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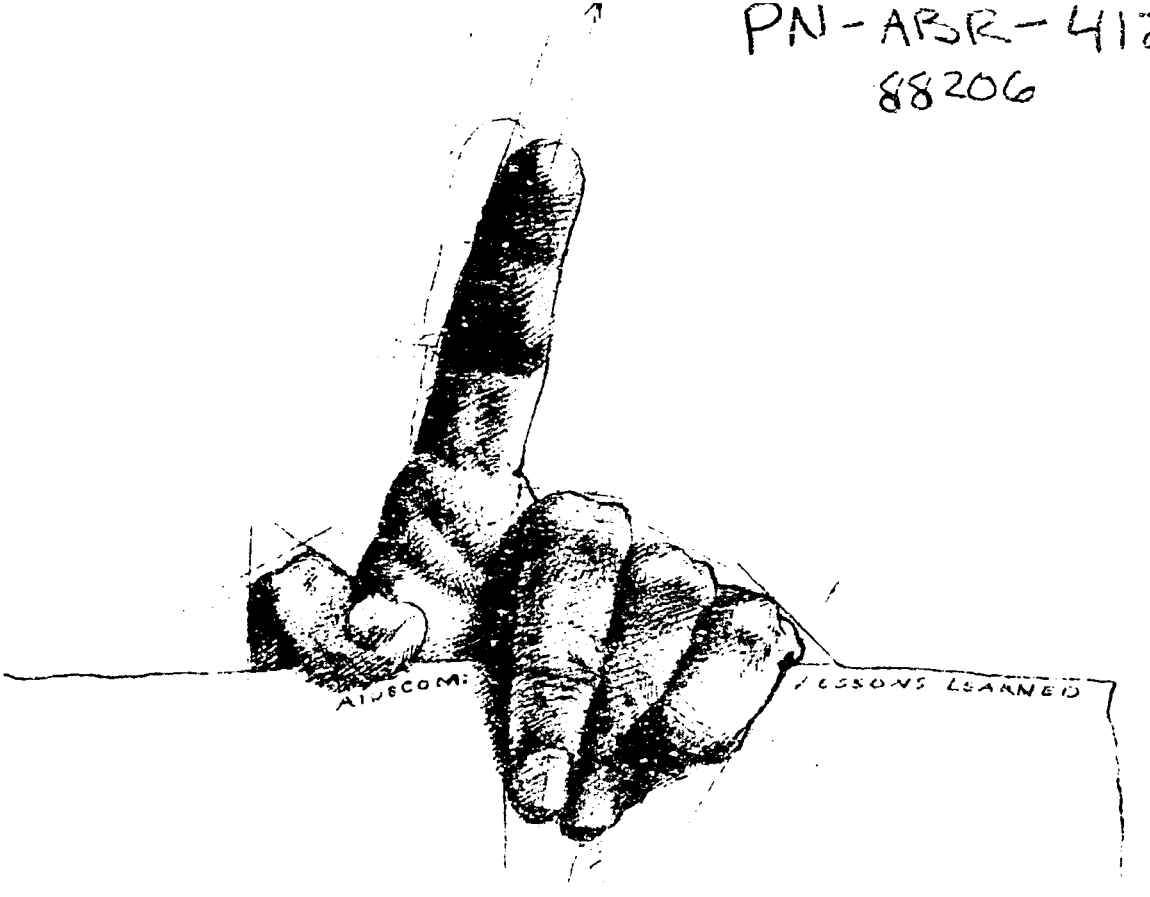

PARTNERS AGAINST AIDS:

LESSONS LEARNED

AIDSCOM

AED

Academy for Educational Development

November 1993

AIDSCOM
Academy for Educational Development
The Johns Hopkins University
Center for Communication Programs
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The Annenberg School for Communication,
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To all those living, working,
and dying with AIDS worldwide
and to all our colleagues and friends
who became part of AIDSCOM,
especially, in memory of
Kenneth P. Dunnigan, M.D.
Alexander J. D. Greeley, Jr.
Edwin A. Tout

AIDSCOM
LESSONS LEARNED BRIEFING

Academy for Educational Development (AED)

Washington, DC

July 22, 1993

Presenters

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Helene Gayle, AIDS Coordinator, Division Chief, HIV/AIDS Division, Office of Health, Agency for International Development

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For two of the presentations, Ann Jimerson filled in for **Michael Helquist,** AIDSCOM Project Director. **Dace Stone,** Senior Program Officer, The Johns Hopkins University, led the discussions. In addition to the presenters listed here, the following individuals provided technical assistance in preparing for the briefing: Amy Dickinson, Catherine Heinhold, Rosemary Hodge, and Crystal Piper. The book was edited by Kay Mason and designed by Gary A. Ridley, Senior Art Director, Porter/Novelli and Sheila M. Woodbridge, Designer.

FOREWORD

AIDSCOM, a name chosen to represent AIDS Technical Support: Public Health Communication Component, was a $24 million, 6-year project of the U.S. Agency for International Development (A.I.D.) awarded to the Academy for Educational Development (AED) in late 1987 and concluded in late 1993.

As prime contractor for AIDSCOM, AED was joined by project subcontractors Porter/Novelli, The Johns Hopkins University's Center for Communication Programs, the Annenberg School for Communication of the University of Pennsylvania, and Prism/DAL. AIDSCOM also worked closely in its programs with other A.I.D.-supported projects such as AIDSTECH, the U.S. Centers for Disease Control and Prevention, and the World Health Organization's Global Programme on AIDS.

AIDSCOM provided technical support exclusively to developing countries—by the end of the project, more than 50 developing countries throughout Africa, Asia, the Caribbean, and Latin America. AIDSCOM's objectives were to increase knowledge and understanding of behavior change for HIV prevention, develop effective prevention methodologies, and strengthen local organizations in their use of modern communication for HIV prevention.

A.I.D. believed that lessons it had learned over the years in communication programs associated with diarrheal disease, childhood immunizations, family planning, and other health areas also could be applied effectively to HIV prevention, and through AIDSCOM's work, that new lessons and perhaps new methodologies could be learned in that process.

AIDSCOM was a different kind of project from the beginning. It came into being and accomplished much of its work at a moment in time when the developing world had only just awakened to the immense threat that AIDS represents. Throughout the world, policy-makers and health professionals were—and still are

struggling to understand what this new disease would mean for their societies, what impact it would have, and how best to combat it. These realities meant that AIDSCOM had to try new approaches, to innovate and be bold where no other prevention effort had had an opportunity to lay a solid basis for action. Many of the programs AIDSCOM supported over the years were (and are) the first of their kind in their countries, and many broke new ground by reaching populations—such as men who have sex with men and sex workers—that had previously been invisible.

This booklet is a record of the final public presentation of AIDSCOM's work and review of the lessons the project learned, which took place in Washington, DC, on July 22, 1993. The book is organized according to order and topics of the various presentations, which were written and delivered by current or former AIDSCOM staff and A.I.D. project managers. For a more formal analysis of AIDSCOM's accomplishments, readers should consult the companion piece to this book, titled *A World Against AIDS: Communication for Behavior Change*.

AIDSCOM was a powerful, pivotal experience for everyone associated with the project. It made a difference and, we hope, saved lives throughout the developing world. We attempt to capture some of what made AIDSCOM meaningful—and special—in the pages that follow.

Michael J. Helquist
AIDSCOM Project Director

A single finger, raised from a clutching hand. Pointing? Perhaps. But that finger might better represent a single critical truth that emerged from all AIDSCOM tried to do:

People are more than their HIV status, their sexual orientation, or their sexual profession. People are more than AIDS "victims"; more than gay or

straight: more than housewife, prostitute, student, or street child.

The importance of this lesson is the challenge it presents to the risk group approach to AIDS prevention. Roy Anderson and Robert May in their article "Understanding the AIDS Pandemic" (*Medicine*, May 1992) describe succinctly the medical community's primary view of HIV prevention when they say, "In the absence of vaccines, the public must understand how the virus is transmitted and what changes in sexual behavior can reduce the risk of infection." They go on to argue that the observation indicates that education should be targeted at individuals who contribute the most to the reproductive success of the infection.

This approach carries two serious flaws. First "education" and "understanding" are rarely the keys to the complex behavior change required by HIV. We have strong reason to believe that behavior changes because: 1) people see a benefit they desire from a new behavior; 2) they see a greater barrier to the old behavior than the new; and/or 3) they believe and trust the channels of communication (media, community, employer, friend, lover, or spouse) that reach and touch them.

While we have no prescription for success, we know that multiple factors contribute to behavior change. We know that skill in negotiating condom use matters. We know that social norms matter. We know that the more we do (the more elements we throw into an intervention) the better overall results we get, even when we cannot explain what role each element of a program plays. And we know that safer sex

behavior is not stable; it is under constant attack and must be supported continually. Epidemiological risk labels like men with multiple partners, prostitutes, street kids, and so on are woefully inadequate as tools to influence behavior. What matters in changing behavior is not only what people do sexually, but which safer sex practice is most appealing to them given their lifestyle, what barriers to safer sex worry them most, and who they listen to and trust. The answers to these questions cross epidemiological target groups and give a different face to AIDS and its prevention.

To put a new face on AIDS is good science as well as good humanity. My hope is that this booklet and its companion publication, *A World Against AIDS: Communication for Behavior Change*, will confirm once again that information alone targeted at risk groups is not the answer to HIV prevention.

William A. Smith
Executive Vice President
Academy for Educational Development

PARTNERS AGAINST AIDS

LESSONS LEARNED

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A Beginning

Stephen F. Moseley
President, Academy for
Educational Development

The Academy for Educational Development (AED), as the prime contractor for the AIDS Public Health Communication Project (AIDSCOM), is pleased to welcome today the Agency for International Development (A.I.D.), its current contractor AIDSCAP, and other colleagues working in international HIV prevention. A.I.D. launched AIDSCOM in 1987, and today's briefing is devoted to the lessons

learned about HIV prevention communication from this project. The purpose of this briefing is to share these lessons with you in hopes that they will benefit you as you proceed with international HIV prevention work.

It has been a long, hard road to arrive at this point. I do not think we could have accomplished what we did without a number of very fine partnerships.

First and foremost is our partnership with A.I.D., which supported the dramatic leadership within this field. Others include our extraordinary partnerships with Porter/Novelli, the Johns Hopkins University, the Annenberg School for Communication at the University of Pennsylvania, and PRISM/DAE Corporation.

AIDSCOM has participated in partnerships from the outset, throughout the project's design, undertaking, and implementation. I don't think there's ever been a closer working team, at least in the history of our activity. I think this teamwork bodes well not only for this project, but also for our relations with our partner institutions in many other areas.

I said it's been a long and hard road, and I meant that personally. As chief executive officer (CEO) of this organization, I'm not as directly involved in the program activity as others; however, AIDSCOM has required the personal commitment of AED in every sense of that word—our staff, our whole organization.

From the beginning, we and many others have been involved in AIDSCOM to try to find a new state-of-the-art to address something for which there is no art or science. Our involvement in this cause has turned us into a different kind of

organization. I've never before made this sort of statement while introducing a program. But it's one that's personally felt throughout this organization.

AIDSCOM has changed for the better the way an organization like ours helps to implement a project on a global basis. It has resulted in a new kind of relationship with the countries and the people within those countries. And it has meant a different relationship between us and A.I.D. even though we work closely with A.I.D. in many other areas.

In addition, these changes have involved taking very controversial stands in how we staffed the program and how we carried it out. I think we have learned a lot through this process.

That's at the heart of the lessons we have learned from a more scientific, or programmatic, approach.

Not all of the early leaders of AIDSCOM are well today. Glen Margo, AIDSCOM's original Project Director, is living with AIDS, and Ken Dunnigan and Ed Iout died earlier this year. We have missed Ken and Ed tremendously. Since their deaths, we have had the extraordinary opportunity of having other people assume key leadership roles, and you will hear from them today. Michael Helquist, AIDSCOM's Project Director, is unable to be here because he donated his appendix to some cause last week. I would like to thank, particularly, Bill Smith, Executive Vice President of AED, for his extraordinary leadership in bringing the program to this point.

This is not the end of this program; it is a beginning. I think a lot of people can benefit from the lessons we have learned through our work on AIDSCOM.

Recognizing AIDSCOM's Contributions

Helene Gayle
AIDS Coordinator, A.I.D.

When A.I.D. started AIDSCOM in 1987, I was a medical epidemiologist at the Centers for Disease Control and Prevention. I was very involved with HIV/AIDS work, but more from the standpoint of epidemiology—looking at the medically related issues of HIV and AIDS. I knew about the work that AIDSCOM and AIDSTECH were doing. But all that communications work seemed alien to me at the time.

Over the years, as I became more familiar with AIDSCOM, AIDSTECH, and the other activities that A.I.D. was involved in, I developed an appreciation of the work that was being implemented through AIDSCOM. I owe AIDSCOM a debt of gratitude for the education it has given me about behavior change and the importance of communication. I think AIDSCOM has taught the world a lot in these areas.

We felt it was extremely important to recognize AIDSCOM's contribution. Today's briefing gives all the people whom AIDSCOM has touched an opportunity to share information, learn from one another, and think about how AIDSCOM's contribution will help shape our work as we continue to face this challenging epidemic.

I would like to thank many people—some are in the audience but many are not—for their professional as well as personal commitment to the project and to this epidemic. I think everyone has noted the very personal commitment that has gone into this project.

I'd also like to thank Melody Frott, who's been the Project Manager from our office for AIDSCOM for the past couple of years. She has helped me understand the project better and has been an advocate on our side for this endeavor.

Five Main Themes

Ann Jimerson
for Michael Helquist

I am filling in for Michael Helquist, our Project Director, who is recovering from an appendectomy and sends his regrets about not being able to join us today. We missed having Michael with us physically during the planning process for today's briefing. Those of you who know Michael's work style will not be surprised to learn that he contributed actively to this briefing, even sending faxes

from his hospital bed. We were fortunate, as well, to have had the involvement of many former AIDSCOM staff in this process.

During the planning process, AIDSCOM staff became increasingly aware that this presentation had to be more than a cut-and-dried summary of facts and findings. All of us who work in HIV prevention know that the epidemic demands that we respond with humanity and passion. As we discussed the meaning of AIDSCOM, we were reminded continually of the invaluable contributions of friends and colleagues—including our own project staff and colleagues in the field—who are living with AIDS or have died from AIDS since the project began in 1987. We are grateful not just for their technical expertise, but for reminding us daily of the reasons why we keep fighting.

We recognize that A.I.D. has moved ahead during the past year and a half with new HIV/AIDS initiatives, including some innovations and strategies that we probably are not fully aware of. Yet the problem of HIV has become even more serious than when A.I.D. began its work in this field.

We will begin our briefing today by reminding you of the context in which A.I.D. began its HIV and AIDS work. We will report first on AIDSCOM program findings, then on research lessons. We are pleased to note that the lines that separate program and research have become a bit fuzzy for many of us. AIDSCOM was intentionally designed to use research to drive programs and let programmatic concerns drive the research agenda.

We challenged ourselves to describe in a few "sound bites" how we would like you to

remember AIDSCOM. We condensed our experience to five main themes. The themes are as follows:

1. People are at the center.
2. Partnerships are critical.
3. Innovation is the best guide.
4. Begin with behavior.
5. AIDS is different

We will mention these themes throughout the briefing and return to them at the end of the meeting.

Getting Started Baseline 1987

Gary MacDonald

I would like to add my words of welcome: thank you for being here today. I was AIDSCOM's Coordinator for Asia/Near East Programs from 1988-91. But I have been working on HIV issues since 1984—unbelievably, almost ten years now. I will probably work on HIV issues for the rest of my career. I'd like to offer an opening perspective on the importance of time.

In a disaster such as HIV disease, when every moment is crucial, we tend to telescope time to the here and now. Everything is real and urgent and needed *now*, right now, this moment. But there is a past in HIV, and I'd like to remind us of it.

In 1987, before A.I.D. launched its AIDS prevention program, the world we lived in was in a very different place vis-a-vis HIV disease than it is today. AIDSCOM had a lot to do with changing points of view about HIV disease in many countries. But we couldn't have done that if A.I.D. hadn't had the foresight to believe that changing perspectives about HIV disease was (and is) important. I think all of us here today would like to commend A.I.D. for that. Thank you.

Where were we in 1987, everywhere in the world, on the subject of HIV disease? Let's remember for a moment.

You will notice that I am not making distinctions between the developed world and the developing world. That's because I don't believe there were many distinctions. We were much alike in 1987; we are much alike today. In 1987, most of the world believed that HIV disease was *someone else's* problem. In the developed world in 1987 and still today, HIV disease is a homosexual or an injecting drug user problem. In the developing world in 1987 and still today in some places, people believe that HIV disease is a problem introduced by foreigners, mainly tourists, mainly Americans and Europeans. HIV is still not something that most of us believe we have to worry about.

I'll never forget my first visit to Thailand for AIDSCOM in early 1988. The official Thais we met were wonderful, extremely polite, noncom-

mind and for some of them, I later learned, convinced among themselves that *of course* Americans would be concerned about HIV disease in Thailand—after all, it was *our fault* but not their concern. Just as people in our own country were convinced that HIV disease was the fault of gay men.

Everywhere in 1987 people could not and did not talk about sex in the context of disease, even when dispensing contraception. Men and women sex workers and men who have sex with men and unfaithful husbands and people who inject drugs did not exist, officially, and even if we knew they did exist polite people did not discuss them. Young people simply did not have sex at all, according to everybody.

Research on sexual behaviors and attitudes and beliefs regarding sex was scarce, everywhere. The data we had in 1987 very often omitted women and men who have sex with men, and it almost always ignored variables that are important to the design of prevention interventions and communication campaigns.

In 1987, few persons living with HIV and AIDS in the developing world were willing to speak publicly about their experience. Few representatives of any kind in developing countries considered it important to attend conferences and international meetings on AIDS. Donor agencies agreed: few believed it was important to sponsor attendance at such conferences by representatives of developing countries.

In 1987, few countries had produced culturally sensitive, audience-specific educational materials about HIV transmission—let alone subjects such as safer sex practices and correct condom use.

In 1987, the idea of a telephone hotline to counsel the worried and the sick was thought to be impractical if not impossible in the developing world.

In 1987, *counseling* to help people change risky behaviors was not considered feasible and few people believed that it would work in most countries.

In 1987, there were many nongovernment organizations working on many health issues in many places but few organizations working on HIV disease. In Manila in 1988, I was flatly turned down by the director of the leading national health advocacy organization when I asked him if his group would be willing to work on HIV issues. There were too many other, more pressing health issues in the Philippines, he said. He was right and he is still right. But the other day, he faxed to tell me that HIV issues are consuming all of his time these days, because they have become priorities for his constituencies, and he asked whether I have any recommendations in terms of managing the demands on his time.

All over the world, much has changed since 1987.

People are talking about sex and safer sex now, and conducting research to help us understand sexual behaviors.

More and more persons living with HIV and AIDS are speaking out, telling their stories. Developing countries are now richly represented at international conferences.

Most governments are now attempting, however hesitantly, to inform and educate their citizens about HIV disease. Educational materi-

als are being disseminated. Thousands of people are participating actively in HIV prevention campaigns, and have been trained how to develop effective information materials and messages that have specific, measurable objectives and outcomes. The media everywhere have been persuaded to pay close attention to AIDS.

Telephone hotlines and prevention counseling programs are no longer uncommon, and fewer people today believe that these important interventions cannot work in developing countries. There are HIV hotlines operating today in Asia, Latin America, Africa, and the Caribbean.

Thousands of nongovernment and volunteer organizations are now working very hard all over the world to slow the spread of HIV. These agencies are in the forefront in many countries and are increasingly considered equals in HIV prevention efforts by governments and donor agencies alike.

AIDSCOM played a key role in these changes. We did not do it alone, of course. Over the years of this project we have had the support and assistance and confidence of so many people: A.I.D. in Washington, USAID Missions, other projects, representatives of government and nongovernment organizations, target audiences—so many people in so many places—helped us willingly and hopefully and with so much energy to make changes happen.

It is important for you to know that it is one of the great privileges of our lives to have worked on AIDSCOM and helped changes happen in so many places. Lives are being saved right now because of those changes.

Today, by putting people first, by encouraging partnerships with new organizations, by applying behavioral science and, above all, by *innovating* in HIV prevention methodologies, AIDSCOM makes a difference. The presentations you are about to hear and see tell the story of how it happened.

I would ask you, here at the beginning, not to forget where we've come from. I would ask you not to underestimate where we have still to go.

The ABC Framework

Susan Middlestadt

Before we describe AIDSCOM's programs, I would like to explain the conceptual background of the project.

ABC Framework

One of the major contributions of AIDSCOM to the field of international HIV prevention has been a fundamental change in the underlying analytic framework that

guides the design and evaluation of interventions. We call our current framework the ABC (Applied Behavior Change) Framework. The ABC Framework builds upon the lessons communicators have learned over the past 20 to 30 years of development communication.

The ABC Framework has the following three components:

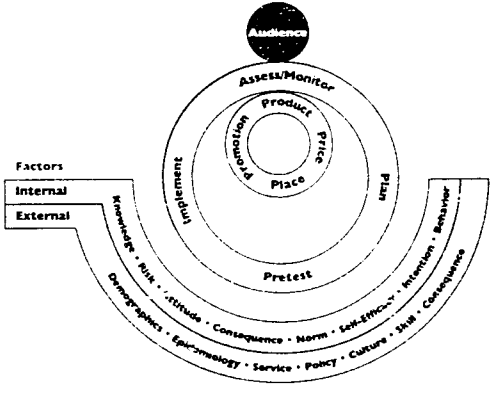
1. The *program planning cycle* takes the program manager through the steps of assessing, planning, pretesting, implementing, and monitoring.

2. The *social marketing cone* assists the program manager in making strategic management decisions, such as whether and how to intervene on product, price, promotion, or place.

3. The *behavior consideration* describes the priority internal and external behavioral factors the program manager needs to understand, target, and monitor.

At the top of the ABC Framework are *audience* and *behavior*. This reflects our belief that

ABC Framework



understanding a particular population is necessary to develop effective behavior change interventions for that population. This is one way that people have been important in AIDSCOM's work.

Begin with Behavior

The ABC Framework represents not only an integration of the disciplines of program planning, social marketing, and behavioral and social sciences, but also a shift from a public health communication model to a behavior change model of intervention design.

Public Health Communication Model

Information —> Behavior

Behavioral Model

External —> Internal —> Behavior

According to a basic public health communication model, information, education, and communication lead to behavior change. Thus, the goal of research for program planning is to determine which information to provide, to whom, and through which channel.

According to a basic behavioral model, external factors in the environment first influence internal factors (people's perceptions or cognitions about their behavior) and then their behavior. To develop effective interventions, one must begin with behavior; understand the internal and external factors that determine, cause, predict, or contribute to behavior, and then design interventions to influence those factors.

Using the behavioral model may mean that we need to design communication that provides information that makes people aware of the con-

sequences of a behavior. But that approach may not always be appropriate or sufficient. It may mean that we need to

- help people develop and practice skills;
- change a social norm;
- increase the availability of condoms; or
- convince people of the benefits of a different behavior.

External/Structural Determinants

AIDSCOM has used a variety of external or structural determinants to set the context for intervention design and represent potential intervention points. These determinants are as follows:

- Epidemiology
- Demographics
- Services
- Technology
- Policy
- Culture
- Skills

The program manager needs to be knowledgeable about these determinants in a particular country to design effective programs. Different programs would be needed, for example, if the seroprevalence is low rather than high in a specific country or population of interest. Also, a country that has condoms and other services or technologies available would need different services than a country that does not. Sometimes, the need may be to develop or provide such services or technologies first before implementing a program. In addition, different programs are needed depending on the sexual behavior patterns prevalent in a certain culture.

Internal/Cognitive Determinants

In addition to the external/structural determinants, AIDSCOM has used a set of internal or cognitive determinants that potentially influence sexual behavior. They are as follows:

- Knowledge
  - Transmission
  - HIV vs. AIDS
- Health beliefs
  - Susceptibility
  - Severity
  - Perceived risk
- Attitude toward behavior
- Perceived social norms
- Perceived consequences
  - Health
  - Other
- Perceived skill
- Complementary behaviors
  - Buying and carrying
  - Talking and discussing

These determinants have come from the basic theories of behavior (for example, Health Belief Model, Social Cognitive Learning Theory, Theory of Reasoned Action) and are being used by many researchers working domestically and internationally.

AIDSCOM's research to understand HIV prevention behaviors in developing countries has indicated the following:

- Knowing about the length of time between HIV infection and AIDS is more important than just being aware of high-risk behaviors.
- In the domain of HIV, health beliefs (for example, peoples perception of their risk or the severity of the disease) and susceptibility

do not operate in a simple way and are not as powerful in motivating behavior change as they have been in other health domains.

- Attitudes and norms, particularly perceived social norms, are important.
- "Nonhealth" consequences are key motivators for behavior change. For example, protecting the family and/or children is a powerful motivator for condom use in many Latino populations.
- Perceived and actual skills represent promising intervention points. For example, to use a condom consistently and comfortably, a person must *be able* to use one and *think* that he or she can.
- The sexual behaviors that place one at risk of HIV infection are complex, occur irregularly, and often are difficult to address directly. Therefore, AIDSCOM often has taken an indirect approach by working through the behaviors that enable or lead to safer sexual behaviors. I call these complementary behaviors. Encouraging talking, discussing, and negotiating with friends and partners can be first steps toward initiating and maintaining safer behaviors.

Given this conceptual background, my colleagues will talk next about AIDSCOM's programs, the strategies that have worked, and our understanding of why they have worked.

Integrated Communication Strategies

Michael Ramah

By following the ABC Framework, we as program planners naturally have worked to develop integrated communication strategies. By integrated, I mean strategies that involve a complementary use of mass media, collateral support media, and interpersonal media to achieve a communication goal. I will explain the different types of media, how we have applied integrated strategies,

and what we have learned from this experience concerning HIV prevention.

Mass Media

Mass media is a one-way method of communication. By the time a message is broadcast via mass media, we have no control over how that message is received. Therefore, it is important to craft and pretest messages so they don't do any damage or cause unnecessary concern. Also, mass media is an efficient way to reach a large audience. Mass media, particularly in the developing world, refers to more than just television; it includes theater, traditional dance, and other methods of reaching a large audience.

Mass media can be very effective in "setting the stage," or preparing people for face-to-face interventions. Mass media can "give permission" for some of the behaviors to support programs. For example, let's say our key strategy is to get young adults to use condoms. We may determine that, before we can communicate directly with the young adults, we need to gain permission from society or parents to do so. Mass media can be used effectively to set the stage for that permission.

Also, mass media messages are short (30 or 60 seconds). And, regarding television messages, repetition works best. This has been a key consideration when we have had to choose between paid media or free media time from the government that was not available at the best times. The temptation is to save funds by relying on free time. But considering the initial investment in creating a commercial, sometimes the better decision is to buy air time so we can strategical-

ly target who sees the commercial and when they see it.

Collateral Support Media

Collateral support materials such as talks, videos, posters, and brochures can be one-way or two-way methods of communication. These materials can be used to communicate directly with a target audience and very effectively with subsets of the general population (for example, health care workers, parents, workers). They are appropriate for any audience that can be communicated with in a group or that can receive the one-way communication (for example, a poster). Collateral materials also can convey a long, in-depth message, which is particularly effective when informing influencers or gatekeepers. The goal with this type of communication is to address an audience as a group to achieve group interaction and consensus for a particular behavior.

Interpersonal Communication

Interpersonal communication is a two-way method of communication. We provide the information, see how the information is received, then adjust our message accordingly. We have found this to be particularly important regarding some of the subtleties in our work. If we just skim the surface concerning HIV/AIDS awareness, for example, we might find that in any particular population, people could recite the facts about HIV/AIDS. We wouldn't be able to measure, however, whether these people had internalized the information unless we had a way of communicating back and forth with them.

Interpersonal communication is used for peer education, prevention counseling, hotlines, and skills training. It is best to use interpersonal communication with people who are most at risk and those who are harder to reach, because it is expensive and labor-intensive.

Applying Integrated Strategies

Integrated strategies have enabled us to segment an audience within the framework of one broad strategy. Integrated strategies involve determining a communication goal and who needs to receive what message to achieve that goal, then planning accordingly. Integrated strategies also have enabled us to determine which medium would work best for each message and for each audience. They have allowed for efficiencies in planning, design, and evaluation. Determining all of our messages from the outset also has led to efficiencies in cost and human resources. Most important, integrated strategies have brought the same strategic approach to achieving our goals: we have designed strategies as a whole and operated and evaluated them in the same context.

We have found that integrated strategies have to be tailored for each region. The combination of variables, or the need to emphasize mass media or interpersonal or collateral communication, varies by region and epidemiology. We have needed to determine appropriate combinations of strategies that reflect the existing technology and the communication norms in the regions where we have been working.

Strategies are based first and foremost on research. The ABC Framework is key to making

as deep an analysis as possible about an audience and its behaviors. This process is rigorous. It requires planning, consensus, and collaboration among all parties. But the process results in the development of the highest quality and most appropriate materials. Instead of responding to a last-minute request for a poster, for example, we have developed each material as part of an overall strategy. Because we already had allocated resources to our strategy, we have had a coordinated approach.

Two Approaches

We have used two approaches for integrated strategies. The first approach is using integrated strategies at the national level, working with a national plan. This involves having a long view of our audiences, their behaviors, and how we want to approach them. Some of the countries and regions in which we have used this approach are Uganda, Swaziland, Tanzania, Brazil, and the Dominican Republic.

The second approach is using integrated strategies with specific target audiences. These audiences have included people in the workplace in Africa (Uganda, Swaziland, and Tanzania) and commercial sex workers in Brazil and the Dominican Republic. This approach involves going beyond the traditional one-time intervention; it involves stepping back and getting a broader view. What do the data tell us the audience needs? What is the best mix of components to reach them? How are we going to do it? How much time is it going to take? This approach also has worked effectively with men who have sex with men.

What We Learned

What have we learned from applying integrated strategies to HIV prevention? We had known that multiple reinforcing messages worked. The news has come from doing it, making it work.

First, we have learned that the skills needed to apply integrated strategies are transferable, because they are planning and management skills. We have taught these skills to our colleagues, who then have passed them on to others.

We also have learned that applying integrated strategies often involves very effective public and private partnerships. Our partnerships have been essential—first, because applying integrated strategies is a large task and, second, because as a planning process it requires the best resources for the job. So we formed partnerships with private-sector NGOs, advertising agencies, and market research firms.

Integrated strategies, as part of the ABC Framework, can help to enhance management skills. We all have been through the frustration of the balance, particularly working with NGOs or government counterparts. We ask ourselves, for example, whether to teach people how to design the content of a poster or teach them how to manage that process. The ABC Framework has enabled us to begin our work with a framework and teach that framework to others. The ABC Framework emphasizes the management of the process: if you know the steps, you can find the appropriate people and resources to do them.

Ultimately, we have learned that applying integrated communication strategies successfully requires vision. We have had to have a sense of

where we were going, why we were going there, and what we intended to do once we got there. Also, from the outset of the program, we have had to think about how to evaluate it.

The following presentations will provide a few examples of how we have applied integrated communication strategies in our work.

An Example: AIDS In The Workplace

Lorraine Lathen-Parker

I'd like to continue the discussion of integrated communication campaigns and focus particularly on the AIDSCOM AIDS in the Workplace (AIWP) projects.

Often, when we speak about HIV prevention strategies and workplaces, the first thing that comes to mind is: why workplaces? When we started working on AIDSCOM, A.I.D. believed that workplaces could be important components in an

HIV prevention strategy because of their economic and social importance.

First, we assumed that if managers and CEOs in workplaces would allow easy access to their employees, then workplaces could serve as invaluable points of access to large audiences. Also, because people usually go to work regularly, AED thought that, through workplaces, we could reach the same audiences with consistent HIV prevention messages that could be reinforced over time. We also hoped that workplaces would allow us to teach proper condom use skills and support employees in their efforts to practice safer sexual behaviors. And we believed that workplaces could act as powerful contributors to social norms and function as environments in which behavior change could be encouraged over time.

In Uganda, where workers at all levels, including the highly skilled, were dying from AIDS, the Ministry of Health and the USAID Mission took a proactive stance to address the issue through two channels: the private sector and community-based organizations.

The Federation of Ugandan Employers was charged with implementing the AIWP component of the Mission's overall AIDS in the Private Sector Program. The Experiment in International Living (EIL), now known as World Learning, was identified as the organization to confront the issue at the community-based level. The target audience consisted of men ages 18 to 35, with the understanding that the knowledge and skills acquired by the target audience would spill over to their families and communities.

After refining and evaluating the Uganda model, AIDSCOM staff worked with local partners to adapt similar AIWP projects in Tanzania and Swaziland.

I will focus on the AIWP project in Uganda because it has been the model for adaptation in other countries. Also, Uganda was the only place where AIDSCOM conducted a full-scale evaluation of its AIWP activities.

Program Dynamics

The AIWP project in Uganda is a strong example of an integrated approach to HIV prevention. It relies on multiple channels and materials to reach the same audience with consistent HIV prevention messages. These channels and materials include formal talks, interactions with peer educators, peer educator cards, the *HIV/AIDS Prevention Trainers Guide*, brochures, and the Ugandan AIDS drama *It's Not Easy*.

The HIV/AIDS Prevention Trainers Guide ensures that all peer educators acquire the same knowledge and skills. The purpose of the peer educator cards is to make sure that educators deliver consistent messages. The back side of the card lists ten things that a peer educator should do every time he or she talks about HIV/AIDS. All of the peer educators carry these cards and refer to them when they are talking with co-workers and friends about HIV/AIDS. In addition, peer educators wear buttons in their workplaces and communities to identify themselves as resources for HIV/AIDS information.

Peer educators also distribute the comic book *Ekanya: Shocked into Sense* in the workplace and through community-based organiza-

tions. The comic book, which was developed to reach sexually active men ages 20 to 35, highlights seven steps to behavior change. Brochures that reinforce the comic book messages are distributed in the workplace and through community-based organizations. For example, the *Change Your Behavior and Prevent AIDS* brochure lists the seven steps to behavior change that are listed in the comic book. The brochures *Knowledge is Power* and *Taking the HIV Test* echo the same messages as the other support materials and also are distributed by peer educators.

All of the components of the AIWP project in Uganda—peer educators, formal talks, comic books, brochures, *It's Not Easy*—seek to clarify the basic facts about HIV/AIDS, promote acceptance of people with HIV/AIDS, and encourage safer sexual behavior. All of the channels and materials reinforce one another and allow us to reach the same audience with consistent messages over time.

Program Findings

Now, I will summarize some of the major findings of the AIWP project in Uganda.

AIDSCOM conducted an evaluation to determine whether the AIWP project was implemented successfully and the extent to which it resulted in changes in knowledge, attitudes, and reported behavior. The evaluation was based on three surveys of knowledge, attitudes, and practices conducted at eight sites between March 1990 and October 1991. We interviewed 1,599 persons from the target population and 61 peer educators.

Because all sites were not measured at all points in time and the organizations were at different stages of program development at the time of the surveys, the sample cannot be regarded as a simple "before-midpoint-after" design; different analyses were conducted depending on the questions to be answered.

I will focus on the analyses that relied on the level of program activity (light, medium, or heavy) as a starting point to evaluate the success of the project. Basically, each of the sites was classified according to the level of reported exposure to the AIWP project interventions. Sites where less than 20 percent of employees reported exposure to the interventions were classified as *light;* sites where 20 percent to 49 percent reported exposure were classified as *medium;* and sites where over 50 percent reported exposure were classified as *heavy*.

Exposure to the AIWP project refers to experiencing one or a combination of the following intervention components: attending formal talks, talking to peer educators, or viewing *It's Not Easy*.

First, we looked at the impact of the interventions on people's knowledge about the incubation period for HIV and their beliefs that others use condoms. We found that the percentages of people who had correct knowledge and held that belief were higher the heavier the degree of exposure to the intervention.

We also looked at the impact of the interventions on condom use. Generally, the more one was exposed to the interventions, the higher the percentage of reported condom use over the

2 months prior to the interviews. Also, the more components of the intervention that a person was exposed to, the higher the percentage of reported condom use in the 2 months prior to the interviews.

All of the changes that I've highlighted were statistically significant at the .05 level.

These results provide evidence for the success of the Uganda AIWP project. The combination of contact with peer educators, attendance at talks about HIV/AIDS, and viewing *It's Not Easy* has been associated with improvements in knowledge and changes in perceived norms.

Lessons Learned

We learned the following lessons from the Uganda AIWP project:

- Strategies with multiple components are powerful. The AIWP project demonstrated the power of using a combination of interventions. By using multiple channels and materials, the AIWP project in Uganda has been able to reach a large audience with consistent messages, reinforced over a long time period.
- Workplace programs can influence behavior change. The evaluation demonstrated that AIWP projects can change social norms, which influence behavior. For example, by raising the perception that others use condoms, the project changed normative beliefs and social norms.
- Workplace programs require intensive and sustained effort. Regarding the peer education component of the intervention, which

is by far the most labor-intensive, one lesson stands out: it takes a great deal of time to train a peer educator who can demonstrate effective communication skills and serve as a role model. Time is needed for screening the peer educator, repeated training sessions, and significant supervision and follow-up.

Audience Segmentation

Kathryn Carovano

My discussion today will focus on audience segmentation and the lessons that AIDSCOM has learned about the importance of audience segmentation through our work in HIV prevention. My work with the project from 1987-92 focused on Latin America and the Caribbean and the particular issues facing women regarding HIV prevention.

Audience segmentation is not a new concept; we already had understood its importance in health communication from AED's work in child survival and family planning.

Even in a small country that seems homogenous, there is no "general audience." A uniform communication program inevitably speaks to some groups, offends others, and is incomprehensible to others. The goal of audience segmentation is to identify primary audiences (those that will buy a new product or adopt a new behavior) from among larger population groups. Segmentation also attempts to define secondary audiences (those that influence the behavior of the primary audience), as well as tertiary audiences (decision-makers, gatekeepers, and others whose support is needed for programs that promote new products or behaviors).

Traditionally, the public health approach to audience segmentation has focused on demographics, socioeconomic differences, and epidemiological data. These and other public health indicators have guided AIDSCOM's work, but we also have sought to develop a deeper understanding of the people we were working with based on behavioral and communication factors.

HIV/AIDS has given us a new way to look at the world's populations. I think of it as a prism: if we think of the general population as white light and HIV/AIDS as a prism that breaks up that light, we find that HIV/AIDS breaks the light into colors we didn't know about before. In other words, HIV/AIDS has segmented populations in a new way.

When we began AIDSCOM in 1987 and looked at what was known about AIDS, we saw

only the primary colors: red, yellow, and blue. We had epidemiological information about who had HIV/AIDS that helped define these colors, or segments. We knew that gay men and commercial sex workers were at risk in several parts of the world. And we knew that health care providers needed information and training, both to protect themselves and to communicate to others.

Those were the primary segments, very broadly defined, that tended to guide our early efforts. Since then, we have seen that there are a lot more colors in the spectrum.

I remember my first trip for AIDSCOM, in 1988, to the Dominican Republic. We toured various sex industry establishments—street corners, drive-in motels, a very high-class brothel, and a dance bar. We noticed small shacks made of straw near the beach, and it was pointed out to us that these shacks were the place to go for oral sex. While the whole experience was eye-opening, I remember most walking through the city the next day and looking at every Dominican woman and man and wondering if I had seen any of them the night before. The night's tour made me acutely aware of how broad and diverse the sex industry was. It also made me realize that the industry involved many more women and men than I ever had imagined.

From the start of AIDSCOM, we have known that careful audience segmentation is critical to developing effective, targeted interventions. Two of our first activities in Mexico examined differences among sex workers in Tijuana and among gay men in Guadalajara. We identified two distinct segments in both populations. We found that some women sex workers saw

themselves first as professionals, while others identified first with their role as mothers. The gay men revealed differences in how they perceived their sexual relations: some emphasized the emotional significance while others were more interested in the sensual experience. We created messages and materials to appeal to these differences as part of our efforts to promote new behaviors among the various segments of what often had been viewed as homogeneous population groups.

Since these first efforts, HIV/AIDS has forced us to make distinctions between different segments of the population on the basis of much more complex criteria. For the time remaining, I will describe some of those criteria and some of the segmentation that has resulted.

Risk Behavior

Segmentation based on risk behavior is the obvious way to take an initial cut at the larger pie. Since the goal of HIV prevention is to reduce high-risk behavior, we would ideally like to know who is most at risk and in need of programs to support change. From there, further behavioral and communication research can determine what approaches to behavior change might be most effective.

The challenge of HIV/AIDS is the nature of the risk behaviors that need to change—most are deeply personal and many are heavily stigmatized. Dr. Richard Parker, an anthropologist who worked on a number of AIDSCOMs projects in Brazil, has described bisexuality as one of the "most hidden and poorly understood patterns of human sexual behavior" and has point-

ed out that a lack of understanding of this behavior limits the capacity to respond with effective interventions. While perhaps true to a lesser degree, infidelity, commercial sex, sexually transmitted disease (STD) history, and certain sexual practices also are tabu in many cultures, making it difficult to fully understand and address them as well. This is one reason why HIV prevention differs from other health promotion efforts that focus on less personal and more accepted behaviors.

Taking that a step further, one of the most important lessons from AIDSCOM's experience researching risk behavior is the awareness of the range of behaviors and people involved. This range points to the need to look beyond traditional assumptions about *who* does what and *what* they do.

AIDSCOM conducted ethnographic research among "street kids" in Brazil and found that their behaviors were as varied as those among people *not* living on the street. One of the most significant findings was that programs designed for "street kids" did not address many high-risk behaviors. Most service providers viewed this population as being made up of heterosexual boys and designed most of their programs to serve them. Most providers ignored minors (the legal definition of "kids") who lived or worked on the street and also happened to be homosexual, transvestite, or engaged in prostitution. They also tended to ignore the distinct needs of girls.

Lumping all youth who live on the street under one label hides an extremely diverse population. And, without explicitly stating it, such

labeling excludes some segments whose behavior is considered inconsistent with the definition of "street kid."

Another important point about segmenting on the basis of behavior is the need to recognize that some behaviors are beyond the control of the individual at risk. One important aspect of AIDSCOM's work was pointing out early the level of risk faced by women, particularly those who were not engaged in prostitution, and the fact that most women were at risk primarily because of their partner's behavior. Because sexual relations involve two people—and the technology available to prevent HIV transmission still requires the cooperation of both—behavior change involves a couple, not just an individual. Many women whose behavior seems low-risk (for example, monogamous married women) still are not safe because of their partner's behavior.

Risk reduction efforts need to focus on the behavior of both partners in a relationship, but particularly on the partner who has the most control. Women do not control decisions about condom use and, in many developing cultures, have only limited influence over sexual decisions. Yet the burden of behavior change is primarily on women, as the burden of family planning also falls on women. The difference is that there are fewer risk-reduction options, making change even more challenging. This was confirmed by AIDSCOM's research among women in Brazil, Tanzania, and Indonesia. Women in all sites perceived their partners as impediments and asked us to include men in our interventions. With the women's encouragement, we have done that.

AIDSCOM also has focused some of its other work directly on men with potentially high risk behaviors. These include customers of sex workers, bisexual men, and men who "stray" from monogamous relationships. It can be difficult to identify these men. However, this difficulty does not justify how little has been done to encourage them to change their high-risk behavior, especially considering how much energy has been spent on programs targeting sex workers. I remember hearing repeatedly how easy it was to find the sex workers in any given city—just ask a taxi driver. But almost any time we mentioned the customers of the sex workers, everyone argued that they were too hard to identify.

In the Philippines and the Dominican Republic, AIDSCOM targeted the behavioral segment of men who might engage in sex outside marriage and stressed the risks associated with infidelity in mass media ads. Other efforts involved more targeted interventions for men in numerous sites in Africa and Latin America. While we had to cast a wide net to reach these hard-to-identify segments of men, it was not impossible and it has been a first step toward targeting a population that has been largely ignored.

Access Points

One of the simplest and most valuable ways to segment audiences for HIV prevention is point of access. Because many of the populations most at risk for AIDS—sex workers and their customers, gay and bisexual men, and "street kids"—often have been called "hard to reach," finding places where *some* can be reached is significant for program planners.

AIDSCOM, probably more than any other international HIV prevention project, has worked extensively on projects designed to reach gay and bisexual men. We adopted this strategy because the epidemiology in Latin America and the Caribbean indicated that it should be a primary focus of the public health response. Also, at the inception of AIDSCOM, many governments had done little to reach gay and bisexual men, despite knowledge that this population's behavior was significant in the epidemic. In Guatemala in 1988, nearly all of the reported cases of AIDS were attributed to male-to-male sexual contact. Yet, when we asked AIDS program officials where or how we might reach men who had sex with men, they had no idea. It was only at the end of our visit that we met someone who could tell us where some of the city's gay bars and hang-outs were located. The Ministry Of Health officials didn't know that these places even existed.

Developing programs for gay and bisexual men in Latin America and the Caribbean highlighted the challenge of targeting groups engaging in socially stigmatized behaviors. This type of individual's public and private *personas* are very different; our challenge was to find points where they overlapped. We were looking for public places where we could reach those who privately engaged in same-sex practices.

AIDSCOM conducted communication and behavioral research among gay and bisexual men in Peru, Indonesia, the Philippines, Brazil, Mexico, the Dominican Republic, Ecuador, and Jamaica. There are many ways to segment the population of men who have sex with men, if

you know who they are. The challenge is finding out who they are, and then finding them. That is why access points are so critical. We recognized access points as important criteria for segmenting this population in ways that would serve the program development process. In other words, to develop effective programs, we needed to know where to reach these men.

In Peru, early research that we conducted with a local NGO, Movimiento Homosexual de Lima (MHOL), revealed some ways. We found that some men would talk to a peer on the street, others were willing to call an anonymous hotline, and others were comfortable coming to the offices of a gay-identified organization. While these groups of men had behavioral and other differences, the most significant factor in program planning was a shared access point. A later AIDSCOM study among gay and bisexual men in Jamaica found that meeting places—or access points—also were significant in terms of the types of social interaction and sexual contact that different groups of men were seeking.

Variations in knowledge, behavior, and attitudes related to condom use also were correlated with place of access among sex workers in La Paz, Bolivia. AIDSCOM and a local NGO, El Centro de Investigacion, Educacion y Servicios (CIES), found that significant differences existed between women who worked on the street, those who worked in brothels, and those who worked in bars. We found the place of work, which also can be viewed as the point of access for program planners, to be *the* most significant variable distinguishing one segment of this population of women from another.

Workplace programs also reflect segmentation of populations based on point of access. In Uganda, Tanzania, and Swaziland, where most sexually active adults were at risk of contracting HIV, one way to differentiate some from all was to target those who could be reached through an existing infrastructure. Workers became a viable segment in the otherwise vast general population because they formed a captive audience that could receive multiple reinforcing messages over time.

In addition, schools provide a point of access to a certain segment of youth. In Ghana and Malawi, we decided to target youth in schools, not because these youth were at higher risk than others, but because they could be accessed in school. Schools offer one of the only systematic channels for reaching large numbers of young people in many developing and developed countries.

Determinants of Behavior

Even more significant than knowing how people behave and where to reach them is understanding *why* they behave in certain ways. AIDSCOM undertook a series of research and intervention activities to find out the "why," or determinants of behaviors. Briefly, the challenge was to look at a specific, concrete behavior and segment populations based on individual experience with, attitudes toward, and perceptions of that behavior. As mentioned previously, the ABC Framework incorporates a series of internal and external determinants that have been identified as influencing behavior.

One factor that we found to be significant in determining whether married women in Tanzania and Brazil were willing and able to *talk* to their partners about sex and HIV prevention (a

very specific behavior) was their beliefs about the consequences of doing so. All of the women recognized potential negative consequences, but women who also saw the potential for a positive outcome were more likely to engage in the behavior than those who did not.

This level of segmentation can contribute to the development of strategies that are designed to influence a specific determinant of a specific behavior in a particular segment of the population.

In summary, AIDSCOM's work has made it clear that, when we look at people, we need to consider much more than whether they are male or female, married or single, gay or straight, young or old, "street children" or not. To develop HIV prevention programs, we need to think about how people differ from others in terms of their risk behaviors, where we can reach them, and what factors we can influence to promote behavior change.

Segmenting audiences on the basis of what we are able to learn about very private, often stigmatized behaviors will remain a significant challenge in the years to come. Creative and rigorous efforts will need to continue to fully appreciate—and respond to—the full range of colors that HIV/AIDS has revealed to us and forced us to address.

Media Campaigns

Michael Ramah

So far, we have talked about where our project started and some of the lessons we have learned. Now, I'm going to tell you about some of our most visible and technically accomplished products: our television commercials for HIV prevention.

Kathryn explained how we segmented our audiences and how we identified the behaviors to address. She also mentioned that during our work with

female sex workers and gay men from 1987-88, we discovered that the audiences we expected to be homogenous were not. She described how we then began to take apart audiences: look at behavior: and decide which behaviors we wanted to emphasize, reinforce, or change.

Once we made these decisions, we looked at the content of our messages. We wanted to *begin* with information, to be sure that there was an *information base about HIV transmission and prevention*. We asked ourselves whether people had the facts and knew the basic meaning of the problem and how it might affect them. After this, we directed our efforts toward providing deeper knowledge, gaining permission, reinforcing information, teaching skills, creating peer support for a particular undertaking, and influencing the way people viewed social norms for an undertaking. Our objective was to encourage people to try a new product or a new behavior.

I'm going to tell you about television commercials from the Philippines and Mexico, both Catholic countries. Both have a very outspoken Catholic Right or at least a Catholic conservative constituency. What's particularly rewarding about these ads is that we produced and aired them in countries where people said that we couldn't do a lot of what we wanted to do. For example, people said we couldn't talk about condoms in Mexico or in the Philippines. We couldn't talk about sex workers, particularly on mass media. Also, we could never talk on mass media about men going to a sex worker. We said that *maybe* we could do these things, and we did.

The Philippines

"*Locker Room*"

The first commercial from the Philippines is called "*Locker Room*." This one was enlightening because of our hypothesis about how men decided whether to have sex, whom to have sex with, and what their sexual behavior would be. We assumed that each man made these decisions alone. However, from our focus group testing, we learned about the concept of "*barkada*," which is a term used in the Philippines to refer to the clique or set of people with whom one associates. We found that some decisions were group or tribal or locker room decisions. We extended the metaphor for this ad and shot it in a locker room.

The ad deals with the normal behavior of young men who go to commercial sex workers. Remember that the sex industry in the Philippines is thriving. And it's not going to go away. However, the tone of the ad is not judgmental. The ad depicts a group of men in a locker room and the banter that is assumed to take place among such men. One man tells the others that last night he went to see his regular girlfriend, who is a sex worker, and it was great—too bad the other guys didn't come. After a lot of chitchat back and forth, the voice of wisdom says, "I hope you used protection." The man replies, "Ah protection. I'm not one of *those* people. I don't need protection." During the discussion that follows, one man says, "Remember our friend Johnny [who did the same thing]? Well, he has AIDS." This news is introduced into the *barkada*, followed by another discussion. It is not resolved in the commercial whether the man is

going to use condoms the next time he sees his girlfriend, but it is clear he is not going to stop seeing her.

In addition to this television commercial, there is a radio "pool-out," a continuation of the television campaign in four radio spots. The radio spots extend the dramatic aspects of this situation, with the men talking in the locker room. In one spot, when the man goes back to see his girlfriend, he *thinks* about using a condom but doesn't. The last spot is a parody of the first, using almost the same dialogue: the man describes his visit with his girlfriend and the other men think, "Oh, you idiot, you didn't use a condom." But finally, the man announces, "Of course I used a condom. That's why I can continue to go."

"*Virgins*"

The second television commercial from the Philippines is called "*Virgins*." This ad looks at young people in school and focuses on a young man and a young woman who are dating. The young man wants to have sex but the young woman is not ready. While walking with her friend, the woman says, "I'm not sure I'm ready to have sex, but he'll leave me if I don't." Then, the guy tells his friend, "Marcy won't put out. I'm not sure I want to stick with her. I can get sex anywhere I want it." The ad deals with the permission to say, "Not yet, I'm not ready to have sex," and reinforces that behavior. The ad deals with real behaviors and real emotions. In fact, the actors in these ads are real kids, not professionals.

This commercial also has a radio pool-out that focuses on the question: Is Marcy going to

give in to her boyfriend Mike or is Mike going to leave Marcy? The drama goes back and forth, until it is resolved with the couple's staying together. They both realize that they don't have to have sex to stay together and that they can wait.

The tag at the end of this commercial is for the AIDS hotline. The response was such that the hotline had to hire extra operators and get an extra line to take the calls. The spots aired until May 1992.

Mexico

The next two television commercials I'm going to describe are from Mexico, also a Catholic country. Just 3 years ago in Mexico, the Padres de Familia, a religious right group, brought suit against the government and particularly against Dr. Sepulveda, then the head of the AIDS program, for corrupting the morals of youth by mentioning condoms. The environment has changed quite a bit since then.

"*Seropositive*"

The "*Seropositive*" ad addresses a unique problem in Mexico. Mexico was one of the first countries to create a law that makes discriminating against people with HIV/AIDS illegal. The law is on the books, but it doesn't mean much. This commercial attempts to address the problem of discrimination by portraying people with HIV and AIDS in Mexican society as more than people who are sick and dying. The message is that the rights of a person with HIV/AIDS are the same as others' rights, and by protecting the rights of those with HIV/AIDS, you are protecting everyone's rights. The ad conveys what it's

like to have HIV/AIDS by showing a "slice of life" for someone with HIV/AIDS and taking this person's viewpoint.

Casting for this ad presented some challenges. For one, we wanted to use an actor whom people could relate to. This meant that the actor could not appear to be gay, a drug user, North American, too old, or too young. Also, most of the actors whom we screened were not willing to play the role of a person with HIV/AIDS. We originally scripted and tested the ad without showing the actor's face. But we finally found an actor who was willing to show his face and we shot it that way. It was much more powerful.

"*Adolescents*"

The last commercial that I'm going to describe is called "*Adolescents*." We were most concerned about this ad because it targets adolescents and implies that they might be having sex. It targets kids who, whatever their behavior, have sex *on their minds*. The ad's tag line is that all people are who they are. This means that many behaviors exist and people have choices about which behaviors they practice. For example, some people are having sex, some people don't know whether they want to have sex, and some want to wait and are seeking reinforcement.

The ad tells adolescents that they are at an age when choices are important. The ad reinforces that it's okay for kids to be doing whatever they are doing. But it also emphasizes that *in this age of AIDS, they should be aware of the trade-offs*. The ad

tells kids that if they need information on protection, then they should get it. And if they want to wait to have sex, then that's okay too.

The commercial consists of a series of close-up shots of young people talking to the camera. One person is someone who is sexually active. The next is someone who wants to have sex, but wants more information first. Another is a young man who says he is having sex and protecting himself. And the last person—probably the reason why the ad wasn't taken off the air—simply says, "Look, I want to wait." The ad ends with the message, "Everyone is who they are. The choice is yours." The ad created no negative reaction, which is encouraging given the context of Mexico a few years ago.

Concerning the content of the message, there are a couple of key points. When we first wrote the script, we wrote it in the studios. But every time we tested it, it fell flat. We finally decided to capture how kids actually talk by going with the ad agency out on the street and conducting "man on the street" interviews. The actors we use appear very natural because we picked up their language almost verbatim and changed their words just enough to get the sentences we wanted.

Regarding casting, we wanted actors for this ad who looked younger than 18, but we couldn't use underage actors. Also, we wanted one actor who was attractive to young women, *as well* as to young men who are having sex with other young men. This was a tough casting call, so we just kept testing. We eventually found a young man to fill this role. Also, as I mentioned before, we did not use professional actors.

All of these decisions were research-driven. We've come a long way from just getting out the facts and information. I think we have made tremendous and significant advances in saying what we want to say and finding innovative ways to say it. For example, none of these ads says "*condom*" directly. But everybody knows—we know this from testing—that the ads are talking about condoms. The lesson is that we don't always have to state the message directly and maybe it's to our advantage not to.

A commercial's message and content must be tailored to the vehicle. Success in this area requires creativity. Our commercials are very well-produced: we had skilled camera people and high quality editing facilities. The commercials for both countries were produced entirely in those countries by local technicians.

Partners: Existing Health Institutions

Julia Rosenbaum

I have been working with AED since 1989 on various health communication projects, including breastfeeding promotion, diarrhea control, reproductive health, and HIV prevention. For the past 16 months, I've served as AIDSCOM's Resident Advisor to the Caribbean Epidemiology Centre, a World Health Organization (WHO) satellite center based in Trinidad, but serving the 19 member countries of the region.

AIDSCOM: Partnerships in Prevention

One of AIDSCOM's notable contributions has been bringing on new partners and preparing them for HIV prevention work. Today, I'll be speaking about our partners "in the field," not our subcontractors, who have served as a different sort of project partner.

AIDSCOM has had 101 formal partners. This total, however, underestimates how expansive and varied our partnerships have been. Some of our single partners actually have been coalitions of five, ten, and 20 affiliated groups. Also, we have had informal partnerships with many organizations through their participation in trainings and outreach activities.

Some of our partnerships have been with Ministries of Health, perhaps the most common counterpart for international health interventions. Others have been with commercial advertising agencies, which had never worked before with what they considered "marginal audiences" and "intangible products," such as reduced sex partners. Still others have been gay theater groups, labor unions, and Adventist youth choirs.

Earlier we reviewed the conceptual ABC Framework that has guided our interventions. Beyond this conceptual framework, AIDSCOM has not peddled a specific model for prevention activities. Instead, we have provided examples of others' work to help our partners define better what might work for them. Each partnership has required crafting and customizing activities. AIDSCOM technical assistance, then, has enabled our many partners to come up with their own answers to address their own problems.

Depending on the circumstances, AIDSCOM has provided ideas, skills, training, core support, credibility, networks, room to experiment and learn, and sometimes just a push to get started and keep going. In many international development projects, partnerships have been developed because these partners have been the most effective implementors of a centrally designed strategy. A distinct feature of AIDSCOM technical assistance has been that our partners have been involved in formulating as well as implementing their own interventions. These interventions, of course, have been compatible with overall AIDSCOM programmatic objectives, such as a primary focus on HIV prevention rather than patient care. But at the field level, our partnerships have been filled with surprises. Those of us who have been lucky enough to work with some of our more "nontraditional" partners have had an energizing and sometimes challenging experience as our counterparts' institutional personalities emerged during the planning process.

Looking back, our partnerships have consisted of two broad types of institutions with different needs for AIDSCOM technical assistance and support. Our first type of partnership has been with existing health institutions, and the second, with institutions new to health activities. I will talk about the characteristics of our partnerships with existing health institutions. Then, John Strand will follow with examples of partnerships with institutions new to health activities.

AIDSCOM Partners: Existing Health Institutions

Who have been the AIDSCOM partners—these organizations that, perhaps new to HIV/AIDS activities, had established mandates to work on health issues? These organizations fall under a number of categories, with several subdivisions within each category. They are as follows:

- Ministries of Health, most often through newly forming National AIDS Programs or existing Health Education Units.
- Multilateral Agencies, such as WHO and several of its regional centers. These centers include, for example, the Western Pacific Regional Office in the Philippines, the Caribbean Epidemiology Centre (CAREC) in the West Indies, and other United Nations agencies (for example, United Nations Development Programme, UNICEF).
- Family Planning Organizations, such as Planned Parenthood affiliates, local reproductive rights groups, private-sector workplace family planning projects, and groups such as Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM) in Brazil, the Caribbean Family Planning Affiliation in the Eastern Caribbean, the Indonesian Family Planning Association, and Asociacion Dominicana ProBienestar de la Familia (Profamilia) in the Dominican Republic.
- Universities, such as University of the West Indies and Makerere University.
- International Private Voluntary Organizations (PVOs), such as Save the Children

Foundation in Cameroon, CARE in Rwanda, OXFAM in the Philippines, and the Red Cross on every continent.

- Bilateral Agencies, such as the Swedish International Development Agency (SIDA), Canadian International Development Agency (CIDA), Norwegian Agency for Development (NORAD), and the British Overseas Development Association (ODA).
- Indigenous NGOs, whose work reaches from the gatekeepers to the remotest villages and most marginal target audiences. These include the Institute for Social Studies and Action (ISSA), Tanzanian Council of Social Development (Tacosode), CHS, FHI, Ikatan Dokter Indonesia (IDI), and groups such as the Traditional Healers Organization of South Africa.

All of the groups listed above were established health organizations that needed to expand their scope to include HIV prevention activities. Their mandate was to respond to key public health concerns. Most had technical expertise in the health arena and their own health promotion strategy and networks. They needed an appropriate and effective conceptual approach to HIV prevention work. For many of our counterparts, that meant learning to infuse new HIV prevention skills and concepts into existing programs and activities. Often, it meant mobilizing limited resources to address prevention work, which many groups considered intangible, unscientific, or politically volatile.

Although these groups already had been working on health issues, introducing HIV prevention as a focus area revealed gaps in the "sys-

tem" and within their organizations. Weaknesses in health services and health policy became more apparent and demanded attention. Therefore, AIDSCOM technical assistance addressed issues of accessibility of health services, testing, counseling, policy, confidentiality, and so on.

Improved Planning and Management

Through the AIDSCOM partnerships, many health institutions have learned an effective planning and management strategy that they can apply to any of their health activities. Often, the AIDSCOM partnership gave the institution its first exposure to knowledge, attitudes, beliefs, and practices (KABP) surveys and other formative research, pretesting, and materials development. Also, many organizations were exposed for the first time to adding a behavioral dimension to health education and prevention activities.

Specifically, AIDSCOM has offered the following:

- Improved planning and management
- Program design skills
- Research techniques and methodologies
- Materials development
- Training (in prevention counseling and condom skills)
- A model for personal and professional behavior regarding AIDS, sex, and risk

Perhaps one of the most essential components of AIDSCOM technology transfer has been working with our health partners to face the human dimension of HIV/AIDS. The idea has been to break away from talking about risk groups—gays, prostitutes, and junkies—and

focus on high-risk behaviors, to avoid the us/them mentality.

CAREC Collaborative Activities

It's difficult to come up with one example of a partnership to illustrate our more than 100 unique collaborative efforts throughout the world. I've chosen to talk briefly about CAREC, because it's the example that is closest to me.

I've just returned from a 16-month posting at CAREC, which is a WHO Satellite Center that is based in Trinidad and serves the 19 member islands of the largely English-speaking Caribbean. AIDSCOM's work with CAREC began in January 1988. This work began with ongoing, short-term technical assistance to a newly funded AIDS Communication Project that was located with the STD unit at CAREC. The AIDS Communication Project was funded by USAID's regional development office. It was staffed with talented and committed professionals who worked with national counterparts to develop national HIV prevention strategies and, at the same time, strengthen national information, education, and communication (IEC) capabilities.

One of the factors that led to our successful relationship with CAREC was the complete continuity of AIDSCOM staff contact. From 1988-93, one primary technical officer and a core group of technical specialists stayed in frequent contact through visits and phone calls. In 1992, advisory services were expanded to the fielding of a resident technical advisor. Over the years, our job was in short: to advise the advisors.

To encourage the development of effective HIV prevention programs, AIDSCOM focused

on improving the understanding and use of social marketing and behavioral research among regional counterparts. From the start, AIDSCOM provided opportunities to "learn by doing."

We worked side by side with CARE/C and CARE/C's national counterparts to develop a sub-regional KABP protocol for use in all 19 countries. Next, we guided its implementation in five of those countries and assisted with interpretation of the KABP results, which often is the stumbling block in this type of research process. Then, we strategized how to develop research findings into programmatic activities by producing national plans and multifaceted media interventions.

These programmatic activities included: 1) training health workers and HIV prevention counselors, 2) promoting improved condom skills, 3) establishing five national AIDS hotlines, 4) developing three national media campaigns, and 5) developing music, theater, and radio dramas promoting prevention. We also worked with CARE/C to develop contractual relationships with providers (for example, research firms, ad agencies) and, most important, how to manage these contracts.

In addition to working with national counterparts, AIDSCOM and CARE/C established relationships with local NGOs to reach audiences that were not accessed readily through the public sector health services. These NGOs organized their own spin-off activities, innovating on CARE/C's basic program in the region. I want to underscore that for WHO working with anyone but national government counterparts was a radical change. The success of these activities has been well documented through evaluation activities.

Through ongoing activities, the AIDS Communication Project at CARE/C grew in skill and in numbers. Beginning a few years ago, the AIDS staff started receiving requests from other CARE/C divisions for assistance with their communication and research activities. By the end of 1992, the formal bureaucracy was soliciting help from the AIDS project to expand communication capabilities beyond AIDS. At this year's annual scientific meeting, the bureaucracy formally adopted a recommendation to expand communication and behavioral research capabilities institution-wide.

CBI (Communication and Behavioral Intervention) became a household word to describe a new approach to prevention and health promotion activities. This institutionalization of the communication methodology was extraordinary and can be traced directly to the USAID regional office's vision of technical assistance, to the openness of CARE/C's management to accept new approaches, to the AIDS Communication Project's skill and dedication, and to AIDSCOMS's collaborative activities with CARE/C's AIDS project.

General Lessons

Through our collaboration with CARE/C and our other health partnerships, we can draw the following general lessons:

- Technical assistance can help health project managers shift program emphasis from information to behavior change.
- Carefully selected partnerships can produce innovative programs with even modest support from external advisors or donors.

- Demonstrated effectiveness can replicate itself in parallel programs.

In my opening, I outlined how our AIDSCOM partnerships have consisted of two broad types of institutions: the first type with existing health institutions, which I've just discussed, and the second with institutions new to health activities. John Strand now will explore partnerships with institutions new to health activities.

Partners: Institutions New to Health Activities

John Strand

While my background is in communication and education, I actually work in organizational and community development. Prior to working with AIDSCOM and AED, I had worked closely for 8 years with NGOs and community groups in Asia on a variety of development issues. In 1989, I began working with AIDSCOM's projects in Tanzania and Uganda. And in 1991, I became the

Asia and Near East Regional Coordinator for the last year of those programs.

AIDSCOM Partners: Institutions New to Health Activities

In almost every country, AIDSCOM has fostered partnerships with institutions that were new to health promotion activities. These institutions fall primarily into two broad categories: *those with specific technical expertise* needed for the design or implementation of HIV prevention interventions and those that I call *constituent groups*.

Included in the first category have been commercial research and advertising firms, as well as university-based research units. In every region, our collaboration with these agencies has left them with new skills in designing AIDS-related KABP surveys, behavioral analysis, message testing, and so on. In addition, AIDSCOM frequently has led to ongoing partnerships between these technical firms and NGOs, community-based AIDS action groups, and even government ministries. But AED already had known how to work with these technical agencies; in this regard, AIDSCOM hasn't been unique.

More than half of AIDSCOM's local partnerships around the world probably belong in the second category, constituent groups. I'd like to talk briefly about our work with these groups.

Constituent Groups

Constituent groups usually have been existing organizations that were active in other areas or embryonic groups formed primarily to engage in HIV prevention work. These have included

womens and gay groups, labor unions, professional or business associations, religious and youth groups, and so on. Some of these institutions—such as those that Lorraine described in the African workplace programs—have had hundreds and often thousands of members. Others have come about from two or three individuals with a passion to become involved.

These constituent groups have been important to AIDS HIV prevention work for a number of reasons.

First, these groups have had *established networks that serve communities* that often have been difficult to reach and most in need of services. As Kathryn noted, local health authorities often have had poor knowledge of and access to these communities and have been ill prepared to communicate effectively with them. The networks have helped us create understanding, respect, and trust. Also, these constituent groups already had a *people orientation*: they knew how to *"talk the talk."* They often have kept interventions focused on constituents' needs and adapted interventions and messages to make them more appropriate and credible.

In addition, these constituent groups have had *more than a professional interest* in HIV prevention. They had been driven to the work in response to the needs of their communities. Their passion and commitment often has kept them involved at times when there have been few support systems and even fewer signs of success.

Finally, for all of the above reasons, these constituent groups have tended to *assume ownership* of their HIV prevention activities quickly. Their ownership has greatly boosted the likeli-

hood of these activities continuing beyond AIDSCOM's involvement.

AIDSCOM's Contributions

Many constituent groups have had passion, commitment, and community networks but have lacked basic organizational, management, and technical skills. AIDSCOM has provided these groups with all sorts of *institutional development assistance*—from core support to management skills to strategic planning—much of which Julia mentioned earlier.

One example of this institution-building is AIDSCOM's support to establish the Remedios AIDS Foundation in Manila, which continues to operate the Remedios AIDS Information Center and the AIDS Hotline beyond AIDSCOM's support. In addition to providing seed funding to establish the Center, AIDSCOM has trained Center and hotline staff; assisted in setting up functional procedures; provided written and audio-visual materials and equipment; aided in forging linkages with Department of Health and other NGO's engaged in HIV prevention activities; and enlisted the participation of prominent local NGO and health leaders as founding members of the Remedios AIDS Foundation.

AIDSCOM also has offered all varieties of *training*; we always seemed to be assembling new information packets for training participants and stuffing more dildos into boxes of brochures, buttons, and of course *condoms*. In addition to AIDS 101, we have provided training in formative research, communication/social marketing for HIV prevention, program management, materials development, prevention coun-

seling, peer counseling, hotlines, evaluation strategies, and women and AIDS programming.

Many constituent groups have sought other things from their partnership with AIDSCOM—links to broader networks and information about what others were doing (for example, what worked, what didn't). In these cases, AIDSCOM has served as a *resource and referral service*, providing contacts, ideas, behavioral intervention models, and examples of new materials being developed. For example, AIDSCOM Spanish-language videos about counseling and universal safety precautions were developed and tested by representatives of several countries working together. AIDSCOM also has used third-country nationals as regional consultants—sending Mexican counselors to lead trainings in Ecuador and using Ugandan trainers for AIDS in the Workplace trainings in Tanzania and Swaziland.

These contacts, materials, and ideas often have triggered what may have been our most unique and important partnerships: those in which we have played more of a *catalytic role*. With some of the more entrepreneurial organizations, AIDSCOM's assistance—whether in seed funding, training, materials, or linkages—has turned out to be just what the respective groups have needed to launch their own HIV prevention programs.

In Jamaica and Indonesia, some seed funding and technical direction jump-started two innovative HIV prevention programs. With a little support from AIDSCOM and the Ministry of Health, a new local NGO called Jamaica AIDS Support initiated a comprehensive peer educa-

tion program for gay and bisexual men. The group then created theatrical and musical productions that delivered HIV prevention messages to general audiences.

In Indonesia, some discrete AIDSCOM technical assistance and a small subcontract enabled Hotline Surya in Surabaya to develop new HIV prevention peer counseling and outreach programs for its youth networks. The hotline's youth volunteers launched peer discussion groups in their schools, while the hotline staff helped local health authorities develop HIV confidentiality policies.

AIDSCOM assisted MHOL, a gay rights NGO in Lima, in designing a KABP questionnaire about condoms and condom use. MHOL then contacted a research firm, conducted surveys of both the general population and gay and bisexual men, and published the findings in a book—all without further AIDSCOM assistance.

In January 1992, AIDSCOM conducted an HIV prevention counseling training workshop for staff from 12 NGOs throughout the Philippines. Within 6 months, two new hotlines had been formed in Baguio and Cebu. Also, another participant in Davao launched a program that engaged bar hostesses in innovative HIV educational dramas and condom promotion skits *in their bars*. Again, none of these used further AIDSCOM support.

For some constituent groups representing more marginalized communities, AIDSCOM has offered needed *linkages and credibility* with other collaborators or donors. This was true in part with Fundacion SOGA, a dynamic gay men's NGO in Ecuador, which has since proven its

capabilities and become well-connected. Also, in Indonesia, the Transvestite Association of Surabaya struggled for 2 years to be seen as more than a convenient high-risk group for seroprevalence studies. AIDSCOM assisted the Association in developing a successful proposal for the WHO/Global Programme on AIDS (GPA) Partnership Programme. Its peer outreach and [illegible]n promotion program now has been under way for more than 6 months.

The opportunities we have had to work with our many partners in Africa, Asia, Latin America, and the Caribbean have provided all of us with our most important and powerful project experiences. I highlighted a few of those experiences here; my AIDSCOM colleagues could each offer many more.

Lessons About Local Partnerships

AIDSCOM has found local partnerships to be invaluable for several reasons.

First, they have enabled us and our programs to remain centered on, and to engage, real people as actors who make behavioral decisions and who influence others to do the same. Our partners have reminded us constantly that our work is really about their lives, families, and communities and tapping the strength of those bonds.

Second, they have increased the likelihood of successful innovation. Our partners have offered us access to and an understanding of those many "cultures within the culture." In addition, they have been driven to push the boundaries of what is socially accepted, to challenge prevailing norms, fears, and prejudices.

This is a thankless but unavoidable aspect of effective HIV prevention work.

Finally, local ownership of the HIV prevention activities will keep this important work alive. The dozens of African, Asian, and Latin American institutions, agencies, and community groups that now are active and equipped with skills and experience in HIV prevention work may be AIDSCOM's most lasting and important contribution.

Unique Materials

Ann Jimerson

As a communication project, AIDSCOM has produced colorful, attractive, compelling, and even outrageous materials. For the past 15 years, I have worked on development communication, on A.I.D.-supported projects and on projects with other funding sources. I have worked on and studied *a lot* of IEC materials. At one time, I was Media/Materials Coordinator at the

Johns Hopkins University and had my hands on just about every family planning material produced worldwide. So I know quite a bit about materials.

In many respects, AIDSCOM's materials don't seem to be much different from those that have been developed in the past 20 to 30 years of A.I.D.-supported health and family planning communication programs. After all, the methodologies that we have used were built upon tried and tested techniques. Yet when I joined AIDSCOM in early 1990, I was stunned. It seemed to me that the project had broken through some limits and pushed models and strategies further than they had been pushed before. I'd like to argue that AIDSCOM's materials are indeed different and tell you about some of them.

The Program Planning Cycle of the ABC Framework

Materials that are developed through any sound communication program share a fundamental characteristic: they are conceptualized, drafted, pretested, created, and their use is monitored through a planning process that demands structured interaction with members of the target audience at critical steps in the development process. AIDSCOM always has applied the widely accepted, rigorous program planning cycle of the ABC Framework to developing materials.

Messages Based in Theory and Research

AIDSCOM's approaches and messages are firmly based in behavior theory and research. For example, the project conducted early

research on condom skills and the relationship of skill and self-efficacy to behavior. We have developed training manuals, pamphlets, and comic books to teach condom use skills. These materials can be used alone or with face-to-face demonstrations of condom use.

For example, we created the *Mario* comic for use with sexually active male sugar mill workers in the Dominican Republic. The comic combines three theory-based approaches designed to increase intention to use condoms. We produced the comic from materials used in an experiment that tested the relative effectiveness of interventions based on perceived social norms, skills, and perception of risk. Susan will describe the findings of the experiment later.

Developed by Audience Members

AIDSCOM materials often have been developed by members of a target audience. Generally, this means that representatives of the target audience have participated in specific steps. For example, we involved the audience to develop our *Los triunfos de Maritza* comic, which we created for commercial sex workers in the Dominican Republic. The artist drew sketches for the comic and left the dialogue bubbles blank. Then, project staff helped the peer educators, who were sex workers, write the script. This is typical of the audience involvement that has taken place in many of AIDS communication projects.

What happens when the "participatory" model goes further, and members of the target audience take nearly complete responsibility for materials development?

Fundacion para la Salud, Orientacion General y Ayuda (SOGA) in Ecuador was a newly formed group of gay men. Among the founding members was a physician. SOGA designed a small study to assess the information needs of men who had sex with men and of physicians who may treat men at risk. With AIDSCOM technical assistance and funding, SOGA used the findings from the two studies to develop pamphlets for the men who had sex with men and a physicians kit with information about HIV/AIDS, sexuality, homosexuality, STDs, and prevention counseling. Thus, the NGOs leaders, who also were members of the two target audiences, conducted the research and developed and pretested the materials, with only long-distance technical assistance from AIDSCOM staff.

Reaching Newly Defined Audience Segments

As Kathryn pointed out, AIDSCOM further segmented the populations we first looked at. AIDSCOM materials reflect some interesting "new" audiences. These include:

- commercial sex workers in Mexico who are swayed by appeals to the need to stay healthy for their children;
- commercial sex workers in the same community who are more likely to be persuaded to protect themselves and their sexy images;
- monogamous married women (while this group is a typical audience for other health-related materials, women who were not sex workers got little attention in the early years of HIV prevention programs);

- married men who stray, as in the Dominican Republic;
- openly gay men, and
- men who have sex with men but don't identify with "gay" messages.

Acknowledging Sex and Relationships

A number of AIDSCOM materials express the reality that sex is about relationships and even that sex is sexy. If the proverbial "martian" had visited me in 1985 and studied all of the family planning materials that used to pass my desk, she could have concluded that family planning was about small, happy families and smart thinking. At least one pamphlet on periodic abstinence directed husbands to play dominoes on those fertile days rather than engage in potentially reproductive activities. These materials often treated family planning decisions as a rational and unilateral process and ignored the complexity of interpersonal relationships, the power balance between the sexes, and the driving blindness of attraction and lust.

AIDS contractors had lived for years under a reign of caution, and family planning associations were in no hurry to break through the modesty. AIDS has forced us out of that mold. Today, many AIDS project materials reflect that HIV/AIDS is about sex and that sex is about relationships, passion, power, money, fear, sensuality, and sometimes even fun.

An AIDSCOM project in a red light district in Rio de Janeiro, Brazil, promoted condoms in a style that was appropriate to the setting with drawings of seductive women tempting men to

use condoms. The "*Maruza*" comic in the Dominican Republic features the character "*Maruza*," a role model for sex workers who skillfully and sometimes deviously negotiates condom use with her customers.

Carrying Innovative Models Overseas

AIDSCOM has carried some innovative models developed to address HIV/AIDS in Western countries to the countries where we were working. People who had worked in developing countries and experienced the frustration of telephone systems doubted that many countries could operate hotlines or that people in societies without a history of hotline counseling would call a stranger for information or counseling. Yet hotlines have worked throughout Asia, Latin America, and the Caribbean and in at least one African country, as people sought anonymous ways to talk with someone about their fears and struggles with behavior change and HIV prevention.

Another new concept has been counseling, not just to comfort people who are infected, but to help people design a personal plan to protect themselves from HIV infection. Counselor training materials developed in Latin America and the Caribbean and in Uganda and Zambia have helped promote HIV prevention counseling techniques worldwide. In fact, the first AIDSCOM counseling training guide, which was developed in the Caribbean, was most recently used in south China to train health care workers and health educators.

Useful Across Borders

Many AIDSCOM materials have proven to be useful across borders. I thought I had seen everything in condom brochures before I joined AIDSCOM. I had seen vague ones and explicit ones, cheery brochures and many that were frankly gross. The AIDSCOM brochure outclasses them all. Straight men and women presume that its made for them. And gay men swear that it depicts two gay men. Its inoffensive and people on every continent seem to accept the gray skin tones as *their* skin tones. Also the written instructions are brief and clear.

Audiences agree that this condom use brochure, which originally was developed in the Caribbean, has been popular in AIDSCOM programs in all regions. A Peruvian NGO reprinted it with its own funds after running out of copies provided by AED; the group distributed more than 100,000 copies. A Peruvian newspaper reprinted the entire brochure. Also, the condom brochure served as a prototype for another brochure developed for WHO's Global Programme on AIDS. The brochure has appeared in local versions in many countries. During a recent visit to India, an AED staff member discovered a small gay NGO that had adapted the graphics and layout and developed their own version. City health programs in Birmingham, Alabama; Boston, Massachusetts; and Washington, DC, printed and distributed tens of thousands of copies with their own program logos. The DC program used AIDSCOM's English and Spanish brochures *and* produced a version with three Asian languages. When people call me now for ideas on how to develop a condom

brochure. I ask: "Why bother?" This material certainly will outlive AIDSCOM.

AIDSCOM developed Spanish-language training videos in collaboration with a video production company in Guatemala. AIDSCOM staff and consultants pretested the scripts in three countries to ensure that terminology and vocabulary were generic enough to use in all Spanish-speaking countries. Discussions with Brazilian health care providers revealed that the messages were appropriate and needed there too, so the videos were dubbed and the accompanying print materials translated to Portuguese. These materials are now being used throughout Brazil.

It's Not Easy, Africa's first feature film on AIDS, has been wildly popular and effective worldwide. The film has been translated to French and Swahili, and an international track has allowed countries to dub the film in languages such as Ndebele, Shona, Zulu, and Portuguese. *It's Not Easy* has been broadcast on television throughout Africa and in Jamaica. It also is popular throughout the Grenadine Islands and the Eastern Caribbean. It has been tested widely in the United States, where it has been found to increase knowledge and change attitudes with all races, especially African Americans. As Lorraine noted, the evaluation of the Uganda workplace integrated strategy demonstrated that the film had been an invaluable component.

Providing Impetus, Focus, and Quality

When AED staff and contractors first visited the countries where we had planned to work, we found that people in the field were hungry

for information about HIV and AIDS. In the early days, we borrowed existing articles and materials and sent them to colleagues, often translating them to Spanish or French. As the project developed its own IEC materials, we found that the materials guided and supported national HIV/AIDS programs and provided impetus and focus for newly mobilizing NGOs. Instant materials enabled groups to proceed with services even while program plans were under way. Having AIDSCOM as "central supplier" ensured quality and technical consistency.

Broadly Disseminated

Through its AIDSCOM contract, AED has distributed hundreds of thousands of materials. In addition to IEC materials, the project has provided countries with multiple copies of existing technical articles, books, and journal articles about HIV/AIDS or communication methodologies. AIDSCOM has published monographs to disseminate research findings and lessons learned in the field. Colleagues have responded enthusiastically to the occasional papers series that reports research study results and to *Preventing AIDS: Strategies that Work*, a series of practical field notes from the project. AIDSCOM's public health communication manual *A World Again: AIDS Communication for Behavior Change* presents diverse applications of the AIC Framework and communication methodologies through examples from AIDSCOM's experience.

We have made our materials widely available. They are based on sound research and have proven to be effective and useful in many settings.

Research Lessons Learned

Susan Middlestadt

During the 6 years of AIDSCOM, we have worked with colleagues in the field of international HIV prevention to conduct more than 100 research studies. Some were qualitative and others quantitative. They included formative research to design interventions, experimental studies to pretest them, and impact evaluations to assess changes in behavior. Small studies involved 20

to 50 participants; large studies, thousands of participants. We used interviews, self-administered questionnaires, observations, and focus group discussions; we stopped people on the street, at work, in schools, in stores, and at home.

Our research activity has been guided and organized by the ABC Framework, which I talked about earlier. This framework has helped us work collaboratively and coordinate the lessons that we have learned. We have found that the key to research and theory based intervention design is continual collaboration and contact between researchers and program managers and between the United States and the field. The ABC Framework has helped us coordinate our work by giving us a common vocabulary.

A common theory-based conceptual framework such as the ABC Framework not only contributes to effective program design, it is critical to efficient evaluation and program replication. It enables the evaluator to discover not only that a program changed behavior, but potentially how or why the behavior changed.

Three Evaluative Lessons

It is impossible to present or even summarize all of our research findings in the time I have today. So I will focus on three evaluation lessons from our more rigorous quantitative studies. I believe these lessons are consistent with what other international and domestic researchers are finding. They are as follows:

1. Risk behavior is decreasing slowly in some key populations. Evidence indicates that the decrease is at least partially due to A.I.D.-funded interventions and programs.

2. Social norms are a key determinant of sexual risk behaviors and can be influenced with communication interventions.

3. Interventions that influence skills encourage safer sex practices.

I have chosen some studies and some data to support these points. I will discuss illustrative findings only. I will examine impact sometimes by discussing changes over time and sometimes by comparing exposed to nonexposed. In all cases, we have conducted our analyses both ways, and the results have been similar.

I will not be able to provide the details of the reports with the full findings, the inferential statistics, and the analyses that demonstrate that the findings are attributable to the interventions. These reports have been published elsewhere including *A World Against AIDS: Communication for Behavior Change*.

Condom Strategies: Dominican Republic

Condom Brochure

One of AIDSCOM's key products was a condom brochure, called *Protect Yourself: The Right Way to Use Condoms*. The brochure was based on a series of research and intervention projects.

First, our observational studies of sex workers in the Dominican Republic revealed that these women had never touched or used a condom. These studies helped us determine the simplest steps for using a condom. Through pretesting research, we developed and sequenced illustrations for these steps, which we used in the brochure.

Also, we adapted the instructions for condom use that we had developed in Latin America and the Caribbean for use in other countries. For example, we found that the illustrations needed to be less abstract and more explicit in Tanzania.

In addition, we used an observational instrument to enable us to systematically assess condom use skills using an artificial penis.

Studies showed that skills could be increased with live demonstrations as well as with the brochure alone. The key question, of course, was: "What is the impact of increasing skill on behavior?"

Comparing Interventions: *"Mario"*

In the Dominican Republic, we conducted a field experiment to examine the role of skills interventions in facilitating condom use. This study also enabled us to compare the effectiveness of a skills intervention with interventions designed to influence two other internal determinants: social norms and perceived susceptibility.

We conducted the study with 300 sexually active men who worked in a sugar mill in Haina, the free zone of the Dominican Republic. We developed, pretested, and revised three interventions to encourage these men to use condoms. All interventions used the main character of "Mario," a *figre* (the Dominican term for a "stud"), and were presented with a flip chart and audiotape.

Skills Intervention

The skills intervention was designed to increase the skill of putting on a condom cor-

rectly. Using a beer bottle in a bar, Mario demonstrates how to put a condom on and verbally reviews the correct steps.

Social Norm Intervention

The social norm intervention attempted to influence the social pressure that the men perceived from their female partners. Mario overhears his girlfriend telling her friend that she wants to use a condom.

Susceptibility Intervention

The susceptibility intervention addressed the men's perceived susceptibility to HIV infection. Several men on the beach discuss the fact that men in the Dominican Republic and particularly in Haina have to worry about HIV. Also, a health professional describes the statistics.

Experimental Design

We selected the 300 men from the employment rolls of the factory. They came to the study room and were randomly assigned to one of five study groups: control, susceptibility, norm, skills, and combined (norm and skills).

Those assigned to the control group received no intervention. They were just interviewed immediately and then once again 2 to 3 weeks later.

Those assigned to the susceptibility group were shown the susceptibility flip chart, flipped by the assistant as the audiotape with the text played.

Those assigned to the norm group were exposed to the norm intervention, and those assigned to the skill group were exposed to the skills intervention.

Those assigned to the combined group were exposed to both the norm and the skills interventions.

Immediately after the interventions, all participants were interviewed by a different interviewer about their condom use and their attitudes, beliefs, normative beliefs, actual skill, perceived skill, and intentions regarding condom use. To assess impact on behavior, the participants were asked to return 2 to 3 weeks later for a delayed post-test.

Impact on Intention

The analyses of the immediate post-test results revealed that some of the interventions affected the intentions of the men to use condoms with their steady partners. Their intentions to use condoms with pickups and commercial sex workers already were quite high.

Compared to the control group, which received no intervention, the mean intention to use a condom with a steady partner was higher for three of the study groups: the group exposed to the combined (norm and skills) intervention, the group exposed to the skills intervention, and the group exposed to the susceptibility intervention. In contrast, those exposed to the norm intervention did not differ in intention from the control group.

Impact on Observed Skill

We also examined the impact of the interventions on the determinants of behavior. The skills intervention had the greatest impact on actual skill (assessed by observing the participant place a condom on an artificial penis).

Impact on Perceived Skill

The skills intervention (both alone and with norm) had the greatest impact on a measure of self-efficacy, the perceived skill at putting on a condom under any circumstance.

Almost across the board, the skills and combined (norm and skills) groups had more positive results than the control group. The group that received the norm intervention did not differ from the control group, and the susceptibility group differed only sometimes from the control group.

Impact on Behavior

The analyses of the delayed post-test enabled us to examine the impact of the interventions on behavior. To assess behavior, we used a behavior grid. The men were asked the following questions about each of the previous 14 days: Did you have sex? What were the initials of your partner? Did you use a condom? and Did you have any other partners?

From these data, we constructed an index of the percentage of condom-protected sex acts. Let's consider the impact of the interventions on a subset of the men, those who reported having sex with more than one partner. We created a graph to indicate, for each of the study groups separately, the percentage of condom-protected sex acts for the immediate and delayed post-test. The results were as follows:

- For the control group, condom use dropped in the period between the immediate and delayed post-test.
- Condom use decreased in the susceptibility group. Thus, the susceptibility intervention had no effect on behavior.

- Condom use stayed the same in the norm group and in the skills group, but this similar percentage represents an increase compared to the control group.
- Condom use increased in both an absolute and relative sense in the combined (norm and skills) group.

Therefore, it seems that the skills intervention alone and in combination with the norm intervention increased condom skill, intentions, and behavior.

Mass Media Programs: Philippines and Eastern Caribbean

A number of AIDSCOM programs were integrated communication programs with significant mass media components. I will be describing the results of two of these programs which were directed at youth. One was developed in the Philippines and the other in the Eastern Caribbean.

Philippines: *"Barkada"*

In 1990, AIDSCOM ran an initial general population campaign (including young adults) in metropolitan Manila. The objective of that campaign was to correct myths and increase knowledge about HIV prevention. We ran a second campaign in Manila that was targeted to young adults. This campaign was called *"Barkada."*

The level of sexual activity among young adults ages 18 to 24 in the Philippines was low, particularly among women. Specifically, 55 percent of the young men and only 9 percent of the young women had had sex.

Thus, our intent was to give the audience permission to not have sex—to tell them that they could wait until marriage and that they should think and talk about it first. Another message for the young men was that they should use a condom if they were going to have sex.

Evaluation Plan

To evaluate this campaign, we conducted and compared KABP surveys of two samples of 300 young adults ages 18 to 24. The surveys assessed knowledge, attitudes, and beliefs with five-point agree/disagree items and behavior with a closed-envelope procedure. We conducted the baseline survey in January 1992 and the follow-up in July 1992. The campaign ran from February to April 1992.

Recall Scores

The recall scores for the campaign were as follows: over 60 percent of both men and women recalled the tagline, "AIDS. *Think about it. Talk about it.*" Over 20 percent recalled the copy and approximately 60 percent recalled the situation for the "Virgins" spot. For the "*Locker Room*" spot, only a small percentage recalled the copy and about 20 percent recalled the situation.

Impact on "Wait until Marriage"

We did not expect to demonstrate an impact on risk behavior. Basically, detecting an impact on delay of intercourse is difficult and involves a longer time frame for the intervention and the evaluation.

There is, however, strong evidence that the campaign had the expected impact on some of

the key internal determinants of risk behavior, particularly for the young men.

We measured the amount of agreement with two beliefs about waiting for marriage at the time of the pretest and again at the post-test. The two beliefs were: "It's important for guys to get experience with sex early," and "It's okay for guys to wait to have sex until they're married." Surveys showed increased disagreement with the first belief and increased agreement with the second belief during the time period between the two tests.

We found similar results with other beliefs. In sum, there is evidence that the campaign affected beliefs about the acceptability of the behavior of delaying initiation.

Eastern Caribbean: *"Parents and Youth"*

In the Eastern Caribbean, our *"Parents and Youth"* campaign was directed at youth and explicitly mentioned condoms by working through parents.

We conducted extensive formative research using national KABP surveys of representative samples of the national populations of several Eastern Caribbean countries. Analyses of these surveys revealed that the major cognitive predictor of condom use was perceived social norms. This suggested that influencing perceived social norms was likely to increase condom use.

Qualitative data from focus groups with parents and youth revealed that these norms included not only norms from friends and partners but also norms from parents. Therefore, as a

first phase, we designed a "*Parents and Youth*" campaign to help parents recognize that many teens were sexually active, to facilitate discussion, and to suggest to parents that condoms could protect them when the parents can't anymore. The campaign reached parents with the slogan, "When you can't protect them anymore. . . condoms can!"

The campaign ran for several months in St Vincent. At the end of the campaign, 100 parents, 100 teens, and 100 other adults were interviewed. Those who indicated they had heard a campaign on HIV prevention, on the radio, and on the topic of condoms were considered exposed. Using this definition of exposed, 72 percent of the sample was exposed to the campaign.

Comparing the exposed group to the nonexposed, the campaign clearly had an impact on perceived social norms. We asked the exposed and nonexposed groups (whether they believed that others (partners, friends, and parents) think they should use condoms. The percentages who believed that others think they should use condoms were higher among those exposed to the campaign than among those not exposed. The differences were statistically significant for perceptions of pressure from friends and partners.

From these and other studies of integrated communication campaigns, we have found that we can influence some attitudes, beliefs, and normative beliefs. While these are not behaviors, ample evidence indicates that they are internal factors likely to function as determinants of safer sex behaviors.

Behavior Change: Africa

Evidence exists that risk behavior is changing and can be influenced. I have chosen some examples from Africa: the workplace intervention in Uganda, the Salama Condom social marketing program in Tanzania, and the "*Get Protection*" campaign in Ghana.

Uganda: Workplace Intervention

The results of the evaluation of the Uganda workplace program were presented earlier. To summarize, the intervention was an integration of several components, including formal talks, interactions with peer educators, and the dramatic film *It's Not Easy*.

Susan McCombie of the Annenberg School for Communication, University of Pennsylvania, demonstrated that exposure to the workplace intervention was associated with change in internal factors, particularly knowledge about latency and perceived social norms. The percentage having correct knowledge about the latency period and the percentage believing that others use condoms was higher the heavier the degree of exposure to the workplace program.

In addition, there is clear evidence that safer sexual behavior increased. The percentage of sexually active adults using condoms was higher the heavier the degree of exposure to the intervention.

Therefore, we have learned not only that workplace programs could be implemented in Africa and that they could facilitate change in risk behavior, but that the active ingredients in facilitating this behavior change were a better understanding of HIV infection and social norms.

Tanzania: *Salama* Condom

One factor that inhibits condom use, particularly in Africa, is the lack of availability of condoms. In Tanzania, AIDSCOM implemented a condom social marketing program to develop, distribute, and promote a new brand of condoms, the *Salama* condom.

We used a local research team to gather information on the availability of the *Salama* condom in three outlets at three different time periods, separately by zone of Dar Es Salaam. The outlets included pharmacies, shops, and what we called leisure outlets (bars, clubs, and hotels).

We gathered data on the percentage of outlets carrying condoms in the eight outer locations of the city, for the three time periods. We distinguished between those outlets carrying any type of condom and those carrying the new *Salama* condom.

Our data showed that the percentage of pharmacies carrying the *Salama* condom increased as expected in the first year of the program. More important, evidence indicated that more shops were carrying not only the *Salama* condom, but also any brand of condom.

In tandem with the outlet audit to assess availability, we conducted a consumer intercept survey of adult males at these outlets to assess impact on behavior. Across the board, there is evidence of increased use of the *Salama* brand. More important, there is preliminary evidence in the males who were intercepted in the outer shops of increased condom use in general.

This research demonstrated that the availability of the *Salama* condom and of condoms in

general increased in three ways: by being available in more outlets, by being available in shops as well as pharmacies, and by being available in more zones of the city. Further, preliminary evidence supports our hypothesis that intervening on a structural factor by increasing availability facilitates behavior change.

Ghana: *"Don't Be Careless, Get Protection"*

In Ghana, the integrated communication campaign emphasized the need to "get protection" and encouraged or gave people permission to wait to have sex. The campaign made use of radio, television, print, and school outreach programs.

This campaign was assessed with a large-scale impact evaluation in two areas of Ghana. Baseline data from a representative sample of about 1,500 15- to 30-year-olds were collected in July 1991 before the campaign and again in July 1992, after the program.

We collected data on the percentage of sexually active people using a condom in 1991 and again in 1992. Among those who were unmarried or who reported they had more than one partner, the percentage of condom use increased significantly.

The Ghana campaign had a unique impact on "noncondom" risk behavior—that is, on initiation of sexual activity. There is some evidence that the campaign increased the age of sexual initiation. In addition, data show that sexual activity among 15-year-old females decreased significantly.

Summary

I'd like to review my main points about the fundamental research lessons that we learned through AIDSCOM's HIV prevention work.

Understand Behavior First

First, when developing interventions, it is better to begin with an understanding of the behavior rather than with assumptions about the type of information people need to change their behavior. Research on the external and internal factors that facilitate and inhibit behavior with a particular population of interest can be used to identify promising intervention points. Then, communication and other social marketing techniques can be used creatively to result in effective interventions.

Second, while the findings differ from population to population and from country to country, I believe that in the domain of HIV prevention, there are two particularly promising intervention points: skills and social norms.

Skills

Skills are the first important intervention point. Interventions that increase skills also increase safer sexual behaviors.

It's important to consider both actual and perceived skills. A person needs to know how to perform a behavior as well as to perceive that he or she can.

In addition to physical skills (for example, using and buying condoms), social skills are important. Social skills include communicating and negotiating for safer sex. Negotiation involves verbal and nonverbal communication. Because sexual behavior involves two people, we

need interventions that help people learn how to influence each other effectively.

There is clear evidence that skills—both actual and perceived, both physical and social—are related to behavior. Increasing skills facilitates behavior change. Further, skills can quite easily be developed.

Social Norms

Social norms, both perceived and actual, are a second important intervention point. Perceived social norms refer to our perceptions about whether others who are important to us think we should engage in a behavior. For example: Do most people who are important to us think we should use condoms? and Who are the important people in this domain?

The perceptions of men and women about their sexual partner's expectations for condom use and response to suggesting or asking for safer sex behaviors are major barriers to encouraging them to use condoms. We often need to remove these barriers.

Other factors that influence condom use include a person's perceptions about the beliefs of friends and relatives, a partner's friends and relatives, and health and religious professionals.

Sometimes people's perceptions of social norms accurately reflect actual norms; sometimes not. Sometimes the public's perception of what others are doing and want lags behind our understanding of the norm, which is based on research.

As I have shown, the evidence indicates that perceived social norms are related to risk behavior.

Social norms can be changed with public communication, and influencing social norms can facilitate behavior change. Risk behavior is changing, but it is changing gradually. We must be modest in our expectations of the time and effort necessary for sexual behavior to change.

There is some evidence that we can facilitate these changes with a variety of communication and other marketing interventions that involve integrated strategies and are based on formative research, tested with research, targeted to segments of audiences, and developed with sound program planning processes.

AIDSCOM THEMES REVISITED

ANN JIMERSON
FOR MICHAEL HUBQUIST

I mentioned at the start of this briefing that AIDSCOM staff had worked to "encapsulate" our experience on the project into five main themes. I'd like to close now with a few words about each of these themes, stressing why they are important to us.

People are at the center.

Simply stated, AIDSCOM has put people at the center of our work. The ABC Framework—as any sound communication effort—places the client, consumer or target audience in the center. Using formative research to develop a realistic profile of a "typical" member of the audience keeps programs on target. But AIDSCOM has gone further than that.

AIDSCOM staff and consultants have been committed to fighting a virus and prejudice and ignorance—all necessary public health strategies. AIDSCOM has brought the human dimension of the disease home. Several of us who came to AIDSCOM from other development programs have felt the difference: our relationships with the people on the forefront of HIV/AIDS work in their countries have been powerful. Our field colleagues have been courageous and enterprising people who continually have reminded us that HIV/AIDS is about people and can't be dealt with in the laboratory, at the computer terminal, or in management meetings alone.

Partnerships are critical.

Development work at its best has always relied on building partnerships with developing country institutions. As we described earlier, AIDSCOM sought and formed partnerships with new kinds of organizations, often developed by marginalized populations that usually are not included in development programs. We often have been primarily catalysts, providing the moral support and technical guidance to set things in motion. We have lent a hand as communities have organized themselves, taken what

they needed of what we offered, and advanced on their own to develop needed programs. Project staff have developed balanced relationships based on trust and respect with people in the field to form true partnerships in creating HIV prevention programs.

Innovation is the best guide.

AIDSCOM has helped change the way that people look at the problem of HIV prevention and behavior change. The project has sometimes stood conventional "development" wisdom on its ear, accomplishing what has seemed unlikely. We had heard the following:

- "You can't set up hotlines in countries where the phones barely work."
- "Homosexual men in Latin America won't identify themselves to you, and certainly won't risk sitting down at a table with government authorities."
- "People with HIV or AIDS will never go public and become HIV prevention advocates as they have in the West."
- "African men *won't* use condoms."
- "You can't conduct national surveys on sexual behaviors."
- "You can't use public funds to talk with people about sex and relationships."

However, we have found through trial and error that when we have challenged conventional wisdom and risked trying something new, we often discovered creative opportunities for change.

Begin with behavior.

A.I.D. established AIDSCOM with a significant research orientation. Often, the project's

earliest in-country activities involved basic formative research. AIDSCOM began, as we mentioned earlier, with state-of-the-art models for developing communication programs and moved those ahead to incorporate findings from behavior change research.

The project's work also has helped our developing country partners shift from using communication to dispense information to applying communication to effect behavior change. After a few years of effort, we became more focused on applying sophisticated behavior theories to analyze much of the data we had collected. We recognized the power of social norms and of skills in HIV prevention. The project's work in behavioral science confirmed what many had thought from the beginning: AIDS would not be "solved" just by perfecting our condom supply logistics or lab work or epidemiologic data. AIDSCOM data helped demonstrate that loading condoms onto helicopters wasn't the whole solution.

The thoughtful application of behavioral research has taken us to a different level of understanding. It has helped us look at how individuals can change personal and often irrational behavior and has helped us find ways to facilitate that process.

AIDS is different.

More so than with most other health problems, HIV/AIDS has demanded that we deal first with ignorance, fear, and prejudice. Time after time, these three elements have become obstacles to programs, interventions, and research. They don't go away by ignoring them, and they

usually reappear even after we think we have dealt with them.

To effectively counter ignorance, fear, and prejudice, we must confront and understand how we each—whether as scientists, programmers, or managers—harbor some of these feelings and traits. So, first there is the problem of stigma. Also, there is the problem that preventing HIV transmission is not a one-time behavior. And, helping an *individual* change is not sufficient, since HIV prevention requires the cooperation of *both* sexual partners. AIDS also is different because the politics, the social climate, the "high profile" of the epidemic, and the ever-expanding "AIDS industry" demand so much of our time and energy. And many of us live with the reality of HIV/AIDS every day, as we see or hear of friends and colleagues, perhaps even ourselves, who struggle to live with HIV or AIDS.

Although AIDSCOM has emphasized behavioral research, we should all be cautious not to let a research agenda be the sole focus of our efforts in HIV prevention. And, although we do need to understand behavior better, we must remember that our ultimate goal is to slow HIV and STDs. There are programs and interventions *ready* and *tested* now that don't require extensive research and have been shown to be effective. We have a responsibility to continue to use and apply what we know and build on *that* foundation the programs of tomorrow.

The Importance of AIDSCOM

Melody Trott
Behavioral Research
Advisor, A.I.D.

I would like to tell you briefly what I think AIDSCOM has brought to A.I.D.'s HIV prevention program. There are, I think, three points.

From the start, from our perspective at A.I.D., AIDSCOM has been fully and deeply committed to the idea of behavior change and the importance of talking about sex. That's pretty old hat now, but it wasn't old hat in

1987 and hasn't been old hat through the life of this project.

I inherited what I like to think of as the "complaint file" from Jerry Meyer and some of my other predecessors. It is filled with letters from people complaining loudly and at length about all of the terrible things that AIDSCOM has done in developing countries. The importance of AIDSCOM's focus, however, was reinforced by the last international AIDS meetings in Berlin. It was clear that the medical community still doesn't have much to offer us and that, for the long term and the short term, behavior change is the best we have to combat this disease.

My second point is that AIDSCOM has pioneered for us many of the communication technologies that are now standard tools for HIV prevention in many developing countries. These technologies started or were perfected right here. They include hotlines, audience segmentation, prevention counseling, condom skills training, and many others.

Third, from my perspective and I think from the Office of Health's perspective, AIDSCOM always has had a very special and unique sense of urgency and commitment to HIV prevention. Many of the original staff came from San Francisco, which was the heart of our own epidemic. They knew this enemy personally. They knew what it would do. They managed to transfer this sense of urgency to their colleagues. Throughout this project, they brought a very special energy and passion to AIDSCOM's work.

Michael Ramah said earlier that the words "*It's Not Easy*" stand for a lot of things in this project, and I think that's really true. The work

has been hard for all of us and I know it's been discouraging. But implementation of this project also has been exciting for all of us, to say the least. We've been blessed with some wonderfully talented people. And we've been blessed on both sides with some very strong personalities. I think with a great deal of affection about those AIDSCOM and A.I.D. staff who were always mediating, calm personalities in what was often a maelstrom of different ideas. The personalities involved, in fact, have given AIDSCOM what all project managers tend to think of as its "project personality." When I close my eyes and think of AIDSCOM, I think of a project that is really bright, fractious, a little impulsive, but always really creative.

In the end, I think we all can say that AIDSCOM has really done its job—and done it well in 22 countries. But more than that, AIDSCOM has defined for us a lot of previously uncharted waters. It's done it fearlessly and many times flagrantly. AIDSCOM has kept us thinking, and it's pushed the envelope. It's pushed it hard. It's taught us a lot.

APPENDIX: ABBREVIATIONS

AED, Academy for Educational Development

A.I.D., Agency for International Development (U.S.)

AIDS, Acquired Immune Deficiency Syndrome

AIDSCAP, AIDS Control and Prevention Project

AIDSCOM, AIDS Technical Support: Public Health Communication Component

AIDSTECH, AIDS Prevention Technology Project

AIWP, AIDS in the Workplace

BEMFAM, Sociedade Civil Bem-Estar Familiar no Brasil

CAREC, Caribbean Epidemiology Centre

CDC, Centers for Disease Control and Prevention

CEO, Chief Executive Officer

CIDA, Canadian International Development Agency

CIES, El Centro de Investigacion, Educacion y Servicios

EIL, Experiment in International Living

FUE, Federation of Ugandan Employers

FPA, Family Planning Association

HIV, Human Immunodeficiency Virus

IEC, Information, education, and communication

IDI, Ikatan Dokter Indonesia (Indonesian Medical Association)

INE, *It's Not Easy* video

ISSA, Institute for Social Studies and Action

JHU, The Johns Hopkins University

KABP, Knowledge, attitudes, beliefs, and practices survey

MHOL, Movimiento Homosexual de Lima

NGO, Nongovernmental organization

NORAD, Norwegian Agency for Development

ODA, Overseas Development Association (British)

Profamilia, Asociacion Dominicana ProBienestar de la Familia

PVO, Private Voluntary Organization

RDO/C, Regional Development Office/Caribbean (USAID)

STD, Sexually transmitted disease

SIDA, Swedish International Development Agency

SOGA, Fundacion para la Salud, Orientacion General y Ayuda (renamed FEDAEPS Fundacion Ecuatoriana de Ayuda, Educacion y Prevencion del SIDA)

Tacosode, Tanzanian Council of Social Development

UNDP, United Nations Development Programme

USAID, United States Agency for International Development

WHO/GPA, World Health Organization/Global Programme on AIDS

AIDSCOM

Partners Against AIDS:

Lessons Learned

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