses to Jeito

The responses of many in the community, not only those in churches, to the Jeito project appear to derive from how the campaign coincided with growing economic inequality and insecurity, increasing resort to sex work for survival, and community recognition that HIV/AIDS is transmitted through sexual activity. Because of this historical confluence, focus groups and extensive interviews with women, adolescents, and pastors in Chimoio in the 1998 study revealed that many actually blamed the Jeito campaign for both the perceived sharp increase in prostitution and promiscuity in the city and the arrival of HIV/AIDS itself. Sensitized to the concerns that churches voiced about the Jeito campaign, the three-bairro survey of 616 people conducted in 2002 included a question for those respondents identified as church members; it asked whether their church had specifically prohibited the use of Jeito condoms. Eighty-six percent of Pentecostal and AIC members responded that Jeito-brand condoms had been specifically forbidden.

Each of the 18 church pastors interviewed in 1998 and the 20 in 2000 used harsh terms in referring to the Jeito campaign and blamed it for the increasing sex

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work and promiscuity in the city. In part as a result of the campaign, according to pastors, church messages specifically prohibited the use of condoms, given its association with promiscuity. None of the pastors interviewed for this research reported being contacted by the Jeito campaign in 1994 or included in its development in any form since then. The leaders of the largest Pentecostal and AIC religious affiliations in the city, the Fraternal das Igrejas (Brotherhood of Churches) and the Asociação das Igrejas Cristão Independent de Moçambique (AICIM, the Association of Independent Christian Churches of Mozambique), reported that they had never been contacted or included in the development of the message or implementation of the program. Both reacted angrily when the campaign was mentioned, and firmly blamed Jeito for stimulating promiscuity among youth.

During the period of this research, the community was just coming to grips with the realization that AIDS existed and was taking many lives. After years of rumors and conflicting information, by the end of the 1990s AIDS became widely accepted as fact. However, it is still rarely discussed within churches, according to respondents and participant observation. When discussed, it is often presented as an indication of sin and immorality, or as a sign of the end times in some millennial theologies. According to many pastors, they rarely, if ever, mention prevention or condom use in Sunday services, because discussing sexual matters explicitly is considered inappropriate at those times. But, in other church functions, condoms, and especially Jeito, are identified as sinful primarily because it is thought that if one is faithful, there is no need for condoms. So, if one uses a condom, it is a sign of sin and infidelity. The comments provided here are representative of the attitudes expressed by all the pastors interviewed.

> In general, we don't give these teachings that its necessary to prevent [use a condom] when you want to play with a woman, that you must use Jeito, no. Because when we say something like that we are not prohibiting prostitution we are saying you can do it, but you must have something to prevent [*prevenir,* or protect oneself]. But we in the church prohibit it, one can't solicit prostitutes *[prostituir]*, or go with a woman outside the marriage *[fora]*. The Bible prohibits that. When we perceive that someone is practicing this, they are taken out of the church and when you're a preacher, you leave your position as preacher. It's the same if a pastor practices this activity [prostitution], he'll quickly leave that day, he's no longer pastor of the church.
>
> [Pastor, Zion Apostle of Mozambique]

> With Jeito, we are teaching people to live a bad life [*má vida,* immoral life], we're teaching this country to use Jeito and live a bad life. Because of this the country has a much worse life *[muito má vida]* through *[atravez]* Jeito. . . . We strongly prohibit a person to go with another woman and one can't be a *mulherengo* [womanizer], you can't solicit prostitution, or whatever man with whatever child. No person can use this, its sinful. Because of this we can't use condoms in church. Because using a condom is sinful always, and because of this we don't need to have condoms or Jeito in the church. We don't want this and don't need this. Because of this we have a country of prostitution because we are promoting the use of Jeito to do prostitution. . . . I can go with another woman and not have any problem, I won't give AIDS to my wife because I used a condom with a prostitute. I'm no longer going to be faithful. Because of this we prohibit it in our church. We don't need it. Because of this we speak very little of AIDS.
>
> [Pastor, African Assembly of God]

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> Here in this church, really I say that one can't use Jeito, one can't use it because when you use it you won't be afraid of sin. When one doesn't use Jeito and doesn't go with another person, it's hoped that you marry to have sexual relations only with your wife.
>
> [Pastor, Apostolic Faith Mission]

Church members echoed these concerns with how the Jeito was being promoted in the community, and the following excerpt is typical.

> One needs to recognize where we can give this propaganda, and not where there are children. We have to see what place, what age can we give this propaganda and why ultimately are we scandalizing *[escandalizar]* our children. . . . It's children who take Jeito and make balloons, it's the children that understand quickly what Jeito is used for, and quickly they [condoms] create prostitution. Therefore, Jeito clearly is well-done propaganda, but we see what is the place that we can give this propaganda to not scandalize the children.
>
> [Member, Vitória Tabernáculo]

Another recurrent theme among pastors in their comments on the Jeito project centered on the commercial aspects of the campaign. Beyond their basic opposition to condom promotion, most of the pastors simply distrusted the Jeito campaign messages concerning AIDS and sexuality because they felt it was a business promotion to make money, or a *"negócio,"* the Portuguese term meaning business, frequently used to describe the campaign. The legitimacy and sincerity of the public health messages were in doubt because the condom promotion efforts seemed part of a commercial enterprise in a competitive and economically insecure social environment where business schemes were perceived to be widespread. The negative reaction to the Jeito campaign and the silence about AIDS in church services belies the deep anxieties about the crisis that pastors and prophet healers expressed in individual interviews. When asked whether they would like to learn more about the disease and be visited by health workers to provide structured seminars or meetings on AIDS, every pastor responded emphatically and positively. Based on these interviews, church leaders apparently have emerged from a denial phase and now express eagerness to become involved in prevention efforts.

One religious NGO in Chimoio, and the only agency with foreign aid funding to promote AIDS education and condom use in churches, indicated that the Jeito campaign has created one of the most difficult barriers to gaining church acceptance of condom use of any kind. One project coordinator stated,

> PSI worked a lot with radio communication in the beginning, which is an excellent medium. But the messages they gave at 12 o'clock when the whole family was gathered around the lunch table was "when you have sex next time with your lover do not forget to use a condom." Those songs, dramas made the churches close up even more as they felt that the way sex was talked about, the way it was promoted encouraged immoral behavior. . . . So the way PSI came in and talked about HIV/AIDS prevention and condoms made it more difficult for us to talk about the issue in church. Thank God that many more understand now and can see through the PSI publicity. [personal communication]

In sharp contrast to one-way communication that characterized the Jeito campaign in Chimoio, local activists from this organization made visits to Pentecostal and independent church pastors and Sunday services to establish a dialogue on how to educate church membership on AIDS. The organization had already established

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relationships with a number of churches in the city by working side by side with church membership in providing social and material support for AIDS sufferers and orphans in the congregations. I attended several church services where activists made presentations on AIDS and behavior. Through careful and patient engagement with the churches, the organization had succeeded in generating a dialogue and had even gained some pastors' support for condom promotion. The organization avoids promoting a prepackaged message, but rather attempts to establish a conversation about how and when condom use might be considered acceptable within church doctrine. Messages of fidelity and abstinence were sometimes included, but what stood out most about the organization's approach was its establishment of long-term working relationships with congregations organized around provision of care to sufferers. In sharp contrast to the Jeito campaign, the process and trust established through this shared day-to-day work has laid the groundwork for a more significant and open discussion about AIDS.[2]

It might be argued that CSM campaigns were not meant to target church members or the poor who are attracted to the message of Pentecostalism; rather, urban youth and those of reproductive age more attuned to the temptations of modern life are the focus. Social marketers may argue that the market is segmented and the objective is not to reach everyone. However, the proportion of church-goers in the population is so large, and the SM message distributed so widely, that the impact of the campaign has clearly extended far beyond any presumed target group. Perhaps more importantly, however, church memberships are fluid as members, especially young people, move in and out of congregations over time so that the SM target populations overlap considerably with the same urban populations that have fueled the Pentecostal movements. In these populations grappling with the new inequalities of modernity, the clash of messages is experienced most acutely.

Responses to Jeito outside the Churches

The negative perceptions of the Jeito campaign extended beyond church memberships as well. Perhaps most alarmingly, among two separate nonchurch youth focus groups interviewed during the community leadership study in 1998, and in 25 formal and informal key informant interviews, participants described a widely circulated rumor that Jeito brand condoms actually brought the HIV virus to the province and that Jeito could therefore give the user AIDS. Ironically, this perception was apparently brand specific, according to informants, and had become so widespread that some reportedly preferred to use generic-free condoms still distributed through the health system. It would be difficult if not impossible to assess, through survey data, how widespread these rumors about Jeito had become, but the replication of the responses across two independently selected youth groups, and among diverse informants, was suggestive and alarming. In response to a question that asked where AIDS came from, one participant responded, "Some say it came from Jeito," while another suggested that "even before Jeito, it came from UNOMOZ, those soldiers," referring to thousands of UN peace-keeping troops that camped along the corridor for nearly a year during the peace process from 1993 to 1994. During discussion about the Jeito rumor in one group, a male respondent stated, "Yes, youth say it's true [Jeito causes AIDS]. Some say that using Jeito prevents AIDS, while others say that it [Jeito] has AIDS inside *[lá dentro]*."

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By 2003, a more specific persistent rumor about Jeito emerged among church and nonchurch informants that was remarkable for its consistency, yet its origins could not be traced. In formal and informal interviews and settings, this rumor was mentioned repeatedly and independently. Informants had heard it said that if one hangs a Jeito condom up to dry in the sunlight for a day, one can eventually see the HIV virus squirming inside, and for this reason these condoms should be avoided. Such rumors could be dismissed as the common and expected result of health promotion in poor communities with low levels of education and few trusted sources of information. Indeed, rumors concerning public health promotions are common and widely reported in Africa, especially around issues related to family planning and more recently AIDS (see Nichter and Nichter 1996). But as anthropologists have tried to argue, such rumors often constitute important community responses and even resistance to health promotions imposed from outside. These responses need to be taken seriously as both measures of distrust between communities and health promoters, and as significant barriers to behavior change. As Nichter and Nichter have stated about family-planning promotions, "What is labelled as 'rumours' are often 'social facts' backed by cultural common sense. Rumors consist of health knowledge which runs counter to that propogated by biomedicine and the state health authorities" (1996:72–75).

Beyond these rumors, some responses raised other questions about whether condoms were actually used after purchase. When asked whether youth are buying Jeito, one respondent stated, "Yes, they buy them but only to show-off *[exhibir]* and not to use them." Another girl responded, "A man puts a Jeito in his pocket for the nightclub but when he gets there he'll go with more than three women. How can you use Jeito like that? He'll return home with it [the condom] in his pocket." In one group of local youth leaders, one participant stated, "The tendency to change [behavior] exists, but above all girls want money to support themselves, so they forget this sickness AIDS."

Conclusion

PSI's Mozambique campaign has been exemplary from the perspective of social marketers. Key steps have been correctly followed, high visibility has been achieved, sales have increased, and competent researchers have evaluated the results in the manner deemed appropriate by the industry. This makes an examination of the campaign all the more compelling as a cautionary tale about the concept and framework itself even, or especially, when done well. It is precisely the formulaic approach to campaign message creation, testing, implementation, and evaluation that may explain what now appears to be a narrow view and assessment of the campaign's impact on Mozambican society. Unfortunately, after eight years there are still no formal independent evaluations of the Jeito campaign that might expand the scope of analysis to examine broader impacts across diverse populations.

Other approaches to monitoring and evaluation of CSM campaigns that incorporate more careful, patient, and rigorous qualitative assessment of community attitudes, perceptions, and concerns are urgently needed. These would certainly include ethnographic methods used in collaboration with local communities that could penetrate the reality behind KAP survey data. Had community perceptions been solicited more judiciously over time in the Jeito campaign, they likely would

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have shown that the moral panic concerning fidelity and intrahousehold distrust was widespread within an environment where resort to sex work is reportedly increasing amid deepening economic disparity. Addressing these community concerns became the core mission of most Pentecostal and AICs that discovered a traumatized population eager to embrace their message; they have now successfully attracted large segments, most certainly a majority, of poor urban populations into their ranks.

Given that the churches have such a strong influence on health beliefs and behavior, as our earlier research has suggested, this clash of messages over the most critical development issue facing the country is especially concerning. The unexpected and startling statements by youth, women's focus groups participants, and church pastors strongly suggest that the SM approach has alienated large and critical sectors of targeted communities. The Jeito campaign hurdled over local community involvement and dispersed a set of messages that may have created even greater barriers to condom promotion, while deepening the mistrust between the aid community and the communities it purports to serve.

Data from around Africa have begun to reveal that CSM in general has not been very successful. As E. C. Green writes,

> After 15+ years of intense condom social marketing in Africa, the result today is an average of only 4.6 condoms available (not necessarily used) per male per year in Africa. That figure was actually a bit higher in the mid-1990s; it has declined somewhat even since then in spite of the explosion of AIDS in southern Africa. The problem seems to be low demand. [2003a:5]

Explanations for "low demand" vary widely, and have triggered a lively debate among anthropologists and public health advocates over what messages should be promoted in light of these difficulties. Some, including Green, have come to embrace the so-called ABC approach: Abstinence, Be faithful, and if not, then use Condoms (Green 2003a, 2003b), arguing that its emphasis on "primary behavior change" explains Uganda's success in reducing HIV prevalence. USAID has more recently embraced the message, and PSI has begun to promote the ABC approach, as well, while continuing its CSM campaigns (PSI 2003b). Others, however, have argued for a more "sex positive" harm reduction approach to behavior change and take issue with the ABC explanation for Uganda's success (Feldman 2003; see also Farmer 2003).

But perhaps the most important aspect of these recent and important debates is that poor target communities are normally left out of the conversation. The ABC message may, in fact, be more palatable to some religious groups, as Green has argued, given its emphasis on abstinence and fidelity, but the focus on message content in these debates obscures a more fundamental shortcoming to the approaches. The Mozambique case reaffirms that the process used in developing messages may be more important than the final message itself. As Feldman argues,

> The difference is not the message, but how the message was conveyed. In Uganda, beginning in 1986, the government, together with the national media, very aggressively de-stigmatized the disease by discussing the epidemic openly. Public discussion about sex and HIV occurred in schools, public meetings and in the workplace. The wall of denial about AIDS, impenetrable throughout most of the rest of the continent, came tumbling down. [2003:6]

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To recognize that the church movements are promoting a message of fidelity that clashes with the Jeito campaign's central theme is not to argue that the church approach should necessarily be embraced by the public health community, as the ABC approach has done, or that AIDS funding should necessarily be redirected toward churches. The conservative message promoted by the church movements may not resonate well with many Western aid workers who work for secular NGOs or within the Ministry of Health, and who may have negative associations with similar conservative movements in their home countries (see Feldman 2003).

In my experience, most expatriate aid workers are dismissive of church movements and their healing practices, misunderstand the churches' histories and roots, and are very skeptical of their intentions and value to local communities. As some might suggest, women's status appears to be subordinated within many of the new churches, and pastors' messages are not themselves the product of church dialogue and participation. I am not arguing here that the churches should be endorsed and their messages promoted, but rather that these movements represent a profound social transformation in poor communities that public health efforts must acknowledge, understand, and engage. The inability of the Jeito CSM campaign and others in the international aid world to recognize the significance of these movements and this clash of messages is of more concern than the content of the Jeito message itself; it reveals the striking dissociation that is produced between the aid world and poor target populations when community participation and dialogue are disregarded.

It is beyond the scope of this article to review the many worthy alternatives to social marketing, which center on participatory, community-based, empowerment-oriented approaches to health promotion generally (see Carlisle 2000; Minkler 1997; Wallack et al. 1993; Wallerstein 1992) and AIDS prevention in Africa specifically (see Campbell and MacPhail 2002; Campbell and Williams 1999; Painter 2001; Petersen and Swartz 2002). However, the Mozambique experience suggests that a primary goal of new approaches should be the creation of frameworks for long-term dialogue between health workers and communities to establish trust and channels of communication, rather than focusing on the top–down imposition of a packaged message, whether it is sex positive or ABC oriented. Potential models in Mozambique might include an expansion of the already existing community leaders' health councils that link health posts to local communities. The creation of formalized local religious health councils, which include AICs and Pentecostals, who would meet regularly with health service authorities to discuss AIDS prevention, HIV testing, and community support for those in treatment, also may prove valuable.

Church activists, drawn from the women's and youth groups found in nearly every church, could be trained and integrated into outreach programs. During this research, in fact, pastors suggested just such an approach. Using aid funding to expand youth-friendly services, volunteer counseling and testing, and school programs with more direct links to local community councils, leaders, and structures can provide clearer channels of communication between health services and communities, address rumors and misconceptions, provide regular opportunities to monitor community attitudes, and solicit suggestions for health promotion efforts. The recent initiation of ARV treatment programs in Africa (Mozambique is now ramping up its infrastructure for a major treatment initiative) provides an opportunity for new

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approaches to AIDS education and prevention that can build on the powerful positive influence of successful treatment on community attitudes and new stirrings of hope. New educational and prevention approaches that begin with community dialogue (however contentious that discussion will be around issues such as condom use), tap local community resources, and link communities to local public sector health centers that provide information, testing, and treatment has the potential to transform AIDS prevention in Africa as this latest chapter in the AIDS crisis unfolds.

Of equal importance is an assessment of why the international aid community has jumped on the SM bandwagon with such eagerness to address the AIDS pandemic in Africa. After reviewing available literature, and witnessing SM in action in Mozambique, the regrettable conclusion is that SM has been promoted for ideological reasons in an era of adjustment and privatization, and not on the basis of demonstrated efficacy or rigorous community-based evaluation of its broader impact on local communities. The highly touted "cost-effectiveness" of CSM simply cannot be assessed in the absence of these data and without consideration of the broader social and historical contexts into which CSM campaigns insert themselves. With a crisis as overwhelming as the AIDS pandemic, can Mozambique afford to exchange community dialogue, participation, and involvement, for a U.S.-style top–down advertising campaign to address the greatest development challenge in its history? As Buchanan and coauthors have poignantly argued,

> Under a different set of assumptions, dialogue—the act of creating a public space for mutual discussion, deliberation and debate—is critical for heath promotion. Health promoters are not in the business of trying to get the public to buy anything. The purpose of health promotion is to give the public control over the conditions that affect their lives and health. Thus, the process of participating in an enduring and reflective relationship with our fellow citizens to discuss and realize the conditions conducive to good health is at the core of health promotion. [1994:55]

SM's transformation of "citizens" with basic rights to health care, into "consumers" who must exchange something they value to obtain items needed to improve health, has far-reaching consequences for health care provision in poor countries; consequences that have neither been adequately considered nor debated by the international health community.

Perhaps the most important "behavior change" needed for AIDS education and prevention in Mozambique should come within international aid agencies and donors. Influenced by the push to privatize, some have succumbed to the controversial logic of "cost-effectiveness," and, in the process, have alienated many in the communities they seek to help. SM may have a useful role to play in combination with other approaches, and there are certainly instances where it has been successful. But more careful and critical scrutiny of CSM may steer international aid resources away from these strategies back toward participatory approaches that will both reveal and, it is hoped, begin to address the most important determinants of "risky" behavior and vulnerability to AIDS: poverty, inequality, lack of public sector safety nets, and declining access to well-funded public sector health services.

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NOTES

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1. One recent study in South Africa revealed a very high utilization rate of condoms distributed for free through the public sector. Condom wastage was reported at less than 10 percent after five weeks (Myer et al. 2001).

2. Although the Jeito campaign did not establish or maintain contact with churches in the city, other NGOs, in addition to the religious AIDS-focused example presented here, made some efforts to include them. A European education-focused NGO collaborated with local churches in school construction, while my organization worked with church pastors in local community health councils.

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