

PN-ACC-922

**AIDS TECHNICAL SUPPORT PROJECT (ATSP)
LESSONS LEARNED: BEHAVIOR CHANGE
INTERVENTIONS BEST PRACTICES**

PREPARED BY

DONNA FLANAGAN, TEAM LEADER, AIDSCAP
ELAINE MURPHY, PATH
ELLEN WEISS, ICRW

PREPARED FOR

HIV/AIDS DIVISION
OFFICE OF HEALTH AND NUTRITION
CENTER FOR POPULATION, HEALTH AND NUTRITION
BUREAU FOR GLOBAL PROGRAMS, FIELD SUPPORT, AND RESEARCH
U S AGENCY FOR INTERNATIONAL DEVELOPMENT

FEBRUARY, 1998

This report was prepared under the auspices
of the U S Agency for International Development (USAID)

The report was written and revised by the
Health Technical Services (HTS) Project
(Project No 936 5974 10, Contract No HRN-5974-C-00-3001-00)
of TvT Associates and The Pragma Corporation

The opinions expressed herein are those of the authors and do not
necessarily reflect the views of TvT, Pragma, or USAID

Information about this and other HTS publications may be obtained from

Health Technical Services (HTS) Project
1601 North Kent Street, Suite 1104
Arlington, VA 22209-2105
(703) 516-9166 phone
(703) 516-9188 fax
[http //www htsproject com](http://www.htsproject.com)
[hts@htsproject com](mailto:hts@htsproject.com)

Contents

| | |
|--|-----|
| Acronyms | v |
| Introduction | vii |
| | |
| I Best Practices for Behavior Change Interventions | 1 |
| A Targeting | 1 |
| B Message Development/Dissemination | 3 |
| C BCI For Environmental Change (Including Influencing Gatekeepers and Policymakers) | 4 |
| D Approaches | 5 |
| 1 Peer Education | 5 |
| 2 Traditional Media | 6 |
| E Sexually Transmitted Infections | 6 |
| F Private Sector Involvement (and Sustainability) | 7 |
| G Prevention and Care | 7 |
| H Research, Monitoring, and Evaluation | 7 |
| I Capacity-Building | 8 |
| J Coordination/Collaboration | 8 |
| | |
| II Gender-Based Approaches in Behavior Change Interventions | 9 |

Acronyms

| | |
|-----------|--|
| AIDS | Acquired immunodeficiency syndrome |
| AIDSCAP | AIDS Control and Prevention Project |
| ATSP | AIDS Technical Support Project |
| BCC | Behavior change communication |
| BCI | Behavior change intervention |
| FP | Family planning |
| FGD | Focus group discussions |
| HIV | Human immunodeficiency virus |
| HTS | Health Technical Services Project |
| ICRW | International Council for Research on Women |
| IEC | Information, education, and communication |
| IPPF | International Planned Parenthood Federation |
| MCH | Maternal and child health |
| NGO | Nongovernmental organization |
| PATH | Program for Appropriate Technology in Health |
| PLWA | Persons living with AIDS |
| PHIV/AIDS | Patients with HIV/AIDS |
| STD | Sexually transmitted disease |
| STI | Sexually transmitted infection |
| UNAIDS | Joint U N Programme on HIV/AIDS |
| USAID | U S. Agency for International Development |
| WHO | World Health Organization |

Introduction

What follows is a compilation of key advice, best practices, and lessons learned about behavior change interventions (BCI) for prevention of sexually transmitted infections (STIs) and HIV in terms of feasibility, acceptability, and outcomes for the target audience. Part I covers information that is applicable to all BCIs. Part II highlights what we have learned about gender-based approaches.

Some of the best practices result from the accumulated experiences of BCI practitioners worldwide. They illustrate generally accepted principles of communication and behavior change as applied to the HIV/AIDS arena. No citation is given for these. In other cases, ICRW, AIDSCAP, PATH, and IPPF studies or activities are cited.

I. Best Practices for Behavior Change Interventions

A. TARGETING

- Identify and segment important audiences — sex workers, clients of sex workers, truck drivers, military personnel, adolescent males, adolescent females, unmarried sexually active young adults, women and men in stable unions, HIV+ persons, persons living with AIDS (PLWA), families affected by AIDS, policymakers, gatekeepers (e.g., teachers, religious leaders), health workers, sports or entertainment role models, media personnel, and other audiences PLWA and their families are also important as BCC agents
- Give careful attention to each audience's knowledge, attitudes, beliefs, values, and practices, and the cultural, economic, and gender-related context in which sexual behavior takes place These can be ascertained through existing and new qualitative and quantitative research as well as from other background information
- Select messages, sources of message, and channels and formats for each key audience based on such research

- In countries that are in the early phases of the epidemic, the most rational and cost-effective programs are those that are designed to reach core transmitters — those whose sexual behavior places them at high risk for infection and subsequent further transmission of infection. If the epidemic has spread beyond this core group to a wider population, then other groups that may be vulnerable (such as young people and some married women) also should be targeted with information and services. Note that focusing activity on these often stigmatized populations has caused serious negative consequences in the past, including denial and misperception of personal risk by people not immediately addressed by the interventions and discrimination rather than assistance for affected communities. Those involved in such programs must seek new ways to realize the cost efficiencies of targeting high transmitters *without* exacerbating the stigma often associated with HIV.
- Groups of people categorized under one heading are not necessarily homogeneous. For example, commercial sex workers may differ greatly in age, health beliefs, working conditions, etc., and thus time, effort, and resources must be allocated to develop effective intervention strategies for each group.
- If momentum and maintenance of behavior change are to be supported and continued, BCC programming must take into account where the target audience is with regard to the stages of behavioral change continuum¹ and the political, cultural, and socioeconomic factors that circumscribe the safer sexual environment of the target audience.
- Program planners should use epidemiological data, such as on the prevalence of STIs and the stage of the HIV epidemic, and demographic data to allocate resources cost-effectively and in appropriate proportions to various target audiences and geographical areas.

1 There are a number of models that attempt to chart and measure the process of change. Most are built upon the work of James O. Prochaska and Carlo C. DiClemente, whose primary model includes five stages in the process of change: precontemplation, contemplation, ready for action (or preparation), action, and maintenance. AIDSCAP projects in Ethiopia, Tanzania, and Thailand have successfully used a variation of this model to guide BCC message development.

- Mobilizing people through the use of women's organizations encourages greater participation in HIV/AIDS prevention (as demonstrated by programs in Senegal, Haiti, and Thailand and in those of AIDSCAP)

B. MESSAGE DEVELOPMENT/DISSEMINATION

- Contrary to conventional wisdom about communication theory, it is possible to develop "transferrable" messages, as evidenced by AIDSCAP's "Emma Says" comic books and the "Fleet of Hope" message, which have been used successfully in Africa, the Caribbean, and Southeast Asia. Where messages can be demonstrated to have near-universal applicability, prototypes for local adaptation can be cost-effective. Pretesting and adapting messages and materials for clarity, cultural acceptability, and maximal effectiveness is nonetheless a basic tenet of BCC.
- For maximum effectiveness, messages need to be delivered to the same audience over a sufficient period of time, through multiple, influential channels, by trusted/admired sources (e.g., peer educators, popular written materials, radio/TV broadcasts, teachers, family members, role models), and in easily accessible sites (e.g., schools, workplace, clinics, etc.).
- Messages should change over time to reflect the target audience's movement through the stages of a behavior change continuum as measured by periodic audience research. (More work is needed to identify indicators that are observable to outreach workers and educators for each stage.)
- HIV/AIDS prevention messages that are a part of larger efforts to address other concerns of the target audience (e.g., fertility, health care, popularity) are more likely to be acted upon than information received in isolation.
- Messages developed for mixed audiences should be thought through and pretested for their meaning to HIV-positive and HIV-negative people. For example, messages to "protect yourselves!" imply that the listeners are HIV-negative and ignore the needs of HIV-positive people and their role in prevention.

C. BCI FOR ENVIRONMENTAL CHANGE (INCLUDING INFLUENCING GATEKEEPERS AND POLICYMAKERS)

- It is unlikely that any individual can sustain a change in behavior without the support of the environment (enabling factors and services) and supportive social norms.

- BCC can help create environmental conditions that facilitate personal risk reduction through.
 - advocacy with policymakers (100 percent condoms in brothels in Thailand — AIDSCAP)
 - working with the media (Jamaica, Beryl Francis — AIDSCAP)
 - working with religious leaders (Senegal, Haiti, Kenya, Tanzania — AIDSCAP)
 - coordination with condom social marketing services (PSI — AIDSCAP)
 - addressing the empowerment of women (the rights of women in South Africa — AIDSCAP; Honduras/AHMON — AIDSCAP, Dominican Republic/ CSW's Congress — AIDSCAP)
 - using intensive mass media to change public perceptions of normative behavior

- An important target audience in BCC programming is gatekeepers — those health care providers, teachers, political and religious leaders, policymakers, and media representatives who may be influential in generating support for or opposition to HIV prevention activities. Solid evidence and well-presented research results can inform and persuade them. Presentations to policymakers are more effective when they include realistic, explicit recommendations for actions that are within the policymakers' manageable interests. Advise policymakers what the data mean for *them* and what you think they *should do* (Policy Project.)

- When the social environment for HIV prevention is unresponsive, targeted, sequenced, and persistent BCC programming aimed at appropriate gatekeepers can have a positive influence.

- Community leaders play an important role in the implementation of sexuality education and services for youth, particularly for female adolescents. Even in conservative communities where girls are sheltered and their mobility is restricted, it is possible to gain community support for sex education of girls (ICRW studies in India — Bhende, 1995, ICRW studies in Sri Lanka — Silva et al., 1997.)
- Workshops for policymakers can positively influence their attitudes and HIV/AIDS programming when they incorporate a gender perspective by highlighting gender differences in HIV risk and showcasing best practices in the region and when they develop skills in gender analysis (*A Transformation Process* — AIDSCAP, 1997, ICRW study in Kenya — Makokha, 1997)

D. APPROACHES

1. Peer Education

- Asking peer educators to work nearly full-time without any incentives will result in demoralization and high drop-out rates (*Tanzania Final Report* — AIDSCAP)
- Training that is too short in duration and/or has a curriculum that is too theoretical will not give peer educators sufficient confidence and practical skills. Peer educators need support and sufficient time to develop the needed communication and role-modeling skills (*Tanzania Final Report* — AIDSCAP)
- Involving other community resource people such as traditional healers, traditional birth attendants, and village health workers in peer education tends to reinforce, integrate, and sustain behavior change messages (*Tanzania Final Report* — AIDSCAP)
- Peer educators who receive regular retraining and effective supervision demonstrate confidence and motivation and are more trusted by peers and the community. (*Peer Education in Projects Supported by AIDSCAP: A Study of 21 Projects in Africa, Asia and Latin America* — AIDSCAP.)

- Peer education projects should evolve beyond group education to include individual counseling for behavior change skills and knowledge of a wider range of healthy living skills that can be presented to peers as options (*Peer Education in Projects Supported by AIDSCAP — AIDSCAP.*)

2. Traditional Media

- In many places, mass media and health education can be reinforced by traditional media such as drama, song, dancing, or puppet shows
- Using community-based theater as a means of sensitizing and educating community members is preferable to print media in some locations, including some rural or marginal urban communities. This is because of the lower costs of production, the ability of theater to capture the specific cultural issues in a community, and low literacy levels in many of these groups (*Tanzania Final Report — AIDSCAP*)

E. SEXUALLY TRANSMITTED INFECTIONS

- A BCC strategy should include efforts both to improve the attitudes of STD clinic staff members toward all clients and to train clinic staff members to educate and counsel their clients. Clients should be taught to recognize symptoms of common STDs, seek appropriate treatment, complete the treatment regimen, and refer partners for diagnosis and treatment
- Women at risk should be counseled to seek diagnosis even in the absence of symptoms. This can be accomplished through community education and mass media. It can be further enhanced by messages given through integrated FP/MCH/STD services.
- Perceived personal vulnerability is a key to sustained behavior change. People living in areas with low HIV prevalence may not see people with AIDS, and therefore focusing on the risks and consequences of STDs in these populations may be the best way to reduce sexually risky behaviors. BCIs should address STDs as serious, preventable, and treatable in their own right, not only as a co-factor for HIV.

F. PRIVATE SECTOR INVOLVEMENT (AND SUSTAINABILITY)

- It is easier to leverage private sector commitment to and financial involvement in prevention activities when the behavior change messages are professionally designed and produced (Final Reports from Dominican Republic, Brazil, Kenya, and Thailand — AIDSCAP)

G. PREVENTION AND CARE

- Providing care and support for people with HIV/AIDS in the community promotes acceptance of HIV/AIDS as a community problem, decreases stigmatization of PHIV/AIDS, increases opportunities for community involvement in developing effective prevention strategies, and may lead to sustainable activities to meet the needs of PHIV/AIDS and their families (Final Reports from Haiti and Tanzania — AIDSCAP)
- Home-based care counseling services that offer no material support to clients tend to de-motivate both the service providers and their clients, making the whole exercise unproductive Mobilizing communities (as well as donors, governments, and the private sector) to provide some resources for afflicted families and individuals could be a fruitful as well as humane approach (Shinyanga cluster report — AIDSCAP)

H. RESEARCH, MONITORING, AND EVALUATION

- No matter what strategies are used, formative research should guide the formation of the messages and approach to any BCI (including activities that target gatekeepers and policymakers) The methods could include key informant interviews, focus group discussions (FGDs), observation, or questionnaires
- Realistic goals for influencing behavior need to be based on an understanding of the process of behavior change Progress toward the final goal can be tracked Intermediate indicators of achievement can provide motivation to field workers and peer health educators who see them as important benchmarks

I. CAPACITY-BUILDING

- Capacity-building in BCI is critical to ensure sustainability and cost-effectiveness over the long run. This is true even for experienced health educators because BCIs involve contextual factors, the enabling environment, and behavioral reinforcement, which makes them much more complex than traditional information, education, and communication (IEC) activities, which frequently entail only the production of messages and materials
- Investing time and money in capacity-building often means making a trade-off, accepting fewer quick results in the short term in order to ensure greater success over the longer term. Funding agencies must recognize this trade-off and support a reasonable balance between these two objectives
- Training workshops are often necessary but seldom sufficient for capacity-building, which also requires periodic reinforcement and updating of information and skills and management support
- Capacity-building also requires systems to ensure good and timely personnel and financial management and technical quality

J. COORDINATION/COLLABORATION

- An effective behavior change intervention requires coordination with and/or advocacy for improvements in important components of the desired behavior, including, for example, improving the availability and ensuring a reasonable price for male and female condoms (and eventually microbicides), STI services, and drugs and developing support systems for partner contacting and referral
- Coordinating BCC and social marketing messages, including their timing and venues, is important, as is coordination with other players — nongovernmental organizations (NGOs), government ministries, clinics, donors, and others

II. Gender-Based Approaches in Behavior Change Interventions

Gender-based approaches must take into account the following

- Adolescent and adult women are often less knowledgeable than their male counterparts
 - Although information is not sufficient for behavior change, it is an important resource and an element of power.
 - Innovative communication channels, methods, and materials can provide women with information about their bodies, sex, male and female condoms, HIV/AIDS, and STIs (ICRW studies cited in Rao Gupta, G , and E Weiss, *Women and AIDS Developing a New Health Strategy*, 1993, Weiss, E, D Whelan, and G Rao Gupta, *Vulnerability and Opportunity Adolescents and HIV/AIDS in the Developing World*, 1996.)
- Although women may be less knowledgeable, men's knowledge is often limited and inadequate.
 - Both male and female STD patients in South Africa believed that condoms can get lost inside the woman and cause her harm Providing these men and women with information about women's reproductive tract eliminated their fears about condom use (ICRW study in South

Africa — Hadden, 1997, see also study of Matatu drivers in Kenya — AIDSCAP)

- A deficit in basic “reproductive health literacy” impedes quality BCI, since a great deal of background information about the body, reproductive functions, etc , is needed by most audiences, over and above specific knowledge about HIV and STIs Improving public and private health education services can thus enable more efficient delivery of all health services, including HIV/STI services

- Gender roles influence sexual risk
 - A discussion of gender-defined roles and their relationship to sexual risk can be incorporated into materials and messages to reach adolescent and adult women and men (ICRW studies conducted with young women in Brazil — Vasconcelos et al , 1997, ICRW studies with young women and men in Sri Lanka — Silva et al , 1997, ICRW studies with young, unmarried female and male factory workers in Thailand — Cash et al , 1997, and ICRW studies with male and female STD patients in South Africa — Hadden, 1997)
 - In Thailand, participation in a peer education programs greatly increased young female factory workers’ understanding of how traditional notions of female passivity and male dominance in sexual decision-making influence women and men’s HIV/STD risk and their awareness of risk-reduction strategies (Cash et al , 1997)
 - Young women in Brazil reported increased autonomy and control over their bodies as a result of their participation in a peer education program that examined how gender roles are socially constructed and result in women’s limited role in sexual decision-making vis-à-vis men (Vasconcelos et al , 1997, see also, Ethiopia male and female adolescents — AIDSCAP.)

- Social norms are not supportive of women who communicate about sex nor of dialogue between men and women about sex and HIV/AIDS.
 - Certification of young, unmarried, female peer educators gives women the social license and role models to talk about sex (Cash et al , 1997.)
 - Social norms about communication can be challenged and have been changed in a number of cultural contexts For example, in Brazil, young, female peer educators were initially taunted by people in the

community and called the “Little Sex Professors ” At a ceremony marking the conclusion of the program, over 400 members of the community attended (Vasconcelos et al , 1997, see also Kenya sexual negotiation study — AIDSCAP)

- Single-sex discussion groups can help women develop the skills and confidence to talk about sex and HIV/AIDS to men in mixed-sex groups (Hadden, 1997, Silva et al , 1997), to partners (Cash et al , 1997), and to family members (Vasconcelos et al., 1997)
- In a school-based AIDS education project in Zimbabwe, boys and girls were separated into single sex groups to facilitate discussion about sexuality After the girls gained confidence, they asked for boys to be included in future sessions (Zimbabwe — AIDSCAP)

- Programs that promote condoms for adolescent and adult women must address the gender-related barriers that inhibit communication and procurement
 - While women face greater obstacles than men in terms of HIV prevention, not all women are powerless to take steps to protect themselves In South Africa, female STD patients who participated in three single-sex sessions and one mixed-sex discussion group that focused on relational and communication issues were significantly more likely to initiate male and female condom use than women who only received a talk on HIV/AIDS (Hadden, 1997)
 - AIDSCAP research on female condom use in Kenya demonstrated that men are not necessarily hostile to a more vocal and proactive role by women regarding means of protection and sexual behavior (Kenya sexual negotiation study — AIDSCAP)

- Women face many limitations in adopting use of male condoms, and, therefore, programs must offer and discuss other alternatives.
 - In countries where it is available, the female condom can play an important role for women When female STD patients were offered the female condom, the method was used by women who previously were doing nothing to protect themselves (Hadden, 1997, female condom studies in Kenya, Brazil, and Zimbabwe — AIDSCAP)
 - Where female or male condoms are not easily accessible, other options must be promoted (Fleet of Hope experiences — AIDSCAP.)

- One barrier to condom use is the desire to get pregnant. A group discussion intervention piloted in an STD clinic in South Africa discussed the role that HIV testing and counseling can play for couples who want to have unprotected intercourse to get pregnant (Hadden, 1997)
- Violence acts as a deterrent to women in negotiating condom use. The issue of violence needs to be addressed within HIV/AIDS programs.
 - An intervention trial in South Africa with STD patients included a mixed-sex group discussion in which men role-played women who had been beaten by their partners for suggesting condom use. The men took their roles very seriously and expressed a new understanding of women's situations (Hadden, 1997)
 - Interventions need to deal with domestic violence as well as the sexual harassment that takes place in the workplace (Honduras — AIDSCAP)
 - Services that intend to encourage disclosure of HIV status and/or partner tracing should take special care to investigate potential risks of violence and should make preparations for handling violence and for providing guidelines to clients and program staff members
- There are gender differences in sexual needs, experiences, and interests that impact the design and acceptability of intervention programs
 - In Sri Lanka, young women's vocabulary about sex and their peer networks were found to be limited, whereas those of young men were more extensive but not supportive of safer sexual practices. A group-based peer education program was less successful at recruiting and retaining young men than young women. (Silva et al, 1997.)
 - It is useful to distinguish between "gender needs" — the immediate needs of women or men to fulfill their gender roles, such as access to firewood and food for women who are responsible for feeding their children — and "gender issues" — gaps in the status or welfare of men and women caused by more distal differences in social roles and privileges that systematically skew the distribution of power and resources toward one sex and away from the other (quoted in part from AIDSCAP Gender Analysis Training — Llongwe and Clark, 1996). While it is more difficult to mobilize communities to address gender

issues, changing those determinants of gender inequities is likely to produce more sustained benefits than just meeting recurrent, immediate gender needs

- Because sexual behavior change is a long-term process and often difficult to measure, interim indicators that reflect a gender perspective must be utilized

- These indicators include communication attitudes and behavior (Cash et al , 1997), attitudes toward violence against women (Hadden, 1997), and attitudes toward traditional gender roles and relationships (Woelk et al , 1997)