Communications
Framework
for HIV/AIDS

A NEW DIRECTION

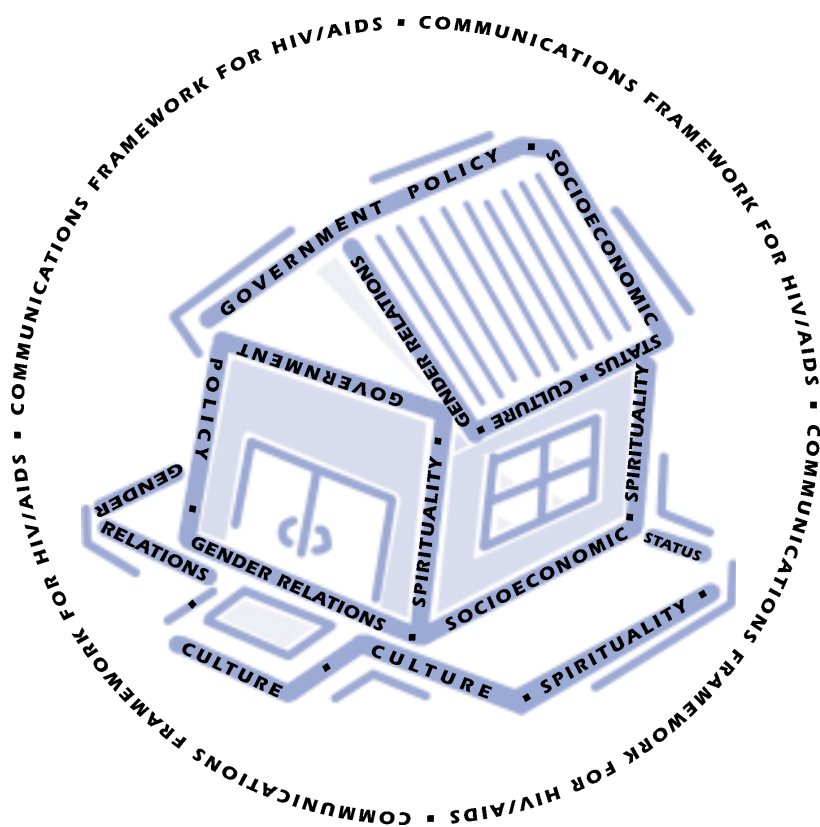**A
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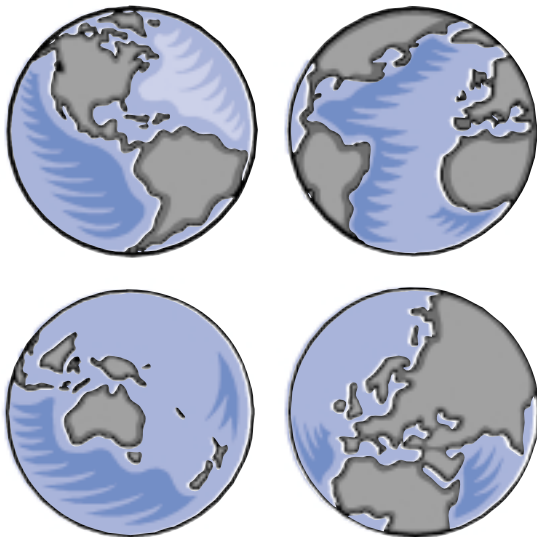
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A New Direction

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Foreword

This document describes the findings and recommendations of consultations on ways to make HIV/AIDS communication considerably more effective in Africa, Asia, Latin America and the Caribbean.

AIDS affects every county in the world, but it is in the developing countries that it poses the greatest threat to life and development. In sub-Saharan Africa, a conservative estimate shows that 150 million people, one quarter of the population, has been affected. Over 22 million Africans are currently living with HIV/AIDS and at least 9 million Africans have already died of AIDS. In South and South-East Asia, over 6.7 million people are living with HIV/AIDS and in Latin America, the figure is 1.4 million people. These numbers continue to rise, with 16,000 new infections occurring every day.

The collaboration, mainly between the Joint United Nations Programme on HIV/AIDS (UNAIDS) and The Pennsylvania State University in the USA and several Cosponsors of UNAIDS, that resulted in the production of this document is noteworthy. It was developed through involvement of practitioners and researchers, 80 percent of whom are from developing countries where they work in lead UN agencies and non-governmental organizations on communications and HIV/AIDS.

The joint consultations have shown that a new direction is warranted on how communication programmes for HIV/AIDS are designed and implemented. The new approach presented in this document shows a way to combine interpersonal communication and mass media in key areas of prevention and care to reduce the impact of the HIV/AIDS pandemic.

We hope that national partners will adapt the Communications Framework and include it as an integral part of their strategies for HIV/AIDS prevention, care and support.

Graham Spanier, PhD
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Executive Director, UNAIDS

August, 1999

The Team Report

Introduction

Under the leadership of the Joint United Nations Programme on HIV/AIDS (UNAIDS), a new and more adaptable framework for HIV/AIDS communications has been developed. Unlike many earlier approaches, this framework is based more on social and environmental context than on individual behavior. This framework was developed through a participatory process guided by both researchers and practitioners. Formulating this adaptable framework involved synthesizing experiences from the African, Asian, and Latin American and Caribbean regions and identifying and taking into consideration the many aspects of HIV/AIDS prevention, care, and support that require different approaches. Experiences from the United States and Europe were also included. UNAIDS' basic assumption was that the logic and theory of HIV/AIDS strategies ought to evolve from within the meanings and values of the affected population.

To enable the synthesis of the new communications framework, UNAIDS sponsored five consultative workshops in collaboration with The Pennsylvania State University. They were held in Geneva, Switzerland (November 1997); Abidjan, Côte d'Ivoire (December 1997); Washington, DC (February 1998); Bangkok, Thailand (July 1998); and Santo Domingo, Dominican Republic (January 1999). Many other specialists and peers reviewed the reports, consensus, and recommendations of the workshops.

Executive Summary

The Joint United Nations Programme on HIV/AIDS (UNAIDS) responded to the increasing epidemic of HIV/AIDS by initiating a participatory research process conducted through five consultative workshops to examine the global use of

communications for HIV/AIDS prevention, care, and support. The primary aim was to examine the adequacy of existing communications theories and models for HIV/AIDS in Africa, Asia, and Latin America and the Caribbean against a backdrop of contemporary communications uses in Western societies. In the five consultative workshops (two global and three regional), 103 leading researchers and practitioners from different parts of the world were invited or consulted by UNAIDS in collaboration with The Pennsylvania State University (PennState).

The major finding was that five domains of context are virtually universal factors in communications for HIV/AIDS preventive health behavior—*government policy, socioeconomic status, culture, gender relations, and spirituality.* These interrelated domains formed the basis of a new framework that could be used as a flexible guide in the development of HIV/AIDS communications interventions. Individual health behavior is recognized as a component of this set of domains, rather than the primary focus of health behavior change.

Most HIV/AIDS communications programs have been aimed at achieving individual-based changes in sexual and social behavior. While aspects of this approach are desirable and should be maintained, evidence from research and practice in many countries shows that existing approaches generally have major limitations; thus, a broader focus is needed. Moreover, there is considerable inter-regional variation in the context of HIV/AIDS. Many of the theories, models, and frameworks currently in use in the regions do not adequately address the unique needs of HIV/AIDS communications. For example, the cost effectiveness of interpersonal communication components of HIV/AIDS behavioral interventions in the regions has been underestimated.

The challenge of this new direction is to ensure a redirection of intervention programs to recognize that individual behaviors are shaped and influenced by factors and domains within a broader contextual focus.

1 The UNAIDS Consultative Workshops

Methodology—Process

Participatory research was used to plan and implement the development of the new framework. An important advantage of participatory research over traditional research methods is that it allows active involvement by those who will be the beneficiaries of the outcomes of the research. The participant-beneficiaries are thus involved in defining the questions, establishing the parameters for the process, interpreting the outcome, and directing the dissemination process. Consistent with the values of participatory research, UNAIDS began this process by inviting comment and input from a broad range of leading researchers and practitioners from all over the world. More than 80 percent of the contributors and participants were from Africa, Asia, Latin America, and the Caribbean. Such broad consultation promotes flexibility for regional adaptation of the framework. Flexibility, in turn, encourages local ownership of the implementation process, since this last and most important step is realized at the local level—in the countries and communities.

There were five consultative workshops held altogether.

Two of the workshops were global, and three were regional, with one each in Africa, Asia, and Latin America and the Caribbean. In November 1997, fifteen leading researchers and practitioners in HIV/AIDS communications were invited to an inaugural consultative workshop at the UNAIDS headquarters in Geneva, Switzerland, to begin reviewing the existing theories and models used to guide HIV/AIDS communications interventions. Under scrutiny was their adequacy both for global and regional application—particularly in Africa, Asia, and Latin America and the Caribbean. Selected participants (see page 95) were invited to contribute papers on relevant subjects. *This first meeting concluded with unanimous agreement that—based on a review of the literature and of experiences in the field—most current theories and models did not provide an adequate foundation on which to develop communications interventions for HIV/AIDS in the regions.* It was agreed that further workshops should be held to seek input from researchers and practitioners in Africa, Asia, and Latin America and the Caribbean, with the ultimate objective of developing an adaptable framework.

In December 1997, the first regional workshop was held in Abidjan, Côte d'Ivoire. This workshop took advantage of the wealth of experience among the participants at the concurrent International Conference on AIDS/STD in Africa. Two discussion groups on HIV/AIDS communications in Africa were convened. One group discussion was conducted in English (nineteen participants) and the other in French (eighteen participants). Participants were practitioners and researchers

involved in HIV/AIDS communications in Africa. Several of the participants were professionals engaged in HIV/AIDS prevention and care Information, Education, and Communication (IEC) and Behavior Change Communication (BCC) interventions in different organizations and countries in Africa. The conclusion of this workshop echoed that of the inaugural consultative workshop in Geneva: *current theories and models did not sufficiently take into account the different situations among African countries and regions.* It was unanimously agreed that a new framework that would include several identified issues and situations was an absolute necessity.

In February 1998, a third consultative (and second global) workshop was held in Washington, DC, to review the input accumulated from the previous meetings. Since the conclusions reached at these meetings were so similar, UNAIDS decided to hasten the development of a new strategy. To identify the needs in Asia, Latin America, and the Caribbean, regional consultative workshops were held in Bangkok, Thailand (July 6–8, 1998) and Santo Domingo, Dominican Republic (January 20–22, 1999).

Participants at these consultative workshops were selected on the basis of their expertise in communications and HIV/AIDS research and practice. UNAIDS was particularly interested in including those who had actually been involved in developing and implementing HIV/AIDS communications strategies in Africa, Asia, and Latin America and the Caribbean.

Participants discussed the approaches they had taken in

their countries and regions, reviewed reports from previous meetings, and recommended steps to be taken to produce a new approach or framework that would be more appropriate for their regions. Many participants provided examples from their countries and regions of successful communications programs for HIV/AIDS. These examples confirmed that, in the future, HIV/AIDS prevention and care communications should ensure that measurable objectives and outcomes are based on the experience of exemplar programs in each region and locality.

Goals

The overall goal for the participatory research workshops was to establish an improved framework and strategy for HIV/AIDS communications in the African, Asian, and Latin American and Caribbean regions. Initially, however, the purpose was to generate ideas on how to develop a new framework and to gather input on the range of content the framework would be expected to support.

The sponsors and organizers felt that it was important for the contributors (and potential users) not only to develop a new framework, but also to "buy into it" and commit to using it. Achieving a high level of participation by key organizations, therefore, was a major process goal.

Objectives

These consultative workshops had three objectives:

1. Review existing theories, models, frameworks, and strategies for their potential effectiveness in communications programs for HIV/AIDS prevention and care in Africa, Asia, and Latin America and the Caribbean.

2. Propose guidelines for developing national and regional communications strategies for HIV/AIDS.

3. Advise on dissemination and implementation plans to activate more effective regional and national communications strategies.

Commonly used communications theories and models were reviewed by researchers and practitioners and found to be limited in their applicability to HIV/AIDS prevention, care, and support. Many of these theories and models focus primarily on individual behavior and make little or no allowance for the role of the social and environmental context of disease prevention interventions. This became increasingly obvious as, during early discussions, the influence of factors of social and environmental context on the effectiveness of HIV/AIDS interventions in Africa, Asia, and Latin America and the Caribbean emerged.

2 Theories and Models Used in HIV/AIDS Prevention

Communication is central to prevention strategies aimed at influencing individual and social behavior. Since there are so many variations in the contexts that determine behavior, it is evident that communications approaches to HIV/AIDS prevention and care need to be reevaluated. This is especially important when behavioral models are imported or adapted to the regions of the world that bear the main burden of the pandemic: Asia, Africa, Latin America, and the Caribbean.

Most theories underlying the models and frameworks used in HIV/AIDS prevention were derived from social psychology and communications. Furthermore, many of these formulations have been borrowed from family planning and population programs, which have successfully advanced the understanding and use of Information, Education and Communication (IEC). However, in-depth evaluations of the applicability of the borrowed theories, models, and frameworks to the special circumstances of HIV/AIDS prevention and care are rarely, if ever, made. One of the principal uncertainties, for instance, is whether communications can be credited as

a determining factor in observed behavior changes. This is particularly true when the mass media form part of the mix. How the differences between the social contexts of the behavioral models' origins and the contexts where the transplanted models are expected to yield positive results influence outcomes is also unclear.

Many theories and models of health behavior change, including reasoned action, social learning, cognitive theory, and the hierarchy of effects, are based on individual psychology. In fact, the assumptions (such as individualism as opposed to collectivism) on which these theories and models are based are foreign to many non-Western cultures. In the majority of non-Western contexts, the family, group, and community play a greater role in decision making. And yet, theories and models based on individualism continue to dominate communications strategies for HIV/AIDS prevention and care.

The models of behavior change most often used to guide health communications programs are the same ones used to inform health promotion programs. These theories and models include the Health Belief Model, the Theory of Reasoned Action, Social Learning and Cognitive Theories, the AIDS Risk Reduction Model, Stages of Change, Hierarchy of Effects, Diffusion of Innovation, and Social Marketing.

1. The **Health Belief Model** (HBM) was developed in the 1950s to predict individual response to, and use of, screening and other preventive health services.

2. The **Theory of Reasoned Action** attempts to explain individual behavior by examining attitudes, beliefs, behavioral intentions, and observed, expressed acts.

3. **Social Learning and Cognitive Theories** are based on the assumption that individual behavior is the result of interaction among cognition, behavior, environment, and physiology.

4. The **AIDS Risk Reduction Model** is based on the belief that one has to label a behavior as risky before a change can be effected. Once the behavior is considered risky, a commitment is made to reduce the behavior before action to perform the behavior is expected. Fear or anxiety and social norms are considered factors that influence moving from one stage to the next.

5. **Stages of Change** is based on the conception that individual behavior change goes through a process involving a series of five interrelated stages.

6. **Hierarchy of Effects** models focus on individual behavior change in a linear fashion, which begins with exposure to information and assumes that knowledge, attitudes, trial, and adoption of the desired behavior will necessarily follow.

7. **Diffusion of Innovation** focuses on the communication process through which new ideas or products become known and used in a target population.

8.   **Social Marketing** is an approach to promoting the acceptability of social ideas through the mass media. Social marketing's well-known "four Ps" (product, price, place, and promotion) have been applied to HIV/AIDS prevention in condom promotion.

While the effectiveness of these theories and models is questioned in light of the growth of the HIV/AIDS epidemic in Africa, Asia and Latin America, their value as important theories and models remains unchanged. For instance, Diffusion of Innovation continues to be a leading theory widely used in programs for social change. Its use of opinion leaders for information dissemination and behavior change is critical in most development communication programs. The interaction between the individual and the environment in Social Cognitive Theory is critical, even though behavior modeling and self-efficacy seem to be the common focus of this theory. Indeed, Bandura now addresses the importance of "collective-efficacy." Thus, participants recognized the notion that key elements of these theories and models must continue to be pivotal; however, they should be applied within a context-based framework, as opposed to a focus on individual behavior. It should be noted that not every theory and model was discussed. Another model commonly used in health promotion programs, PRECEDE-PROCEED framework, was not specifically addressed. PRECEDE-PROCEED (Green and Krueter, 1999), as a guiding framework, does take into account the social and political environment of individuals' health, the new

UNAIDS framework is inclusive of health promotion and communication strategies for the context.

Existing Theories and Models in the Context of HIV/AIDS Communications

These models and theories, based on similar principles, were designed to address health prevention from individual, linear, and rational perspectives. While these theories and models may have been confirmed to be effective in some societies, including developing nations, for addressing certain diseases, participants agreed that there was a need to revise theories and models used for communicating HIV/AIDS prevention and care messages in Africa, Asia, and Latin America and the Caribbean. Thus, even though these models and theories have increased knowledge and awareness of HIV/AIDS, they have not brought about commensurate changes in behavior.

Seeking to influence behavior alone is insufficient if the underlying social factors that shape the behavior remain unchallenged. Many communications and health promotion programs proceed on the assumption that behavior, alone, needs to be changed, when in reality, such change is unlikely to be sustainable without incurring some minimum of social change. This necessitates attention to social environmental contexts.

HIV/AIDS communications must be culturally appropriate, although, when certain dominant cultural and traditional norms and values favor the conditions for the

spread of HIV/AIDS, communications practitioners may need to challenge them. However, there is a danger that when outside influence and money back these challenges, local communities often reject what they consider a cultural assault, regardless of how reasonable the outcome or how honorable the intentions of the outsiders. Positive health behaviors are more likely to be attained and sustained when the people within a cultural setting are involved in a contextual transformation process.

UNAIDS recognizes that a new communications framework is needed to focus on populations in Africa, Asia, and Latin America and the Caribbean, which have not been adequately served by conventional prevention strategies and packages. While any new framework may draw on relevant components of existing theories and practices, a new focus, based on experience gained and research carried out in these regions, should be placed on responding to varied social contexts. In particular, communications strategies—particularly when addressing HIV/AIDS in Africa, Asia, and Latin America and the Caribbean—should evaluate ideas and assumptions that may be considered foreign. Effective approaches can only be developed and refined when the framework for each region, nation, and locality is locally derived.

Participants at the five consultative workshops (two global and three regional) noted the inadequacy and limitations of current theories and the models derived from them. Chief among the weaknesses identified were

● The simple, linear relationship between individual knowledge and action, which underpinned many

earlier interventions, does not take into account the variation among the political, socioeconomic, and cultural contexts that prevail in the regions.

● The emphasis on quantitative measures (rather than qualitative inferences or a combination of both) results in distorted interpretation of the meanings and realities in observed behaviors.

● External decision-making processes that cater to rigid, narrowly focused, and short-term interests tend to overlook the benefits of long-term, internally derived, broad-based solutions.

● The assumption that individuals can or will exercise total control of their behavior has led to a focus on the individual rather than on the social context within which the individual functions and a disregard for the influence of contextual variables, such as culture and gender relationships.

● There is an assumption that decisions about HIV/AIDS prevention are based on rational, volitional thinking with no regard for more true-to-life emotional responses to engaging in sexual behavior.

● There is an assumption that there is a sequential, linear relationship between knowledge, attitude, belief, behavior, and practice (KABBP), when engagement in sexual intercourse often precedes any rational decision based on full or even partial knowledge of risk-taking behavior.

● There is an assumption that creating awareness through media campaigns will necessarily lead to behavior change.

● There is an assumption that a simple strategy designed to trigger a once-in-a-lifetime behavior, such as immunization, would be adequate for changing and maintaining complex, life-long behaviors, such as consistent condom use.

● There is a nearly exclusive focus on condom promotion at the exclusion of the need to address the importance and centrality of social contexts, including government policy, socioeconomic status, culture, gender relations, and spirituality.

● Approaches based on traditional family planning and population program strategies tend to target HIV/AIDS prevention to women, so that women, rather than men, are encouraged to initiate the use of condoms, for example.

Programmatic Frameworks Reviewed

In addition to the theories addressed earlier, the following four program frameworks were reviewed:

● Academy for Educational Development (AED)

● AIDS Control and Prevention Project (AIDSCAP)

● Program for Appropriate Technology in Health (PATH)

● Johns Hopkins University's Population Communication Services (PCS)

Some common elements in the existing frameworks were considered immensely useful in developing a context-based communications strategy for UNAIDS. These are traditional elements in the social marketing approach, but may well add to the present contextually focused framework. These elements are

● information gathering and analysis

● planning process

● pre-testing the strategy (messages)

● elements of implementation

● monitoring and evaluation

● feedback to planning

However, the lack of contextual focus was seen by participants as a major limitation of these frameworks. Other international organizations working in the field of development communication have also realized these types of limitations. In a document that re-directs its work in communications for development, the Rockefeller Foundation (1999) states that there is a need to move "away from a focus on individual behaviors…and on to social norms, policies, culture and a supportive environment" *(Communication for Social Change,* p. 15).

3 The Contextual Domains: A New Direction

The results of the evaluations show that there are five interrelated domains of context that should be the focus in developing future communications strategies for HIV/AIDS prevention, care, and support. These domains are

Government Policy—the role of policy and law in supporting or hindering intervention efforts.

Socioeconomic Status—collective or individual income that may allow or prevent adequate intervention.

Culture—positive, unique or negative characteristics that may promote or hinder prevention and care practices.

Gender Relations—status of women in relation to men in society and community and the influence on sexual negotiation and decision making.

Spirituality—role of spiritual/religious values in promoting or hindering the translation of prevention messages into positive health actions.

As indicated, structured discussions based on research and practice yielded five key domains of context—government policy, socioeconomic status, culture, gender relations, and spirituality. These domains are interrelated, although they do have different impacts on preventive health behaviors. The focus on the context in the new framework does not undermine the importance of the individual. The framework recognizes that the individual is a product of the context, and for HIV/AIDS communications strategy to have a meaningful effect, intervention programs should begin with one or a combination of these domains. Thus, individuals should still be targeted, but only in the context of their interaction within a domain or a combination of domains. To this extent, the new framework could draw on salient and relevant elements of existing theories and models. A discussion of each of the contextual domains follows.

Government Policy

Governmental policy and law play critical roles in programs aimed at controlling the spread of HIV/AIDS. Government actions can either promote or hinder efforts to reach the goals of HIV/AIDS communications. For example, government policy is crucial to addressing the challenges presented by discussion about vaccine trials and the new combination drugs therapy. Ethical, legal, and financial considerations must be

taken into account when discussing and planning communications interventions to address these issues. Recent changes in world politics show a trend toward the establishment of democratic governments. In this process, unlike a few years ago, more opportunities are now available to create a public environment in which a richer debate of HIV/AIDS issues can result in a better-informed public. Yet the reality is that public debate on HIV/AIDS issues remains, in many countries, too often poorly informed, sensationalist, and damaging to HIV/AIDS prevention.

Some of these challenges could be met by working through regional organizations such as the Economic Community of West African States (ECOWAS), the Southern African Development Community (SADC), the Association of South East Asian Nations (ASEAN), the Organization of American States (OAS), the Caribbean Community and Common Market (CARICOM), and the Central American Common Market (CACM). These organizations can provide important channels for addressing some regional issues relating to HIV/AIDS, both independently and collectively.

In the future, successful, sustainable health policies will be increasingly determined by the capacities of societies, communities, and individuals to face up to the realities of their problems. This process should involve all sectors of a society and should draw on, but not be overtaken by, external and international expertise and resources. Involving people in such debates requires effective, culturally sensitive, and inclusive communications policies, which can be facilitated through interpersonal communication and media campaigns.

This bold UNAIDS effort has identified several key
issues that must be taken into consideration when ana-
lyzing the role played by governments in establishing
national and regional policies. The following key issues
related to government policy should be considered
when operationalizing the framework:

● Setting the media agenda should be part of the
initial information gathering and analysis.

● Issues of tourism, migration, violence, and rape of
women by military men require governmental
support for adequate solution.

● An important role of government is to foster
inter- and intra-regional collaboration in plan-
ning, including sharing lessons learned within and
between regions and facilitating cross-border
interventions.

● Policy, largely government policy, can play a sig-
nificant role in creating an environment that sup-
ports positive behavior change. This has been
evident in the vigorous anti-smoking campaigns
of the United States and Europe. After achieving
limited success in targeting individuals' smoking
behaviors, the targets are now the contexts within
which smoking takes place (e.g., creating
smoke-free institutions and facilities).

● In national efforts to prevent HIV/AIDS, politi-
cal will has made a difference in a country's
response. The political will of a president, such as
President Museveni of Uganda, who is a leading

advocate for HIV/AIDS prevention, has proven invaluable. Senegal's policies of requiring regular screening and providing needed treatment services for sex workers, Brazil's policy of providing treatment to people living with HIV/AIDS, and the 100 percent condom availability and use policy in Thailand are all examples. Political will in providing funds for specifically proven prevention interventions, such as needle exchanges, and discouraging political rhetoric that moralizes and criminalizes sexual orientation of, for example, men who have sex with men, is essential. Policy is also very important in protecting women in the commercial sex industries, by ensuring measures such as state-funded regular health screenings and check-ups for sex workers.

● The international pressures for change—whether they take the form of television music video channels or debates surrounding the Cairo and Beijing conferences on reproductive health and rights—need to be balanced with the indigenous capacity to generate informed public debate and to subject policies to informed and critical scrutiny.

● Based on successful experiments, some South-South exchanges of personnel and programs should be organized to encourage more interaction and learning.

● At a minimum, a process of public debate, informed by good quality information, should be encouraged, so relevant issues are brought forward. This will allow for developing of the capac-

ity within a country to provide analysis of the issues and the communication of that analysis to the public at large—particularly through the broadcast and print media.

● A political environment that acknowledges public opinion should be encouraged, so the public can communicate their perceptions and opinions on the policy-making process.

● Focus on risk situations that increase vulnerability to HIV/AIDS, such as migrant labor, refugees and displaced persons, and commercial sex.

● Above all, government policy should promote a vibrant civil society where media are able to express diverse viewpoints and non-governmental bodies are sufficiently well-informed and confident in making positive contributions to national debates.

Socioeconomic Status

Lower socioeconomic status makes a group more susceptible to many diseases, including HIV/AIDS. People in poor health have repeatedly been shown to be more likely to develop AIDS soon after infection with HIV.

Economics is a factor in providing individual, group, and governmental access to an adequate supply of condoms—and to combination drug therapies, where they are available. In resource-poor countries, various studies and reports have dealt with socioeconomic status

and other factors related to HIV/AIDS. In Thailand, for example, women with more education and greater household income displayed more accurate understanding of HIV/AIDS than lower-income, less-educated women. There is new evidence that the 100 percent condom policy that was adhered to by sex workers is increasingly difficult for sex workers to uphold, due to the economic downturn in Thailand. Sex workers who once refused higher payment for not using a condom are now accepting such payments.

Knowledge of HIV/AIDS was found to be almost non-existent among respondents in urban slums in India, especially among women. Another study in India found that illiteracy, linked to poverty, created a gap in knowledge about HIV/AIDS. Urban women of low socioeconomic status in Argentina were found to be particularly vulnerable to AIDS as a result of their gender and lower-class status.

It is evident that the socioeconomic context is a crucial domain in the success of HIV/AIDS communications. The following key issues related to socioeconomic status must be considered in the implementation of the framework:

● Issues of affordability, especially in clinical interventions such as combination drug therapies and technological interventions such as supplying condoms, must be dealt with. Many governments and most individuals could not afford combination drug therapies even if they were available. Economic factors are particularly salient when the

potential sustainability of behavioral outcomes beyond the end of a planned intervention is assessed, as it should be.

● Address the impact of poverty on individuals and communities and its relation to safer health practices.

● HIV/AIDS should be considered a developmental and social problem. Consequently, the allocation and distribution of resources to address the pandemic should be considered along with other existing social and development problems.

● Other issues affecting general accessibility to health care must be analyzed within each context and addressed in the planning of communications interventions for media and interpersonal communications.

Culture

Culture is the collective consciousness of a people. It is shaped by a sense of shared history, language, and psychology. There is no right or wrong culture, despite differences in communication codes and meanings. Certain elements of culture tend to remain over time while others change. Unfortunately, culture is too often seen as a static set of never-changing values and norms. Armed with a list of negative individual health beliefs and practices, the unenlightened practitioner inevitably blames those beliefs and identifies them as cultural barriers. Beliefs are often a product of culture, but not the

reverse. Beliefs are often used as a proxy for culture, so that beliefs and knowledge about illness become the focus of culturally appropriate messages and interventions. In fact, the term *belief* is often contrasted with knowledge. From the perspective of biomedicine, "belief" sometimes connotes erroneous ideas that constitute obstacles to appropriate behavior. Consequently, it is reasoned that individual negative practices or behaviors could be labeled cultural beliefs, and they are often labeled as barriers.

The dominant value system of Western cultures, to varying degrees, tends to view the self as a product of the individual. On the other hand, many other cultures view the self as a product of the family, community, and other environmental influences over which we neither have, nor want, control.

Culture is often viewed as an exotic collection of beliefs and practices and is mistakenly believed to exist only in Africa, Asia, Latin America, and the Caribbean. An example of this occurs when health educators and campaign planners ignore local health knowledge and seek information about local idioms of expression to better communicate health messages. In other words, there is little attempt to convey understanding through viable channels of local belief and practice. Instead, these channels are used to disguise imported knowledge by presenting it in the local idiom. Beliefs or knowledge of illness and traditional health practice should become the substance of local (or culturally appropriate) messages and interventions.

Unfortunately, culture has become widely equated with negative individual health beliefs and practices. Hence, culture is seen as a barrier to "real" knowledge, and cultural barriers are commonly cited as a reason for the failure of ill-conceived health communications programs.

This kind of misapprehension has led some health communicators implementing programs in non-Western regions to undervalue the importance of oral communication as a genre. However, traditional oral communication continues to maintain its potency and currency, and it frequently plays a key role in health promotion.

Culture is the central feature of any society. All people belong to a culture, and some might even share more than one culture. It is crucial for health communicators working on HIV/AIDS prevention, care, and support to examine thoroughly not only negative behaviors, but also contextual and individual values. These include positive elements (to be promoted) and existential elements (unique to the culture but not posing a threat to health and well-being). (For more on health and culture, see Airhihenbuwa, 1995.)

The following key points should be considered in factoring cultural variables into HIV/AIDS communication in the new framework:

● The style and use of language in many cultures should be understood for possible application in communications strategies, particularly at the interpersonal level. For example, some languages more than others commonly employ parables,

stories, and idiomatic expressions to convey messages.

● Relationships within the family and community should be explored, particularly as they relate to making decisions about adopting preventive health behaviors and caring for the sick.

● The centrality of family and community, rather than the individual, in decision making needs to be taken into account.

● The fact that individual beliefs, although they form a part of the culture, do not explain the whole cultural context, needs to be recognized. Belief, therefore, should not be allowed to become a proxy for culture, though it should be acknowledged as one of the many aspects of culture.

● Differences in cultural characteristics should be recognized, and messages should be relevant to the context.

● Media and interpersonal communications professionals must be involved from the initial planning all the way through to evaluation.

● Recognition of who the caregivers are in any community, and an understanding of their roles, is critical.

● The use of home-based care in many cultures requires systematic and regular information

updates to improve patient management and
support.

● Whenever possible, traditional healers should be
involved in program planning and implementa-
tion.

Gender Relations

Gender can be defined as the opportunities, roles,
responsibilities, relationships, and personal identities a
particular society prescribes as proper for women and
men. These attributes are socially constructed and
learned both individually and collectively. Gender roles
are influenced by many other determinants, such as
race, culture, community, time, ethnicity, occupation,
age, and level of education. While sex may be biologi-
cally determined, gender is socially defined.

Gender roles and relations are having a significant influ-
ence on the course and impact of the HIV/AIDS epi-
demic. Gender role definition influences the ways that
men and women are vulnerable to HIV transmission
and mediates the impact of living with HIV/AIDS.
Gender relations are affected by social, cultural, and
economic factors, and can control differential access of
men and women to care and support services.

Gender-based approaches to HIV/AIDS include
attempts to understand the ways that gender influences
the following:

● risk, as well as societal vulnerability

- the experience of living with HIV/AIDS

- the impact of individuals' relationships within the family

- individual HIV/AIDS-related illness or death within a family or community

- response to the epidemic at the individual, community, and national levels

A gender-based response aims to enable both sexes to protect themselves against HIV infection, to access proper care, and in general, to cope better with the epidemic. A gender-based approach does not mean that men and women will become the same. It means that opportunities in the lives of men and women will not depend upon their sex and that equal weight is given to the knowledge, experience, and values of both women and men to increase the quality and duration of their lives.

Gender issues are linked directly to the efficiency and sustainability of HIV/AIDS interventions. Minimizing the differential effect of HIV/AIDS on women can create more balanced participation and benefits for both sexes. It may also serve to lessen the gender imbalances characteristic of many societies. This should encourage better utilization of all human resources and more effective and equitable distribution of benefits. Involving both men and women means that the resources will be used more efficiently and the outcomes are likely to be more widely accepted.

Unfortunately, programs aimed at changing men's behavior tend not to challenge the contextual determinants of their behavior. Instead, the emphasis is often on condom use alone. But if the aim is to change behavior, the focus must extend beyond the availability and use of condoms. Attention should be paid to the roles and responsibilities of men. Rather than focusing only on women, programs should include all the different social roles and norms that affect the sexual behavior of men and women.

A key element in discussing the goals and objectives of communications in HIV/AIDS programs is to increase gender equity by strongly discouraging negative gender stereotypes within the target context, such as images of violent and irresponsible male sexuality or the stereotypically seductive woman who has the power to lure "innocent" men. The very foundation of HIV/AIDS prevention is based upon promoting responsible and respectful sexual behavior for both men and women.

In most societies, gender determines how and what men and women are expected to know about sexual matters and their attitudes toward sex. These gender ideals are part of a child's socialization process, and expectations about sexual knowledge and attitudes are already well-formed among adolescents. These ideals and expectations should be surveyed, and prevailing gender inequities should be addressed in communications programs. This would help to foster more respectful and caring sexual relationships when these children and young people become sexually active, and conse-

quently, assist in reducing the spread of HIV/AIDS. For example, condom use assumes an equal distribution of power in sexual relationships; the woman may have the intention and the will to adopt this behavior, but the actual act requires the active cooperation of the male partner.

Poor women are especially vulnerable to coercion from their male partners, since they may be economically and emotionally dependent on them. Poor women are more likely to be constrained in their choices about relationships and living situations than middle-class women. Concerns regarding food, shelter, and care of their children may overshadow concerns about HIV/AIDS.

Migration of labor from villages to cities due to urbanization is another factor that has made women especially susceptible to sexually transmitted diseases, including HIV/AIDS. Male migrant workers, separated from their families for long periods, may visit sex workers and return to their villages with HIV/AIDS, which they, in turn, transmit to their partners.

The following are key issues regarding gender relations to be considered in operationalizing the framework:

● Work toward the elimination of gender stereotypes in education. There must be recognition that, in addressing gender, we are referring not only to women, but also to men. It is critical to understand gender roles and the relations of power and negotiation within and among those roles.

- Equally important in understanding gender relations for communications is the relevance of who is communicating in relation to what is being communicated. This is particularly crucial for communicating messages about roles and responsibilities of caregivers in the family and community.

- Gender issues should be taken into consideration not only at the initial stage of planning a communications program, but also through implementation, as well as during the evaluation of those programs.

- Close the gender gap in education, illiteracy rates, school attendance, adult education, enrollment, and technical training, with emphasis on rural women.

- Revise educational curricula to promote gender-relevant knowledge and appreciation of women's roles.

- Eliminate persistent negative images, stereotypes, attitudes, and prejudices through changes in education, socialization, the media, and advertising.

- Promote universal access to education.

- Address issues of women's rights and bridge the inequity gap in gender relations.

- Needs assessment must have a gender analysis component. This can also be called an analysis of the situation of men and women.

Spirituality

Spirituality encompasses belief and value systems ranging from organized religion to individual and collective values whose embrace represents a guiding principle on which meanings are based. Spirituality is a much broader and more inclusive concept than religion, even though the two terms are often used interchangeably. According to Relv (1997), "spirituality encompasses hope; faith; self-transcendence; a will or desire to live; the identification of meaning, purpose and fulfillment in life; the recognition of mortality; a relationship with a 'higher power', 'higher being' or 'ultimate'; and the maintenance of interpersonal and intra-personal relationships." Spirituality is grounded in the belief that there is a supernatural being or force that regulates the interaction of living beings with their visible and non-visible environment. There is increasing evidence in the scientific literature of the link between spirituality and positive health behavior. This link has always been recognized among traditional healers, whose healing modality is in part based on the belief in the power of supernatural forces to regulate human behavior.

For example, the use of the AIDS quilt in the United States has proven very successful in galvanizing communities to support HIV/AIDS prevention and care efforts. However, this same quilt does not have the same meaning and value among Afro-Brazilians. They believe that it symbolizes an attempt to "wake up" the spirits of the dead who, based on their spiritual values and beliefs, ought to be allowed to rest in peace. This collective value is both spiritual and cultural and should

be taken into account in communications for HIV/AIDS.

Religious leaders have important roles to play in HIV/AIDS prevention and care. At the very least, they can appeal to the moral code of their followers. Most importantly, they can provide a supportive environment for people and families of people living with HIV/AIDS.

One cannot assume that religion is a hindrance and that tenets are the same in all countries. For example, Senegal is 95 percent Muslim, and yet condom use appears to be readily accepted in the country, if the current high levels of distribution and consumption serve as an indication.

Given the wealth of experiences in interpersonal communication in the faith community, religion-based programs should focus on forging alliances with communities so that efforts to confront HIV/AIDS become synergistic. Interpersonal communication is indeed a form of communication with which religious institutions have a wealth of experience.

The response to HIV/AIDS, therefore, must be based on key principles embraced both by the public health and religious communities. The following are key issues related to spirituality to be considered in implementing the framework:

● A nonjudgmental attitude should be adopted toward all religions, and a partnership built with religious leaders.

- Provide a protective spiritual environment for acceptance and support, and consider the human rights of persons living with HIV/AIDS.

- Promote an open climate for discussing and presenting accurate information about sexuality and HIV/AIDS while dispelling misinformation and fear.

- Address the role of alcohol and other drug use in HIV/AIDS epidemics.

- Forge alliances with health care providers, so the spiritual dimensions of care and support are nurtured.

- Embrace the understanding that spirituality is broader than religion and that religion is an important entry point to communities.

- Promote the value that we must humanize persons living with HIV/AIDS.

4 *Regional Frameworks*

As mentioned earlier, regional workshops were held in Africa, Asia, and Latin America and the Caribbean. Since 90 percent of the new cases of HIV occur in these regions, these workshops were central to the development of the new framework. Each region was unanimous in identifying or endorsing the five domains—government policy, socioeconomic status, culture, gender relations, and spirituality—as the focal contextual domains. This in no way diminished the recognition of the role of individuals within and across the domains. In addition to the five domains, each region identified two additional key areas considered specific to and critical within that region. These additional key areas are not exclusive of the five domains, but represent an attempt to accentuate those areas known from experience to be pivotal in establishing sustainable goals in each region. In addition, these key areas could apply to all the regions regardless of where they were identified.

This section discusses the regionally specific key areas that must be considered along with the five contextual domains.

Toward an African Framework

The consultative workshop on HIV/AIDS communications in Africa was convened by UNAIDS at the International Conference on AIDS/STD and TB Control in Africa in Abidjan, Côte d'Ivoire, in December 1997. Two separate groups were convened on the same day. One discussion was in English (nineteen participants) and the other in French (eighteen participants). Participants were practitioners and researchers involved in HIV/AIDS communications, particularly as IEC officers, in different organizations engaged in HIV/AIDS prevention and care in Africa.

Africa has faced serious challenges at different stages of the spread of HIV/AIDS. During the mid-1980s, the major challenge was the persistent denial of the presence of the disease in many African communities. Reasons included the refusal to put a human face on the epidemic, fear of the potential negative impact of open recognition of the epidemic on tourism, and the protection of persons with HIV/AIDS from stigmatization due to government policy. A second period in the early '90s broke the silence about the disease. During this period, however, HIV/AIDS prevention focused only on high-risk behavior groups, such as sex workers and truck drivers. Such an exclusionary emphasis neglected all the other segments of the public. In addition, most governments did not focus on a systematic response to HIV/AIDS, and they generally did not support plans for appropriate communications strategies.

Recent figures on the HIV/AIDS epidemic continue to show that Africa remains by far the continent with the

most unsettling HIV/AIDS reality. More than 60 percent of HIV cases (21 million) are currently in sub-Saharan Africa. Heterosexual transmission is the most common form of transmission. This explains why 80 percent of women infected with HIV live in Africa. Similarly, almost 90 percent of children infected with HIV live in Africa.

During recent years, Southern Africa has experienced a rapid increase in the infection rate. For instance, more than 25 percent of new cases reported in South Africa occurred between 1997 and early 1998. Countries such as Botswana and Zimbabwe also showed high rates of HIV infection. In Botswana, the number of pregnant women infected with HIV increased by 43 percent in 1997. Similar increases have been reported in Zimbabwe.

By contrast, however, success stories are also emerging from Africa. Uganda, for example, has proved that effective mobilization, combined with political support, is crucial to containing the epidemic. School programs, community mobilization, involvement of church and community leaders, attention to rural sectors, and government support explain the relative successes in Uganda, particularly among younger populations. Similar results are also evident in Tanzania, where prevalence among the 15–24 age group dropped by more than 50 percent over a six-year period. Another example is Senegal, where there is commitment at all levels and infection rates remain relatively low.

The new HIV/AIDS communications framework should allow for an understanding of the emotional

basis of preventive health behavior as opposed to focusing exclusively on preventive actions based in rationality. Emotion (such as seeing a loved one suffering from AIDS) has played a major role in the decrease of new cases of HIV in Uganda.

Communications efforts have been at the core of these and other successes. Starting in the mid-1990s, communications strategies in some African nations were focused on large-scale information dissemination, in the belief that this would bring about behavior change. This was combined with assurance of blood safety, access to treatment for STDs, and large-scale condom availability. However, the spread of the disease continued to grow not only among the so-called high-risk behavior groups but also among all the other population segments— particularly women and young people.

Based on past experience, it has become necessary to design an appropriate communications framework for the African region aimed at equipping nations and organizations with the tools to develop their own HIV/AIDS programs.

The Abidjan workshop served as a forum for discussing a wide range of issues concerning the adequacy of HIV/AIDS communications programs. For instance, the effectiveness and limitations of the new combination drug therapies must be factored into HIV/AIDS communications programs to avoid raising false expectations. At the December 1997 International Conference on AIDS and STDs in Africa, an announcement was made to launch an African HIV/AIDS drug superfund. The UNAIDS communications adviser immediately

initiated a content analysis of two major newspapers in Abidjan to determine the coverage of HIV/AIDS before and after this announcement. The result showed that the overwhelming majority of news coverage on HIV/AIDS, before the announcement, was on the importance of prevention and education. However, after the announcement, attention was focused on combination drug therapies. This was in spite of the fact that limited resources and high HIV rates prevailed in the region. Prevention and education are still the most viable means of controlling the epidemic.

Another recognition was that AIDS messages need to be stated in appropriate cultural terms to make them more sensitive to varied social and economic contexts. It was emphasized that further collaboration with community and religious leaders is needed to ensure the involvement of community organizations. Reflecting the relative success in Uganda and Senegal, discussions stressed the role of government policy in creating an environment conducive to behavior change.

Recommendations

Discussions yielded rich information for future development of HIV/AIDS communications programs. In addition to the five domains addressed earlier (government policy, socioeconomic status, culture, gender relations, and spirituality), recommendations were made for two additional key areas tailored to the needs of the African regions. These are (1) a community-based approach, and (2) regional cooperation. It should be

noted that these two additional areas of emphasis may also be applicable to other regions.

Community-based Approach

● Communities should be involved in supporting outreach and peer education activities. Cultural values of communities must be allowed to play a central role in behavior-change communications in Africa. While some behavior change might have been achieved in increased condom use, several sexual practices that increase risk of HIV infection remain unchanged. This is an area where culturally appropriate strategies are crucial to success.

● Education should be channeled in the context of development and should address the effect of HIV/AIDS on agriculture and industry through strong workplace education programs. Moreover, the sustainability of programs and their ownership by communities should be ensured by encouraging broad participation at each stage of planning, implementation, and evaluation.

● Both quantitative and qualitative research methods should be used to assess or evaluate communications programs at the community-based level in order to get a realistic picture of communications problems and to gauge successes and uncover weaknesses. This should be a continuous process to help address gaps in communications, refine messages, choose appropriate channels, develop more acceptable IEC materials, address

training needs, and close gaps in knowledge and skills.

Regional Cooperation

● Government cooperation and policy are needed to mobilize resources and stem the increase in HIV cases. Creating supportive environments by making adequate services available is crucial. Whenever possible, multilateral organizations and forums should be used to broaden the scope for negotiating and promoting African interests.

● Other countries in the region should aim to discover why the HIV incidence is low in Senegal and declining in Uganda. These cases can serve as models to guide implementation of programs.

● Work should be directed toward institutionalizing action and achieving sustainability by (1) understanding why some programs facilitate positive results at each level of implementation, and (2) establishing synergy between multiple programs and organizations to enable the mutual attainment of common goals.

● Governments should play a central role, through policy and agreements, in the issues of intercountry border crossing and migration. Regional organizations such as Economic Community of West African States (ECOWAS) and Southern Africa Development Community (SADC) can provide important channels for addressing these regional issues relating to HIV/AIDS.

Toward an Asian Framework

A mixture of skills and experiences from various fields—academia, non-governmental organizations (NGOs), community-based organizations, media, and government—was represented at the regional workshop in Bangkok, July 1998.

Asia, the most populated region in the world, witnessed the arrival of the HIV/AIDS epidemic in the early 1990s, relatively late compared to other regions of the world. However, after a very short period, infection rates began to worry public health authorities. In Thailand, for instance, infection rates grew rapidly among drug users and sex workers. In China, between 1996 and 1998, an estimated 200,000 cases were reported.

Most cases have been found among intravenous (IV) drug users, although heterosexual infections have increased, especially among sex workers. India has the largest number of HIV-infected people (4 million), although this is only 1 percent of the adult population. As in China, a large number of cases have been detected among drug users. However, rates among pregnant women in some regions have reached 4 percent. The incidence of HIV infection among truck drivers in Madras has also increased significantly.

Most other countries in Asia present lower rates. However, this may not remain the case, since there is no guarantee that individuals will not engage in risky behaviors at some point in their lives. For instance, there are indications that drug use and commercial sex are both prevalent.

In Thailand, an estimated 800,000 people are HIV-infected. HIV is especially prevalent among commercial sex workers and their clients and IV drug users. Thailand has developed an aggressive campaign to promote condom use, persuade men to practice safe sex, and provide alternative opportunities to young women who want to enter the commercial sex business. Results have been mostly positive, although there is evidence that rates are still high among IV drug users.

Rapid infection rates have also been observed in Vietnam, Myanmar, and Cambodia. Again, infection rates are very high among commercial sex workers and their clients and pregnant women. The estimated number of HIV-infected people in Asia is more than 6 million, and it is expected that by the year 2000 one of every four Asians will be HIV-positive.

The status of Asian HIV/AIDS and communications prevention programs was discussed in Bangkok. The main goal was to develop a communications framework specific to Asia. Participants from Thailand, Vietnam, China, India, and Malaysia represented three sub-regions: South, Southeast, and East Asia. The group did not presume that the output of the discussion would be applicable to or reflect the entire Asian region.

Drawing upon discussions of the five contextual domains, two specific key areas of focus, based on the Asian situation, were added. At the socioeconomic level, in the past few years, several countries in the region have undergone economic restructuring. These changes have had an impact on social issues. For example, the economic liberalization in Vietnam since the mid-1980s

has contributed to an expansion of the sex industry and drug trade.

At another level, spiritual leaders in Asia are seen as a crucial link in community support systems and must play an important role as educators and care providers. Thus, spiritual leaders, too, need communication skills to be effective in reaching their constituents.

Recommendations

In addition to the five contextual domains (government policy, socioeconomic status, culture, gender relations, and spirituality), two key areas specifically important to the Asian region were identified. These key areas were (1) the communications context, and (2) the epidemic situation. The communications context includes the dimensions that must be taken into account in HIV/AIDS communications interventions.

Communications Context

● Interpersonal communication strategy should include consideration of the originator of the message.

● Group communication strategy should consider the size of the group, since the approach to effective small-group communication is different from that of large-group methods.

● Targeted communication strategies should be designed for the workplace environment.

Epidemic Situation

- Given the relatively low incidence of HIV in some Asian countries, designers of future communications programs should seek guidance in countries that once had low incidences and are now experiencing increases. Effective prevention strategies should be based on future projections. Otherwise, the present situation could lead to a false sense of security.

- Lessons should be learned from other epidemics in the region, such as STD/STI. HIV/AIDS programs, for example, can be integrated with STD treatment.

Toward a Latin American and Caribbean Framework

The current reality of HIV/AIDS in Latin America and the Caribbean, where nearly 1.3 million people are living with HIV, shows different dimensions. On the one hand, it resembles the reality of industrialized nations, given that most infections occur among men who have unprotected sex with other men and among IV drug users. For instance, in Mexico, some studies show that nearly 30 percent of men who have sex with men are HIV-positive, while 3–11 percent of IV drug users are also infected with the virus. On the other hand, heterosexual transmission has increased over the past years. According to the UNAIDS/WHO 1998 Report, in Brazil, a decade ago, about 6 percent of all cases were detected among women. Today, that figure

has jumped to 25 percent of all cases. In some countries, pregnant women with HIV have been detected at high rates. In Honduras, for instance, current estimates show that 1 percent of pregnant women are infected with the virus. In Haiti, back in 1993, nearly 8 percent of pregnant women were HIV-positive. The picture of treatment and care in Latin America and the Caribbean is also fragmented. Some countries have made great advances in guaranteeing provision of all available medications. However, accessibility and availability of HIV drugs are still irregular in most countries in Latin America and the Caribbean.

In the English-speaking Caribbean, no clear regional pattern emerges, given the presence of both high and low incidence rates in countries across the region. Most cases occur via heterosexual transmission, while transmission among men having sex with men accounts for 14 percent of the nearly 10,000 reported cases in the region. However, the doubling time for AIDS cases in the region is estimated at four to five years.

There was a two-fold basis for the discussions at the workshops. The first discussion was based on the report of the previous global consultative workshop in Washington, DC, which described the process of the project and conclusions reached up to that point. The second discussion arose from a presentation of a framework based on the five contextual domains (government policy, socioeconomic status, culture, gender relations, and spirituality) together with the observations and variations introduced during regional consultative workshops in Bangkok and Abidjan.

After the initial country reports, the development of the contextual framework was presented and discussed. There was consensus around the importance of taking into account the five domains when developing HIV/ AIDS communications programs, while retaining that which worked well in previous models and approaches. For instance, the strengths of past approaches lay in the methodology followed in communications programs. This methodology, no matter which model is used, must ideally include issues of needs assessment, planning, pretesting, implementation, evaluation, and feedback to planning. However, because some elements are missing from current communications programs and interventions (e.g., advocacy and greater involvement of people living with HIV), and given the increase of the epidemic, alternative models are urgently needed as the basis for more effective interventions.

While alternative approaches must be sought, the urgency of the disease needs to be kept in mind. This means that effective short-term programs must be developed at the same time that work proceeds on developing a new strategy. The capacities of organizations of people living with HIV and men having sex with men, NGOs, and others need to be strengthened, so they may be more effective in helping to control the epidemic.

The issues highlighted in the group discussions belonged to one or more categories of the five domains of the contextual framework. In addition, two interrelated methodological aspects of communications were also introduced. The first includes needs assessment,

planning, pretesting, implementation, monitoring, and evaluation. Feedback must also be part of this aspect. The second methodological aspect includes issues of influence, including social pedagogy, mobilization, social advocacy, and government policy advocacy. Social pedagogy mainly relates to the increasing need to learn how to co-exist with the epidemic. Mobilization refers to issues of political will and commitment at the international, national, and local levels. Social advocacy was described as issues related to establishment of proper laws on HIV/AIDS (e.g., access to drugs and treatment) and human rights. Finally, government policy and advocacy refers to the role that UNAIDS must play as an advocate for political commitment from governments on HIV/AIDS issues.

As indicated above, these two methodological aspects are interconnected, showing that there is constant feedback between the two processes. Careful attention must be given to the fact that political and social advocacy affecting decision-making processes might be needed before any technical work (methodology), such as a communications campaign, is conducted. Political decisions often affect the types of messages that will be part of a communications campaign, which means that even if a communications campaign is methodologically sound, it may still be limited in impact, due to political issues and decision making.

This conceptual framework allows us to further show that communications should no longer be focused solely on issues of information and messages for behavior change alone, but also on every other aspect of the HIV continuum (prevention, care, and support).

Recommendations

In addition to the five contextual domains, two other key areas of interest were identified at the Latin America/Caribbean regional workshop. These are (1) advocacy, and (2) involvement of positive persons in communications programs.

Advocacy

● Advocacy is needed on different fronts throughout the region. For instance, issues of men who have sex with men tend to be ignored in some countries. Thus, advocacy must be conducted at local and national, as well as at international, levels.

● The need to strengthen support groups is increasing. Advocacy must play a critical role in this process. For instance, where necessary, access to basic health services must be advocated for people living with HIV/AIDS.

● Efforts must be made to develop strong partnerships among the media, government, and NGOs. However, this must be achieved through negotiation, sensitization of media owners, and proposal of sound communications strategies.

● UNAIDS must play a variety of roles in this process: as a facilitator of processes, to promote prevention, and to promote greater attention at the individual and family levels through advocacy before policy and decision-makers.

- The creation of a Latin American regional speakers' bureau is one way to strengthen education and prevention programs. People living with HIV/AIDS might feel more comfortable sharing their experiences in countries other than their own, where there is little chance of being ostracized or discriminated against.

- At the ethical level, people involved in delivering HIV/AIDS programs must be self-critical and look inward to assess whether there is personal and organizational commitment to the work. Advocacy must be made to all audiences so as to gain political will and commitment.

- Issues such as violence, cultural values, human rights, education, spirituality, and law must also be taken into account in communications. However, on the issue of human rights, some participants believed that in Latin America this term might have, in certain contexts, a negative connotation. Thus, other terms such as *human dignity* or *citizenship* might be used to avoid greater resistance.

Involving HIV-Positive Persons in Communications Programs

- Persons living with HIV/AIDS must be involved in the planning, implementation, and evaluation of communications programs. In this regard, negotiation and consensus among government,

international organizations, and other groups affected by the epidemic is crucial.

● HIV/AIDS has a close relationship to emotion and feelings. Behavior change does not occur in any one particular way. Entertainment, music, and humor are central elements of Latin American and Caribbean cultures and must be used in education and prevention programs.

● Communications campaigns are no longer limited to prevention messages, but should take into account the health continuum from prevention to care and support.

● Communications strategies must be localized, so specific groups and areas might be targeted (e.g., urban and rural populations and vulnerable groups). Programs must guarantee plurality and diversity and promote consensus (by keeping AIDS in the media and on social agendas).

5

The Future:
Translating the Framework into National Communications Strategies

The Changing Communications Scenario: Toward a Participatory Media

Increasingly, health priorities need to be determined through debate and dialogue. National health care authorities are operating in a world where there is an expansion of consumer-responsive media. This could enable people to participate in the decisions affecting their lives, rather than having their lives shaped for them. Community-based media have the potential to educate, entertain, and inform, while providing opportunities for discussion and debate on issues such as HIV/AIDS.

These dialogues will no longer be scripted exclusively by government experts or international NGOs and agencies, but will emerge in public forums. Once greater pluralism and democracy begin to guide the process, more dynamic strategies will animate these debates.

Entertainment education is an example. This innovative media strategy is defined as the process of putting educational content in entertainment messages in order to increase knowledge about an issue, create favorable attitudes, and change behavior over time concerning the educational issue or topic (Singhal and Rogers, 1999). The voices of women, the economically and politically marginalized, interest groups (including NGOs), and other stakeholders in community and national life are finding venues in community-based media for expressing their unique perspectives.

National media in many resource-poor countries are being transformed from state-run broadcasting and government press monopolies to many smaller, often more dynamic, commercial operations serving niche markets. In Uganda, for example, the liberalization of radio broadcasting has led the government to scale down dramatically its investment in Radio Uganda, while new commercial organizations, such as Kampala's Capital Radio, with its emphasis on Western popular music, have become increasingly popular. Capital Radio's program *Capital Doctor* has found new ways to make HIV/AIDS and other health issues relevant to ordinary people. At the same time, however, several of the new Christian radio stations have been offering programming with ambiguous and sometimes negative messages about condom use.

For health workers, this process of media fragmentation and democratization raises a number of issues. One of the most important is that communicating a single message to a national audience has become much more

complex. State-run media monopolies allowed health professionals to reach their audiences at a single stroke. Opportunities to transmit messages through a single mass medium are declining. Even in many of the countries where the ability to retain state control of the media is strongest, compelling forces move toward more open and multi-channel media. Many states struggling to maintain national media systems have turned to private sector sponsorship to supplement their funding. In political terms, tendencies favoring greater democracy (no matter how tentative) increase the pressure for greater pluralism and add distance between the ruling political party and the mass media.

These challenges notwithstanding, the increasing diversity in media ownership offers health communicators even greater opportunity to communicate timely health messages. For example, messages encouraging people to wear condoms during sex or elevating the status of women in media are finding increasing acceptance in the smaller media. In addition, media fragmentation may help health communicators reach different audience segments with more specific messages. But the costs (production, human, and material) are inevitably greater. Moreover, the privatization of the media also raises the concern that development and health workers may be reinforcing a global, commercially driven process. Some argue that attitudes in resource-poor countries are being manipulated and shaped by external forces over which the countries have little or no control.

A new and adaptable communications framework has been developed. This framework is grounded in the

context within which HIV/AIDS occurs, spreads, and assails communities, countries, and regions. Whenever appropriate, it will draw simultaneously on the behavior-changing power of interpersonal communication and on the informational power of the mass media.

Communications Practice and HIV/AIDS Prevention

Media campaigns and interpersonal communication complement each other in the development of communications interventions for HIV/AIDS prevention and care. The mass media can convey information efficiently and thereby provide effective support for face-to-face communication. The combination of mass media with interpersonal communication allows for addressing diverse individual and group concerns while honoring the delicate, private nature of human sexuality. One example of an effective interpersonal communication is *oramedia*—a term coined by Ogboaja to describe a traditional network of oral communication channels in the African context, which is equally applicable in several cultures of Asia and Latin America and the Caribbean.

Published materials on the success of interpersonal communications in HIV/AIDS are scarce. This is due in part to the relatively limited funding for interpersonal communication interventions. Funding has been limited primarily because interpersonal communication reaches fewer people than the mass media. However, many practitioners have found that interpersonal communication has been successful in addressing the sensitive issues

of sexual behavior in Africa and Asia. Moreover, the costs and benefits of interpersonal communication have not yet been adequately assessed. Interpersonal communication results in behavior change that cannot be evaluated as easily as creating and maintaining awareness through the mass media.

Another problem is that mass media campaigns on HIV/AIDS prevention are criticized in part for unfounded claims by researchers and practitioners that behaviors were influenced when simple awareness was the only possible outcome. Although mass media campaigns, typically of limited duration, are necessary for promoting and maintaining awareness, behavior change requires sustained promotion among groups and individuals. This requires an interpersonal communication component.

Media campaigns are also useful in reinforcing interpersonal communication by, for example, focusing on gender roles in the family and the community. This has encouraged men to engage in the dialogue on HIV/AIDS prevention, rather than placing the entire burden of decision making on women. The importance to men of their families and their protective roles in their families and community can be reinforced by the mass media.

Mass media campaigns can also help challenge the assumption that increased knowledge of HIV/AIDS alone leads to safer sexual behaviors. Targeting each segment of the community with appropriate messages is critical for reaching a population with diverse modes of knowledge production and acquisition. Also, cultures

vary in their reliance on new knowledge as a motive for behavioral change. The strength of associations between and among knowledge, attitudes, and practices also differs from one culture to another. Understanding these cultural variations is essential for communications interventions. The traditional assumption that knowledge automatically leads to behavior change is no longer accepted.

Broadcast HIV/AIDS public service announcements (PSAs) have typically carried non-specific and uncontroversial safe sex information. In most cases, PSAs have been designed to increase knowledge rather than influence behavior. The promotion of condom use as a preventive health behavior message has appeared in less than a third of HIV/AIDS PSAs. So far, the majority of PSAs have been aimed at general audiences. They have generally provided vague, visually inexplicit material; avoided addressing barriers to behavior change; and have rarely provided specific recommendations. Almost without exception, PSAs have been limited to increasing the awareness of HIV/AIDS. This approach is inconsistent with the goals of HIV/AIDS prevention campaigns, which are to address contextual domains that could lead to behavior change.

Another factor to be taken into account is that HIV/AIDS practitioners have begun to initiate community-based and community-wide programs. In contrast to typical communications campaigns, community-wide interventions are long-term, more complex, and by necessity, involve extensive community participation. While properly developed and well-imple-

mented mass media campaigns can play a vital role in increasing knowledge and public awareness of the issues, more resources need to be invested in interpersonal communication. And it must be pointed out that communications campaigns alone cannot change community infrastructure, bring about and enforce policies, or increase resources (such as condoms or needle exchanges) and services (counseling, testing, or medical care).

In summary, the responses from countries represented in the consultative workshops highlighted the following key issues crucial to effective communications for HIV/AIDS prevention, as well as other themes that remain somewhat problematic for HIV/AIDS prevention, care, and support programs:

● Integrate HIV/AIDS prevention with STD/STI treatment, given the proven success of this strategy.

● Locate HIV/AIDS messages within the broader context of a country's social economic reality, recognizing that HIV is both an economic and social crisis.

● Develop HIV/AIDS communications strategies with due consideration to culture, gender relations, power structure, religion/spirituality, individual and government economic status, and the individual and collective roles of these dimensions in HIV/AIDS prevention and care.

● Promote community participation by planning

and carrying out people-centered programs that induce broad-based participation.

- Use mass media and interpersonal messages either independently or jointly in communications strategy.

- Recognize the role of alcohol consumption in the spread of HIV. This is particularly important given that some societies favor alcohol consumption.

- Support the availability of condoms as well as teaching their proper use.

- Advocate for communications to address the importance of laws prohibiting violence against women, including domestic violence and rape by men in the military.

- Encourage communication with and between parents and siblings so that HIV/AIDS can be discussed in whatever manner the culture and family support parent-sibling discussion.

- Collaborate with private sectors and recognize the important role of non-governmental organizations, so their roles and capabilities are strengthened.

- Develop targeted programs for specific populations, such as taxi drivers.

- Use participatory and qualitative research, so the beneficiaries of programs are involved in planning, implementation, and evaluation. This type of

research has allowed several countries to identify problems and audiences that had originally been overlooked during planning of communication interventions.

● Identify the differences within a country or region, for example, rural vs. urban and lowland vs. highland.

● Recognize the importance of human rights as they relate to the legal protection of persons living with HIV/AIDS, including such communications strategies as disclosure in vaccine trials, prevention of mother-to-child transmission of HIV, and access to treatment drugs, including anti-retrovirals. Each of these poses ethical issues.

● Develop programs for specific populations, such as curriculum integration for school-based HIV/AIDS education programs and workshops for worksite-based HIV/AIDS education.

● Maintain awareness through the mass media—such as by addressing existing misconceptions about HIV/AIDS—while recognizing the limitations of sole reliance on the media to spur action.

● Recognize the implications for men having sex with men. This continues to be ignored in some countries' HIV/AIDS prevention programs.

● Use evaluation as a strategic element in all communications strategies. Pretesting must also be emphasized in all communications programs as a crucial component of effective message and mate-

rial design. Moreover, the epidemiological context of HIV/AIDS must be understood through systematic research in order to design more effective communications programs.

● Promote the openness to explore new ideas and approaches to influencing audiences. Early school education on HIV/AIDS prevention might be an effective way of addressing a problem in some places. However, political will and commitment are needed, which means that advocacy work must be directed to ministers of education and other decision-makers.

Recommendations

In the context of HIV/AIDS, both short-term solutions and long-term change are needed to alleviate the impact of AIDS. The contextual domains present some challenges to be addressed, since they do not lend themselves to linear intervention strategies directed to solving problems without reference to the causes. It is critical to identify relevant social, cultural, and behavioral norms that could be encouraged or changed to reduce risk situations that tend to favor the spread of HIV/AIDS. Following are some of the key issues for achieving the goals and objectives related to the five domains of context. These recommendations are grouped into interpersonal communication, mass media, and program intervention.

Interpersonal Communication

● Identify the role and function of interpersonal communication strategies. For example, identify the potential of entertainment education by using humor in AIDS messages and discussions about sexuality to promote open discussion among couples, peers, and friends.

● Create opportunities for communities to discuss issues through interpersonal communication.

Mass Media

● Define the role and function of communications interventions, including social mobilization and advocacy.

● Train personnel and participants, whether from within or outside the targeted social context, in the use of effective mass media strategies.

● Assess the information environment, particularly in light of the competition between health and other communications priorities for media space and time.

Program Intervention

● Make a distinction between planned communications and news items that are not within the purview of health interventionists.

● Identify what is meant by cultural meaning, so the understanding and appreciation of "culture" is not limited to individual beliefs.

● Use indigenous resource persons, such as opinion leaders and traditional healers, to serve as facilitators for communications planning.

● Use flexible approaches to intervention, rather than one-size-fits-all formulas.

● Cover the continuum from prevention to care in communications strategies.

● Treat communities as holistic, but segmented, targets of information, rather than as single audiences.

Communications Matrix

Domains	Issues	Analyses	Outcomes	Strategies	Evaluation
Government Policy					
Socioeconomic Status					
Culture					
Gender Relations					
Spirituality					

The above matrix could represent the guide to applying communications in the new framework. In this matrix, we have the five domains that have been identified. Each domain will have several issues, and some of the issues (e.g., capacity building or stages of the epidemic) may transcend multiple domains. For each issue, a country should analyze the issue based on research and experience from the regions. The next step will be to identify specific outcomes in responding to the issue within one or across more than one contextual domain. Examples could be changing social morals, changing policies, or strengthening positive cultural values. Following identification of outcomes, strategies for realizing these outcomes should be identified. For example: Should the channel be media or interpersonal communications? If media, should it be TV, radio, newspaper, or magazine; and should it be "sweep" (a comprehensive coverage) or "spotting" (a targeted coverage)? If interpersonal communications, should it be small group, targeted opinion leaders, or captive audience (e.g., market, school, or motor park)? Next is to identify specific messages based on past successes. Finally, there should be a mechanism to monitor and evaluate the planning, process, and outcome of the intervention.

6 The Framework: From Local to Global

The new UNAIDS framework for communications is informed by a combination of research and practice that is congruent with conceptual and practical understanding within each cultural context. Particularly when used to address HIV/AIDS in Africa, Asia, and Latin America and the Caribbean, communications strategies could incorporate selected elements of existing approaches, but must not be rigidly modeled on them.

A communications strategy must go beyond merely disseminating messages. It should provide evaluation research demonstrating that these messages have been truly effective. Evaluation should be a continuous process, encouraging the community at the grassroots level to examine its own problems and to participate in the construction of solutions. Both quantitative and qualitative methods of evaluation should be used. Sometimes, guided but informal monitoring and evaluation within the community is vital to revealing the real needs of the community and to obtaining reliable information on sensitive sexual issues.

Communications interventions should be based on an evaluation of the current approaches to communications for HIV/AIDS and focused on developing a global response that takes into account regional guidance and consultation. Involving people in such planning, implementation, and evaluation processes requires effective, culturally sensitive, and inclusive communications policies facilitated through interpersonal communication, education, and mass media campaigns. This also applies to methods of communicating across cultures, such as oral communication and language elasticity. (Language elasticity consists of cultural expressions, particularly words of advice and encouragement, that are often couched in adage, allegory, and metaphor. They may not mention the subject of discussion, the meaning of which is, however, clearly understood by those engaged in the communication.) Thus, sensitivity to culture should be central to the design of communications interventions both in the media and in interpersonal communications.

Through the consultative process, UNAIDS reached the conclusion that current conventional theories and practices concerning health behavior are too limited and appear to be inadequate for an adaptable communications framework. The five domains of context that emerged as factors to be considered in HIV/AIDS preventive behavior in a revised communications framework have been discussed earlier.

After much discussion about the process and outcome, it was agreed that the new framework should focus on key issues that need to be addressed and the capacity to address them in a given context. It was also agreed that,

given the outcome of the meetings, the focus should not be on the development of an alternate theory but on a flexible approach to addressing HIV/AIDS prevention and care globally with regional specificity. As a result, the framework should identify the key issues and components to be addressed. The specifics of these will be left to each country in order to ensure that local differences are appropriately represented and addressed. The following are some principles to guide the formulation of communications frameworks for HIV/AIDS communications interventions at the national level:

● Target audiences should be clearly identified in the framework, so their specific needs can be addressed appropriately.

● Media environments are changing rapidly, so partnerships with the media should be cultivated to encourage leaders in media organizations to advance appropriate HIV/AIDS communications.

● Communications interventions should be seen as a combination of mass media and interpersonal communications.

● An adaptable communications framework ought to be based on a combination of strategies focusing on the contextual elements of government policy, socioeconomic status, culture, gender relations, and spirituality.

● Communications strategies should address the entire range of health services—from prevention to care.

● Community-based approaches to intervention, wherein community members and institutions are involved from the planning phase, should be supported.

● Opinion leaders should be mobilized and included in communications strategies, particularly in interpersonal communication.

● Communications should be targeted to people in communities who can be channels of information, such as teachers and traditional healers.

● Communication message construction for HIV/AIDS should involve both the sender and the receiver. Use an inclusive, eclectic approach rather than an "either-or" model.

● Familiar contexts, wherein sender and receiver are relating to similar cultural codes and meanings, should be the foundation of communications interventions.

● Regional, national, and local strategies that promote conceptual and practical ownership of a project should be encouraged.

● Regional contexts should influence communications strategies.

● An institution can be considered as much a channel or medium as an individual.

● Interpersonal communication, particularly when addressing issues that are considered to be cultural or spiritual, should be strongly encouraged.

Communications Framework for HIV/AIDS

●   Support for prevention communications should be strengthened, given that the limitations of new combination drug treatments may create a false sense of security in the most vulnerable populations.

The House-to-Home Metaphor

The framework is represented as a house whose structure will vary from region to region and country to country. Residents of a "house" transform it into a "home" through their culture, spirituality, economic resources, gender and family relations, and the policy and rules that govern interaction in the home. Thus regional, country, and community specificity will transform the house into a home. Every house has a foundation, a roof, and a body designed to respond to the conditions in the environment—the context. In the new communications framework, the five domains are represented in the foundation, the roof, and the body of the house, depending on the goals, objectives, and strategies that will be employed in a given communications intervention. The regional and country specificity will be captured in the different architectural, structural, climatic, material, spiritual, and cultural meanings that will transform the house into a home (see figure 6.1, p. 84).
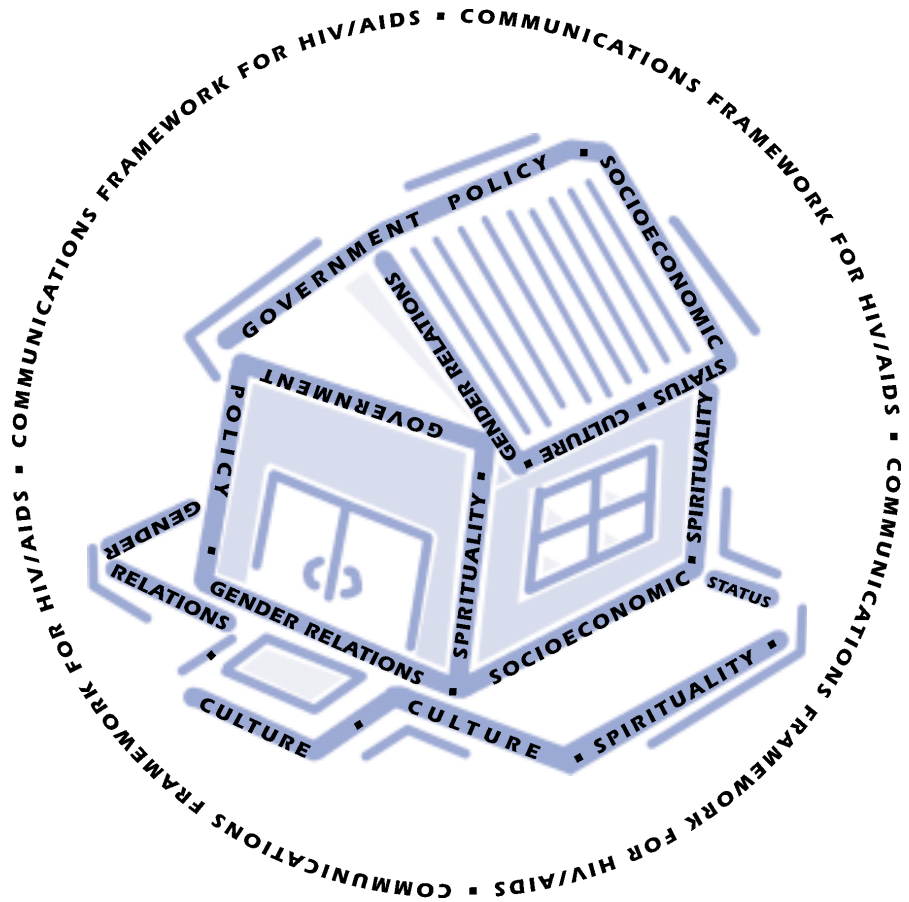
House-to-Home Metaphor

Figure 6.1

The framework should help to generate discussion about the relationship between the focus of a communications program and each phase of an HIV/AIDS epidemic. Different approaches and messages may be appropriate for each stage.

Components of the framework should involve: (a) a definition and scope of communications interventions; (b) the "how-to" strategies in communications; (c) aspects of program development—specifically capacity building, credibility building, policy advice, and resource mobilization; and (d) the evaluation of strategies and outputs in planning and implementation.

Finally, as one would expect in any house, there should be doors for entrance and exit. In this framework, there will be a double door, which will have the key issues and processes for implementing a strategy on one panel and the key steps and processes for evaluation on the other panel. The windows will offer opportunity for every region and country to address their specific conditions consistent with the stage of the epidemic in their context.

For example, in a program making condoms available to clients of sex workers, the national government may be located at the roof of the communications framework to establish policy that would ensure 100 percent condom availability. Maximizing use of the available condoms, however, may require identification of societal expectations of women engaged in the commercial sex industry. Thus, gender relations may be located at the foundation of the framework. Other related contextual domains are the walls of the framework—socioeconomic status and cultural and spiritual factors at the community, institutional and individual levels.

In another situation, the inability to translate public awareness into positive health behavior may necessitate locating spirituality at the roof, representing faith communities. It may be necessary for leaders of different faiths to target various communications messages to focus on different population sub-groups. Meanwhile, culture could be located at the foundation. Culture could be used to identify local communications processes that would lead families and communities from awareness to behavior change. In this latter example, the roles of gender relations, socioeconomic status, and government policy may be examined as doorways and windows into determining appropriate strategy.

Conclusion

This monograph does not include a discussion of the steps that need to be taken to operationalize the regional frameworks; this should take place at the country level. In fact, providing operational steps would defeat the purpose of the participatory process that characterizes this initiative. The next step in this process is for each country—or a group of countries—in the regions to develop a forum wherein researchers and practitioners could meet to develop methods of operationalizing the regional frameworks with their own contexts. This is where the house is transformed into a home.

Appendices

Glossary

ACORD – Association de Cooperation et Recherche pour le Development

AED – Academy for Education Development

AIDS – acquired immune deficiency syndrome

AIDSCAP – AIDS Control and Prevention Project of FHI

AIDSMARK – Project of Population Services International

BCC – behavior change communications

CCISD – Centre for International Cooperation in Health and Development

FHI – Family Health International

IEC – information, education, and communication

IPPF – International Planed Parenthood Federation

ISAPSO – Integrated Service for AIDS Prevention Support Organization

JHU – Johns Hopkins University

NAP – National AIDS Programme

NASCP – National AIDS and STD Control Programme

PATH – Program for Appropriate Technology in Health

PCS – Population Communication Services, Johns Hopkins University

Penn State – The Pennsylvania State University

PSI – Population Services International, USA

SAfAIDS – Southern Africa AIDS Information Dissemination Service

SFH – Society for Family Health

STD – sexually transmitted disease

UN – United Nations

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNDCP – United Nations International Drug Control Programme

UNDP – United Nations Development Programme

UNESCO – United Nations Education, Science and Cultural Organization

UNFPA – United Nations Population Fund

UNICEF – United Nations Children's Fund

USAID – United States Agency for International Development

WHO – World Health Organization

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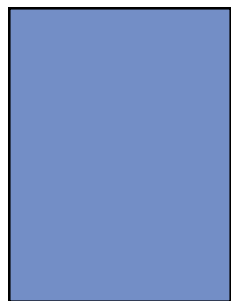
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