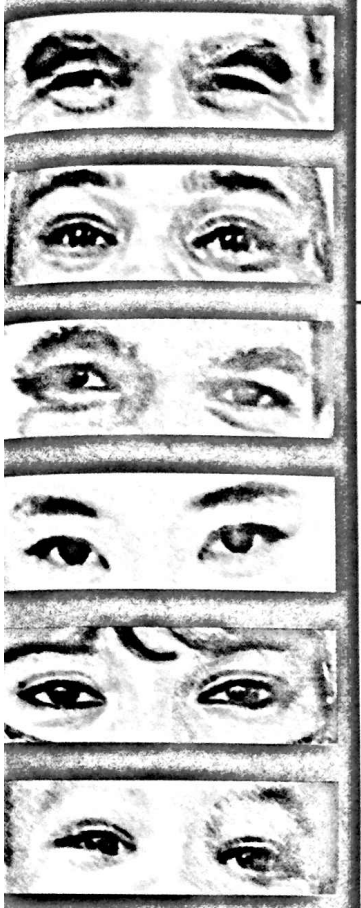

INTERNATIONAL COUNTERPART FORUM

VIII INTERNATIONAL CONFERENCE ON AIDS

STRATEGIES FOR HIV/AIDS PREVENTION AND TREATMENT EDUCATORS

A REPORT FROM THE INTERNATIONAL COUNTERPART FORUM, HELD DURING THE VIII INTERNATIONAL CONFERENCE ON AIDS IN AMSTERDAM, THE NETHERLANDS, JULY 1992

THIS REPORT SUMMARIZES DISCUSSIONS OF STRATEGIES FOR

- *Educating gay men*
- *Educating people in non-urban settings*
- *Educating low-literacy populations and individuals*
- *Educating women*
- *Educating injection drug users*
- *Educating children, adolescents, and young adults*
- *Maintaining behavior change*
- *Using peer-to-peer education*
- *Using culturally specific modes of communication*
- *Using the mass media as an educational tool*

The International Counterpart Forum, held during the VIII International Conference on AIDS in Amsterdam, was designed to give HIV/AIDS prevention and treatment educators from all over the world an opportunity to meet for focused roundtable discussions. Planned by an international advisory board of leading educators, the forum was created to fill a need for formalized networking opportunities among Amsterdam conference participants involved with HIV/AIDS education. In her introductory remarks, Rashidah L. Hassan, RN, the forum moderator, described the goal of the forum as the sharing of strategies with others who do similar work. As Ms Hassan commented, the International Counterpart Forum was "an opportunity for HIV/AIDS prevention and treatment educators to tell one another what they know best—how to implement effective programs."

The forum, funded through an educational grant from the Wellcome Foundation Ltd. and Burroughs Wellcome Co., drew 80 participants from 22 countries, including Bulgaria, Canada, Colombia, Finland, India, Israel, Morocco, Peru, Senegal, South Africa, the United Kingdom countries, and the United States. With HIV/AIDS education experience ranging from village education programs in developing countries to policy planning in multinational foundations, the participants each selected one of 10 discussion topics that reflected their interest and/or expertise. During the facilitated discussions, the educators described their program strategies and ideas, sharing successes, failures, and plans.

HIV/AIDS prevention and treatment education messages have to be more than "use condoms" and "get medical care." Communities need basic information on the biomedical aspects of the disease, on HIV antibody testing, on treatment options, and on other sexually transmitted diseases. In many regions, HIV/AIDS education can take place only in the context of other fundamental improvements in access to healthcare and in socioeconomic status.

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Prevention messages must address not only condom and safe-needle use, but also ways to negotiate for and eroticize safe sex. All of these are necessary to normalize safe sex in people's lives.

Information campaigns should also identify resources for HIV antibody testing and counseling, for substance-use treatment, for case-management services, and for current information on HIV and AIDS. Other less-concrete but also essential issues to be addressed include the importance of self-esteem, positive role models, and peer- and family-support networks. The focus at the forum, however, was not on the specific content of HIV/AIDS prevention and treatment messages for different communities, but on effective methods for getting the information across.

To provide a framework for these focused discussions, the evening began with three overview presentations designed to address the global challenges facing HIV/AIDS prevention and treatment educators. In the first, Chuck Frutchey, of the San Francisco AIDS Foundation, described the challenge of having more and more information on prevention and treatment issues to deliver. As educators learn more about the target populations, they find that these must be broken into subgroups—what was women includes rural women, poor urban women, sex workers; what was gay men is now younger gay men, gay men of color, non–gay-identified men, gay male substance users. This population segmentation allows for more-tailored and more-effective education messages, but also requires additional programming and funding in a climate of limited resources.

While the amount of educational work to be done continues to grow, 10 years of global experience has led to many successful techniques and strategies. Program evaluation indicates that prevention education does work, and it is important to design an appropriate evaluation component for all educational programs. Currently, evaluation is done inconsistently, and often is designed only to satisfy funding agencies rather than to provide relevant and appropriate feedback.

In his overview of the strategic issues that face AIDS service organizations across Europe, Nick Partridge, Chief Executive of the Terrence Higgins Trust in the United Kingdom, outlined several key issues. First, it is essential to ensure that local and national educational programs are effectively targeted to at-risk populations. A recent survey of agencies involved in prevention education in the United Kingdom determined that, in a country in which 70% of those with AIDS are gay or bisexual men and 62% of those who tested positive this year for HIV are gay or bisexual men, very few agencies funded to do AIDS prevention work conduct comprehensive programs for gay men. Among the obstacles to conducting such programs are uncertainty on how to contact gay men, concern about the stigma attached to "risk groups," the sensitivity of the prevention education messages, and the belief that prevention work is being done by "someone else."

In addition to targeted education campaigns, there is a growing need for cooperation among AIDS service organizations. With the integration of clinical trials across national borders and the ease with which people living with HIV or AIDS can move between countries in the European Common Market, it is imperative that European service organizations cooperate in sharing treatment information. The European AIDS Treatment Group has been established to create a cooperative effort, as well as to advocate for additional clinical trials that incorporate the needs and demands of people living with HIV in their design and implementation. In addition, newly formed AIDS service organizations in the changing societies of central and eastern Europe need to be encouraged and supported. The more-established community-based and AIDS service organizations in northern Europe must work with their newer counterparts to devise strategies for efficiently and effectively sharing their successes, failures, and resource strategies.

In the final overview presentation, Emilio Velásquez, of Organización SIDA in Tijuana, Mexico, echoed this need for international cooperation not only among AIDS organizations but also among governments and nations. The current wave of anti-gay violence in Mexico City serves as a reminder that violence and homophobia are among the many obstacles that face HIV/AIDS prevention and treatment educators; they are obstacles that call for a strong international response.

Following the three overview presentations, the focus of the International Counterpart Forum turned to the 10 facilitated discussions on specific issues, challenges, and strategies in HIV/AIDS prevention and treatment education. This report presents summaries written by the facilitators of those discussions, and we hope that you will find it to be a valuable resource. ■

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Strategies for Educating Gay Men

Nick Partridge

The history of the AIDS epidemic has shown that gay communities have created new models of health promotion and innovative approaches to primary and secondary prevention. In particular, safe-sex campaigns have been created worldwide, as have new models of care, support, and information for people living with HIV disease and AIDS. Furthermore, AIDS educators in the gay community have not been selfish about those new models; they have been shared, adapted, and used by others addressing the AIDS crisis. For example, Pink Triangle in Malaysia was founded as a gay community organization in 1988. It is now recognized by the government as an important resource, and its telephone information line is used by anyone who is concerned about AIDS.

HIV/AIDS educators from Canada, Malaysia, The Netherlands, the United Kingdom, and the United States, meeting to discuss the next step in educating gay men, agreed that there is much to be proud of. However, all the participants were angered and concerned by the continued underfunding of this fundamental and ground-breaking work. One participant from the United States pointed out that, in the eleventh year of an epidemic that has disproportionately affected gay men, no federal funds have been targeted to support HIV prevention work for gay and bisexual men. Similarly, in the United Kingdom, a recent survey has shown that only one percent of the agencies funded to conduct HIV health education have a comprehensive program for gay men.

The participants offered several explanations for this lack of funding and focus: the political difficulty many governments have in funding gay community organizations

SAFE-SEX CAMPAIGNS HAVE BEEN CREATED WORLDWIDE, AS HAVE NEW MODELS OF CARE, SUPPORT, AND INFORMATION FOR PEOPLE LIVING WITH HIV DISEASE AND AIDS.

(commonly recognized as simple homophobia); the misinterpretation of the partial success of changing the sexual behavior of gay men in the mid-1980s as a job well done once and for all; and, paradoxically, the vigorous promotion of the message that "everyone is at risk." This message has tended to undermine the urgency of HIV prevention work for gay men and has lowered the perception of risk among gay and bisexual men.

Needs Assessments

Conducting needs assessment is one strategy for combating this inertia and inaction. The experience of the participant from Canada was particularly encouraging. There, a national government-funded survey documented the knowledge, attitudes, and behavior of 5,000 gay and bisexual men. By statistically demonstrating the health education needs of this community, the survey led to an increase in government funding for programs that target gay and bisexual men. In addition to serving as a needs assessment, the survey itself was a safe-sex initiative in that the process of being interviewed helped the respondents to think about their own sex lives. By taking gay men's needs seriously, the survey also functioned as a community development tool. Some of the men who were interviewed requested information on how to volunteer for safe-sex campaigns.

Community Development Programs

Community development programs formed the core of the discussion, just as they form the core of most of the successful work that has been done with gay and bisexual men. Right from the start, promoting safe sex involved acknowledging,

THE NEEDS OF VERY FRAGILE COMMUNITIES OF PEOPLE WHO DO NOT WISH TO IDENTIFY THEMSELVES AS GAY—FOR EXAMPLE, TRANSVESTITES AND TRANSSEXUALS—MUST BE LISTENED TO CAREFULLY AND RESPONDED TO APPROPRIATELY.

respecting, and working with people's existing sexual practices and desires. The aim was, and still is, to make sex less risky through the least disruptive and minimum necessary modifications. The crucial tool was plain, honest, explicit discussion of safe sex as often as possible in as many situations as possible, using a wide variety of means—workshops, public discussion in the gay press, helplines, and outreach projects, among others.

The crucial method was the mobilization of a whole community through a cascade or diffusion process, in which a small group of people talked to a larger group, who in turn talked to a still larger group, and so on until the whole community had been reached. This peer education is effective because people tend to accept what they learn from their trusted equals. Feedback was particularly important in helping to compile a whole range of community responses and solutions to the threat of AIDS and HIV. This HIV/AIDS health promotion was conducted by voluntary and self-help groups that were receiving little or no official support, except in countries such as The Netherlands and Denmark, which showed unusual foresight. Perhaps the best-described approach of this kind was the "STOP AIDS" campaign in California. The one-on-one peer education strategy of this campaign was designed to enhance the social diffusion of safe sex by using, elaborating on, and reinforcing existing community structures.

Three participants, however, commented on the difficulties they had encountered with this model. In Manila and Moscow there is no gay community as such; indeed, the word "gay" has only very recently been used. Others pointed out, though, that this is not dissimilar to the experience in London and New York, where "gay" gained wide acceptance only in the past 20 years. It was suggested that a common mistake is to assume a level of community that does not exist, and that gay community development is often started by HIV prevention work.

Similarly, the needs of very fragile communities of people who do not wish to identify themselves as gay—for example,

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Strategies for Educating People in Non-urban Settings

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HIV/AIDS prevention and treatment educators with a range of backgrounds and constituencies met to discuss strategies for providing education in non-urban settings. Their experience is drawn from remote areas of Canada, Hawaii, Scotland, and rural areas in the southeastern, midwestern, and western United States and from working among hard-to-reach at-risk individuals in Brooklyn, New York.

While difficult to define precisely, non-urban settings include small towns, villages, unincorporated areas, places "where the road gets wider," and places where there are no roads. Although prevention and education efforts in these areas may face some obstacles similar to those in inner-city areas, non-urban settings have unique needs and pose unique challenges.

When community leaders participate, their partners and social networks often will also get involved.

Where the Streetlights Stop and the Sidewalks End—Obstacles to HIV/AIDS Education

Many descriptions of non-urban settings—"beyond the end of the bus line," "hours away from a hospital or healthcare"—emphasize the isolation of these areas in terms of transportation, services, and support. Rural settings often have no local hospitals, clinics, or healthcare providers. Access to primary healthcare, including prenatal and infant care, is often limited, as is access to drug-treatment programs, sexually transmitted disease clinics, and HIV antibody testing. People living with HIV disease may have limited access to immunologic testing, drug-assistance programs, and clinical trials, and often have no case-management services, no pharmacy support, no aerosolized-pentamidine services, no "meals on wheels," and little availability of home-care services. There may be no social agencies to provide up-to-date information and no peer-support networks or groups. Even condoms and lubricants can be hard to get.

In some rural communities, socioeconomic conditions, including unemployment and underemployment, inadequate housing, poor sanitation, lack of public utilities, substandard education, no child care services, and inadequate or absent health insurance, may complicate AIDS education efforts.

In rural communities it is difficult to ensure anonymity. Where HIV testing and HIV/AIDS services are available, they may be provided only on specific days. As a result, those who visit the clinic on those days are suspected or may feel they will be suspected of being HIV-infected or at risk. Because there is usually less ethnic diversity and less acceptance in rural settings of those who are "out of the norm," people with HIV may be more likely to suffer from discrimination. Conservative religious values may amplify bigotry, homophobia, and the stigmatization of those infected with or at risk for HIV, and may restrict the use of explicit education materials on risk reduction.

In scarce supply are local leaders and positive role models for HIV/AIDS education. Volunteers may be harder to mobilize, and there is a smaller population from which to draw them.

Strategies for HIV/AIDS Education

The participants agreed that urban solutions cannot be exported to non-urban settings: The educational messages must be culturally specific and "home-grown." Educators who design or implement interventions must learn the history, context, and sensitivities of the community.

There are many mainstream sites where HIV prevention and treatment education can be provided, including schools, hospitals, churches, fraternal or women's organizations and special-interest groups, recreational or agricultural clubs, businesses and workplaces, and government-sponsored public health facilities. While these mainstream locations may help HIV/AIDS educators to reach some of the community, other strategies are required for some hard-to-reach populations, such as farm adolescents, trailer-park residents, the homeless, gay and bisexual men and women, non–gay-identified men who have sex with men, migrant and seasonal workers, cannery workers, truck-stop and bus-stop prostitutes and their patrons, individuals who go to parks, beaches, or rest stops for anonymous sex, and drug users.

Peer-to-peer communication is often the most effective way to provide HIV/AIDS education. Key community members to be recruited as educators include those active in parent-teacher organizations, local business people, teachers, nurses, and other social or political leaders. This helps avoid "missionary-style" programs from those who believe they have the answer to the community's problems. As a part of the community, educators can show that they have a commitment to the people and to the education message. Peer educators often become role models, and encourage others to become involved. When community leaders participate, their partners and social networks often will also get involved. Personal contacts can lead to support from local organizations, and eventually to special community projects such as an AIDS awareness day, street-side HIV information tables, and HIV "wheel of fortune games" at a county fair.

A sense of ownership by local leaders and the empowerment of the participants will help to ensure that the program can be maintained within the community.

Developing and supporting these "seed people" is an essential part of effective education programs. A sense of ownership by local leaders and the empowerment of the participants will help to ensure that the program can be maintained within the community. Participants emphasized that patience and a realistic attitude are required. As one participant commented, educators should "expect a long time frame—not three months, three *years*."

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Strategies for Educating Low-Literacy Populations and Individuals

Emilio Velásquez

Educators working in Germany, Kenya, Mexico, The Netherlands, Thailand, the United States, and Zambia met to share their experiences in conducting HIV prevention and treatment education among low-literacy populations. Despite the diversity of the countries represented, there was immediate empathy among the participants as we discussed the challenges of our work. The rural-to-urban migration trend, economic conditions, and the general information delivered by the mass media create similar situations in communities worldwide with regard to the AIDS epidemic and the difficulty of conducting HIV/AIDS education. Patience is one of the most difficult things for educators to achieve when dealing with a life-threatening condition such as AIDS in their communities. While recognizing that social change is slow, many educators would like "instant relief" from the epidemic and the challenges it presents. Reflecting the experiences of the participants, the discussion focused primarily on HIV prevention education.

RURAL-TO-URBAN MIGRATION, ECONOMIC CONDITIONS, AND INFORMATION FROM THE MASS MEDIA CREATE SIMILAR SITUATIONS WORLDWIDE IN THE DIFFICULTY OF CONDUCTING HIV/AIDS EDUCATION.

Need for Comprehensive and Culturally Relevant Strategies

The category *low literacy* encompasses different degrees of language and reading skills. One problem cited was that of monolingual immigrants in countries in which the government does not provide information on health education and resources in other languages. One participant with experience in educating US inner-city populations described the two key aspects of low literacy as ability and lifestyle. In US cities, most people have received compulsory education and can read at some level. In terms of lifestyle, low-income inner-city people are leading a survival existence in which reading is a luxury; one must account for time, convenience, and resources.

One of the recurring themes of the discussion was the importance of recognizing that, for most low-literacy populations, HIV disease occurs in a context of many other social ills, including poverty, unemployment, inequality between the sexes, and drug and alcohol use. Educational messages on HIV prevention must be part of a comprehensive approach to primary and public health issues.

IN TERMS OF LIFESTYLE, LOW-INCOME INNER-CITY PEOPLE ARE LEADING A SURVIVAL EXISTENCE IN WHICH READING IS A LUXURY; ONE MUST ACCOUNT FOR TIME, CONVENIENCE, AND RESOURCES.

In addition, educational materials and tools must be culturally and linguistically relevant to the target population. Some of the early materials developed for HIV prevention education were directed at urban gay populations, and do not translate well to other audiences. Educators in Asia and Latin America have engaged the help of religious leaders to make people more receptive to HIV prevention messages. In Mexico, educators have used the shock technique—graphically showing the ravages of AIDS and then describing prevention measures that incorporate culturally and socially based attitudes, behaviors, and practices.

Obstacles to Effective Education

One important obstacle in educating low-literacy populations is that women lack power in many societies. Despite efforts to educate women on issues around HIV disease, cultural attitudes toward women may prevent them from seeking information and help. For example, many Latin American women who have recently immigrated to the United States cannot seek HIV testing or other health services without their husband's permission. The husband may be HIV-infected, but unwilling to deal with the shame of others knowing of his serostatus, bisexuality, or illicit drug use. Women may meet with resistance and/or violence if they ask their partners to use condoms. For many women, an HIV educational session may increase, rather than reduce, their fear.

Another obstacle the participants cited was the difficulty of explaining the complex medical and scientific concepts of HIV disease to low-literacy populations. Most participants agreed that, essentially, people need to know what to do, and to be given the opportunity to ask why and to get more information.

IN ADDITION TO A VARIETY OF MEDIA APPROACHES, PEERS AND TRUSTED LEADERS WHO SPEAK THE SAME LANGUAGE MUST BE RECRUITED TO MOTIVATE CHANGE IN THEIR COMMUNITIES.

Two additional obstacles discussed were the lack of evaluation data on the different and relatively new programs and the special technical assistance needs of nongovernmental organizations and community-based organizations in developing countries in designing programs that comply with the funding requirements of agencies in the developed world.

Education Strategies

The participants agreed that constructive use of the media is a useful strategy for delivering prevention and treatment information to low-literacy populations. Diverse and creative media tools based on needs assessments within the target communities need to be developed. Once developed, these materials have to be tested in the community for cultural and linguistic sensitivity. One suggestion was to use the mass media approach of a 30-second sound bite accompanied by an AIDS information hotline number. Other suggestions were using story telling and distributing audiotapes of the European soap operas that address AIDS issues. In some rural areas, traditional drama and theater may be useful.

In addition to a variety of media approaches, peers and trusted leaders who speak the same language must be recruited to motivate change in their communities. Multidisciplinary coalitions of diverse populations can help energize and support educational programs. ■

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Strategies for Educating Women

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During the opening session of the VIII International Conference on AIDS, women with HIV disease from 34 countries were introduced to the audience. This ceremonial acknowledgment reflected a growing recognition of the increasing number and ongoing needs of women with HIV disease and those at risk for infection.

Educators from Morocco, Senegal, and the United States met to discuss strategies for bringing HIV/AIDS prevention and treatment education to women. The discussion covered a number of areas—the promotion of safe sex and needle practices, support and services for HIV-infected women, educational and political efforts that target institutions and service organizations, and broad-based social changes in both developing and developed countries.

Obstacles to Effective Intervention

In most developing countries, the social standing of women is low and they have little power. For example, when it comes to using condoms for preventing HIV transmission, many women have no bargaining power with their partners or, for sex workers, with their clients. As one participant commented, "Their bodies do not belong to them." Sex-education campaigns, including AIDS-prevention education, can succeed only as part of a larger, concurrent effort to increase women's social status, overall health, and economic autonomy. AIDS education and treatment must be provided along with other basic services such as literacy training, employment training, and public and primary health services. In all countries there are considerable obstacles to effective education, but for HIV/AIDS educators who work in developing countries, in which women have lower status, greater needs, and narrowly defined social roles, these obstacles are even greater.

The US participants echoed the need to improve the overall status of women, and also focused on the need to empower women who have HIV disease, an essentially invisible population. Because of the stigma of AIDS, few women are willing to publicly declare their HIV status. The result is that HIV-positive women are isolated and lack access to support and services and that most funding, services, and prevention interventions are not directed toward or tailored to women. Also, limited awareness of the prevalence of HIV infection in women lulls many into a sense of false security and complacency, and thus may lead to more women becoming infected. The community organization and demand for services that are strong in the gay community have not yet been duplicated in other communities. As one participant noted, HIV-positive women can be a very valuable resource for creating effective education and advocacy, and they should be supported and encouraged to move from being isolated and afraid to being in a position to make decisions about their own lives and to serve as public educators.

SEX-EDUCATION CAMPAIGNS, INCLUDING AIDS-PREVENTION EDUCATION, CAN SUCCEED ONLY AS PART OF A LARGER, CONCURRENT EFFORT TO INCREASE WOMEN'S SOCIAL STATUS, OVERALL HEALTH, AND ECONOMIC AUTONOMY.

Strategies for Empowering HIV-positive Women

A number of efforts have been made to disseminate accurate information to increase the visibility of, and provide support for, women with HIV. One participant described a peer-counseling program in which women with a recent diagnosis of HIV infection are matched with women who have known of their HIV disease for more than a year. These peer counselors, who are paid for their time, meet with the women in person and by phone to provide information, counseling, and support on coping with HIV disease.

One participant started a monthly newsletter, *WORLD*, as a way of establishing support and connection for HIV-positive women. The newsletter, which now goes to subscribers in 47 states in the US as well as 13 other countries, combines personal stories with education and resource listings on HIV/AIDS. In addition, the organization that publishes the newsletter organizes retreats for HIV-positive women, providing a safe, supportive setting for them to share their experiences.

BECAUSE OF THE STIGMA OF AIDS, FEW WOMEN ARE WILLING TO PUBLICLY DECLARE THEIR HIV STATUS.

Another tactic for raising awareness on the issues of HIV disease in women is ongoing education and advocacy among service providers. As one participant described, the New Jersey Women and AIDS Network not only provides education on AIDS to women's service organizations but also provides education on women to AIDS service organizations. In addition to its education and training programs, it works with medical clinics to arrange gynecologic and infectious disease services at the same site and to educate the clinic staff on the manifestations of HIV disease in women.

In addition to establishing peer support networks and newsletters, and to improving and expanding the provision of services, it is essential that women be represented on policy-making boards and in the political arena. Political activism has increased the visibility of women with HIV disease, influenced programming and funding decisions, and helped individual women with HIV disease gain access to positions from which they can speak to their own needs and to those of other women.

Strategies for Prevention Education

Delivering prevention and treatment information effectively depends on using messages tailored to different groups of women, using peers to deliver those messages, and gaining access to a variety of different social networks. For instance, a group of educators put together safe-sex packets, which included information, dental dams, condoms, latex gloves, and lubricant, and demonstrated and

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Strategies for Educating Injection Drug Users

Robert H. Remien, PhD

A group of HIV/AIDS educators, five from the United States and one from India, met to share their experiences in providing education to injection drug users (IDUs). Despite differences in culture, sex, race, ethnicity, and age in the communities they serve, the participants have found many common challenges in providing HIV/AIDS prevention and treatment information to this and other multiple-substance-using populations. In the discussion, the participants described the obstacles they face, shared successful and unsuccessful education strategies, and offered one another new and creative ideas for planning interventions.

Obstacles to Effective Intervention

One of the major difficulties in delivering successful interventions to IDUs is the lack of resources available for these communities. There is typically a lack of services such as basic healthcare, HIV and other medical testing, drug treatment, and counseling. The members of these communities too often need resources that others may take for granted—jobs, housing, transportation, child care, nutritious meals, and insurance. When these basic needs are not met, it is difficult to prioritize caring for oneself in terms of preventing HIV transmission and looking after one's health. It was emphasized that we cannot ignore the impact of poverty on people's lives and the fact that

IN THIS POPULATION, EFFECTIVE HIV INTERVENTION CANNOT TAKE PLACE IN *THE ABSENCE OF* TREATMENT FOR ADDICTION.

people often turn to drugs in response to a whole host of social and interpersonal problems. It was underscored repeatedly that in this population, effective HIV intervention cannot take place in the absence of treatment for addiction.

Too often, we the HIV educators and the way that we try to deliver our messages to drug-using communities are barriers. The problems associated with illiteracy are many, and are often forgotten by educators and healthcare workers. Whether because of pride or even machismo, illiteracy is typically not freely acknowledged by those without reading skills. In addition, chronic drug users may have limited attention spans and poor cognitive skills. The "fancy, glossy pamphlets" that we produce and admire often have absolutely no impact on the populations we are trying to reach. Moreover, some people may not be able to read or understand the lengthy consent forms required for participating in some interventions, and may exclude themselves without acknowledging this.

In our own efforts we have learned that merely providing information is not enough to bring about behavior change. As one participant commented, "We thought that giving out condoms and bleach would fix the problem, but behavior is more complex than that—and doesn't change just because we make things available. Our work needs to go beyond just getting the message across." It was pointed out that there is a tremendous lack of knowledge about the determinants of high-risk behavior, whether it be drug use, needle sharing, or sexual activity. Too often we think of drug users as being at risk only because they may share contaminated needles, forgetting that they are also sexually active. In many cases we have been successful in getting people to change their drug-use behavior but not their sexual behavior.

Denial is another major barrier to successful intervention. This may be denial on the part of the drug users, as well as on the part of the communities in which they live, whether it be at the level of the family, the church, or the local government and policy makers. Unfortunately, the community often does

WE MUST NOT FORGET THAT PEOPLE HAVE MANY IDENTITIES AND ARE MORE THAN SIMPLY "SUBSTANCE USERS."

not understand the chronic nature of addiction, and much-needed aftercare for those in recovery is not funded. Too often, family members will not acknowledge that drug use is taking place, and they may be deliberately unwilling to address the problem when there is a secondary gain, such as the income from selling drugs.

Several issues that affect access to care that are specific to this population were mentioned, such as the strict laws against and the punishment for possessing illegal substances or disposable needles (eg, in India) and the problems associated with "illegal alien status" and the fear of discovery.

Another obstacle is the difficulty in getting important messages about reduced-risk drug-use behavior to adolescents, because of their youth and their sense of invulnerability in thinking about the future. In addition, the drug-use behavior of adolescents is typically different from that of adults. Younger people tend to use drugs more spontaneously (eg, at parties when influenced by peers), and there is no planning stage at which one might intervene. It was pointed out that sex workers and many chronic substance users will use condoms with their clients and their "side partners" but not with their principal sex partners. This may, in part, be a result of the messages we have given these communities, and it leaves many at high risk for HIV transmission.

The participants also shared examples of failed educational efforts. For example, an attempt to institute a needle exchange program next door to a public school met with widespread community opposition. African American and gay white outreach workers trying to intervene in a white Appalachian

WHENEVER POSSIBLE, IT IS ALSO IMPORTANT TO LINK SERVICES SUCH AS DRUG TREATMENT, COUNSELING, FINANCIAL ASSISTANCE, CHILD CARE, AND SETTLING IMMIGRATION STATUS TO HIV AND HEALTHCARE SERVICES.

community met with disaster. As another example, trying to "lump together" substance users of different ethnicity, class, sex, and age in a support group was unsuccessful. We must not forget that people have many identities and are more than simply "substance users."

Strategies for Successful Intervention

The discussants strongly agreed that, for any intervention to succeed, the educators must work with the community in which they are trying to intervene. There are many ways to include the community in the development of

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Strategies for Educating Children, Adolescents, and Young Adults

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In discussing HIV prevention and treatment education for children, adolescents, and young adults, it is crucial to understand that, as with all other affected and infected populations, there are significant differences within these populations that affect the direct provision of services. These differences include age, sexual orientation, race, ethnicity, primary language, location, educational background, socioeconomic status, family of origin/choice relationship, housing status, drug use, religious influences, and even political affiliations. Our roundtable comprised HIV/AIDS educators from Colombia, Finland, France, Israel, and the United States, who shared their experiences in working with a range of young people. Throughout the evening, the educators focused on specific obstacles to effective intervention and discussed models and activities that have been used with their target groups.

Obstacles and Challenges

There are universal obstacles that exist in educating this population. For instance, all the participants commented that the conservative religious influence in their countries or regions was a consistent barrier either to work around or to avoid. In addition, there is a barrier of distrust between adolescents and adults. This barrier seems never to be breached, and serves to keep the educators on their toes to provide age-appropriate and age-relevant information to their audiences.

One participant named five specific challenges in providing effective education services for young people:

1. discussing sexuality
2. finding an appropriate place to discuss AIDS in the school curriculum
3. planning creative lessons
4. talking to parents about AIDS and addressing the belief that "AIDS is not a problem here"
5. educating teachers about AIDS

Education Strategies

In Israel, the difficulty of discussing sexuality was overcome by framing HIV disease as an immune system disorder and a health education issue. The moralism and sexual implications of HIV were removed, and the disease was discussed as part of a comprehensive health education curriculum—an approach that has proved successful. In a program used in Bogotá, Colombia, educators frame HIV/AIDS prevention education as a part of the larger topic of love, sex, and self-esteem.

In Israel, the difficulty of discussing sexuality was overcome by framing HIV disease as an immune system disorder and a health education issue.

For many educators, providing interesting and consistent messages to adolescents is one of the greatest challenges. In France, regional contests have been held in which young people submit ideas for videos that deal with HIV prevention and care information. The winner from each region has his or her idea made into a video for distribution. In Jerusalem, student questions and concerns at the death of Rock Hudson formed the basis of a successful curriculum on HIV/AIDS. The students were involved in designing the model curriculum, which has since been adopted by educators in El Salvador, The Philippines, and Thailand.

Talking to parents about HIV/AIDS is a key challenge in providing HIV/AIDS prevention and treatment education programs for children and adolescents. In Bogotá, Colombia, the parents and adults of the community are the first to be educated on HIV/AIDS issues. Educators report that, after the adults have been informed, they have no fears or reservations about allowing and supporting the project for the young people. In many locales, the issue of AIDS is not addressed because people feel it is not a problem in their community. In their silence, parents and adults deny the impact of the HIV pandemic on their lives. As with the Colombian educators, educators in New York found that once they had facilitated discussion among the parents about HIV and its impact on their communities, the parents were amenable to allowing HIV education in the schools.

Providing teachers with the information, training, and resources necessary to teach students about HIV/AIDS prevention is essential. The participants shared several examples of programs that have been designed to train schoolteachers to provide HIV/AIDS prevention and treatment information. The National Education Association (NEA) Health Information Network, in Washington, DC, coordinates a national program to train educators from the elementary to the college level in AIDS prevention education, emphasizing the special needs of youth of color and gay and lesbian youth. The project staff works with teacher's unions to generate support for including HIV education in all school curricula, and with community-based organizations to build local support for the teachers who will be providing the HIV prevention education. The NEA Health Information Network has produced two videos for teachers, "Strategies for Teaching About HIV and AIDS" and "Counseling Condoms."

In France, regional contests have been held in which young people submit ideas for videos that deal with HIV prevention and care information.

After a national peer counseling project was unsuccessful, teachers in France were instructed on providing HIV prevention education in the public schools. The program has evolved, and currently combines students and adults in regional education teams. In Finland, HIV prevention education and condoms are provided in the classroom, but by volunteers from a community-based gay organization rather than by the schoolteachers. Because of the pressure from extremely conservative education ministers, teachers at the lower levels are relieved to have a volunteer organization come into their classrooms.

Education Strategies Beyond the Schools

The participants described other strategies for reaching young people outside the school setting. In Colombia, street-based outreach brings information to sex workers.

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Strategies for Maintaining Behavior Change

Chuck Frutchey

Most HIV education programs have focused on delivering information to people about primary prevention and treatment. This work is essential, and has been shown to be highly effective in producing significant changes in knowledge and behavior in populations to whom sufficient resources are allocated (such as gay and bisexual men). But, as we know from recent research in several large cities (Chicago, Pittsburgh, San Francisco, Seattle, and Sydney), as well as from experience in other campaigns to change health behaviors, this initial effort must be swiftly followed by longer-term and more-intensive efforts to maintain those changes. This reinforcement will hopefully transform short-term alterations in behavioral patterns into lasting and fundamental changes. Education programs that result in only an initial effect and are not followed by maintenance efforts will have only a transient impact on the HIV epidemic.

IT IS DIFFICULT TO CONVEY THE IMMEDIACY OF HIV PREVENTION AND TREATMENT MESSAGES WHEN THE TARGET AUDIENCES SEE NO EVIDENCE IN THEIR DAILY LIVES TO SUPPORT THE NEED FOR CHANGE.

Obstacles to Maintaining Behavior Change

The participants in the discussion, which included HIV/AIDS educators from Canada, Finland, Peru, South Africa, and the United States, agreed that the initial behavior changes, such as initiating condom use or seeking HIV antibody testing, were easier than the maintenance efforts. Encouraging consistency includes convincing people that the threat of HIV is real, constant, and imminent, as well as fundamentally addressing many factors in the lives of individuals. Several participants noted that in their locale the number of cases of HIV infection is low, and it is difficult to convey the immediacy of HIV prevention and treatment messages when the target audiences see no evidence in their daily lives to support the need for change. Successful maintenance efforts may partly depend on strategies that make the threat of HIV real in people's everyday lives, such as using PWAs as speakers and educators.

It was also noted by most of the participants that long-term behavior maintenance strategies were hampered by the lack of a solid education and understanding in the general population concerning basic sexuality, health education, and comprehensive medical care. Success seems much more likely in a population that is grounded in these areas, because this allows individuals to place the establishment of long-term behavior change strategies within a broader context of health and well-being. Getting people to listen to our messages over a long period of time is difficult unless their knowledge base and belief system provide a basis for incorporating our messages into their lives. The tendency of so much HIV prevention and treatment education to use slogans, sound bites, and abbreviated messages needs to be combined with this more holistic approach.

Another obstacle discussed was that, over time, the target population and HIV/AIDS educators alike stop operating in "crisis mode." People's attention is pulled in many directions, not just in ours. We must compete more for people's time and attention.

Designing Strategies

To be effective in maintaining HIV prevention and treatment behavior changes, programs must cover much more than just HIV as a disease. Beyond prevention and treatment issues, people need to come to terms with how HIV affects other aspects of their lives, including their relationships with family, friends, and care providers; their sense of self and self-esteem; their feelings of guilt, rejection, or shame; their religious and spiritual beliefs; and their concept of the future. Without relating HIV education to these and other factors in people's lives, HIV education messages may be only interesting facts and ideas, and lack the immediacy and reality necessary for integration into everyday life. This "entire lifestyle" approach is much more difficult to design and implement than are approaches that address only initial behavior change.

There was also a sense that the success of the educational message depends on the extent to which the message spreads into the community. One participant commented that, while "positive" ideas and behavior can spread as quickly as "negative" ones, "negative" behavior has always had a greater allure and draw. We cannot directly reach everyone who is at risk or needs treatment information, so diffusion must be incorporated into the design of educational programs. This includes programs that give people decision-making skills. There was consensus that one-on-one or small-group counseling sessions are the most effective way for people to explore the far-reaching effects of HIV in their lives. Often full-weekend (or longer) focused programs, or more extensive therapy, are needed. Through these intensive sessions, people are given the opportunity to find out what they need to maintain healthy behavior and gain decision-making skills. They can then become effective role models and teachers for their peers.

WE CANNOT DIRECTLY REACH EVERYONE WHO IS AT RISK OR NEEDS TREATMENT INFORMATION, SO DIFFUSION MUST BE INCORPORATED INTO THE DESIGN OF EDUCATIONAL PROGRAMS.

In discussing the reality of living with HIV, prevention and treatment educators need to make sure to include the reality of not maintaining healthy behavior. People must know that "slipping" does not mean "failure" or that they are a "bad person." And, the realities of both healthy living and dying must be addressed.

This effort to place HIV in context with other aspects of individual lives must be extended to those who interact with AIDS-affected persons as well. Physicians, family members, clergy, and others must all have the

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Strategies for Using Peer-to-Peer Education to Change Community Norms of Behavior

Rashidah L. Hassan, RN

A common problem in HIV/AIDS education is gaining the trust of the target populations, since many of those most affected by HIV disease are members of groups that have a strong, historically based distrust of "official" information and the "outsiders" who deliver it. People will often listen to their peers, however. The challenge is to make members of these groups qualified HIV educators and to provide them with the tools needed to do the job.

The participants in the discussion were a diverse group of HIV educators, ranging from a representative from Bulgaria, where there is no accurate HIV/AIDS information being widely distributed, to a representative from Kenya, where young people

Many of those most affected by HIV disease are members of groups that have a strong, historically based distrust of "official" information and the "outsiders" who deliver it.

are trained to go from village to village providing education, to representatives from a large multinational corporation and foundation that provides peer counseling, testing, and support groups. The various representatives all use peer education in their outreach to women, sex workers, adolescents, and others affected by HIV/AIDS.

The Benefits of Peer Education

The basis of peer-to-peer education is sharing ideas, rationales, and possible solutions from the personal perspective of the educators with those who are in similar circumstances, have similar experiences, and have similar problems. The willingness of individuals in a group to speak candidly, from a personal perspective, about the issues that affect the whole group fosters a trust that is not afforded to authority figures or those outside the group. Each participant at this forum discussion had both a personal and a programmatic commitment—a community commitment—to a particular group, whether they were gay men, women, adolescents, or sex workers. This personal commitment appeared, again, as a common element in the development of peer-education programs, and is sought when educators are recruited.

Having many persons trained and available as community resources for accurate information is a tremendous support for community education and treatment information programs.

A major benefit of this approach is the empowerment of the individual. Many people who are personally confronted by the HIV epidemic, by either their own infection or the loss of a loved one, believe that they are alone or uniquely affected. For these participants, one of the positive outcomes of peer education is their realization that they are not alone, that there are others who are confronting similar issues or have dealt with the problems they are now facing. The bonding that occurs opens the doors for dialogue and the sharing of concerns and solutions. Peer education leads to better community outreach by personally committed people; grass-roots presentation of risk-reduction or treatment messages; increased self-esteem for the educator; and trust, motivation, and support for sustaining healthy change.

It was also agreed that not every peer educator needs to be involved with a formal outreach program. Having many persons trained and available as community resources for accurate information is a tremendous support for community education and treatment information programs.

Training Peer Educators

The methods of recruiting peer educators were diverse among the group. Most candidates were motivated by a strong commitment to protecting or preserving their community, while others were motivated by a negative event or experience—eg, finding out their serostatus in a nonsupportive setting and not wanting this to happen to others, or having a bad experience with a particular treatment and wanting others to know what questions to ask.

The screening and final selection of peer educators is somewhat subjective, with the interview being the most frequently used method. Among the important factors that are determined in the interview is the person's integration in the particular community. The program managers listen for how the candidates speak about their group, and try to get a sense of their caring for the group and their motivation for wanting to educate others, preferring those with the "noble cause" as their motivation. Because of the amount of time and personal sharing that peer educators must commit to, this motivation is essential.

Having a standardized training program is crucial both for making sure that the information being shared is accurate and current and for evaluating the program.

Potential peer educators must also demonstrate their commitment in more easily measured ways. For example, do they show up on time for trainings and meetings? Have they read the materials? One participant commented that, particularly for PWA peer educators, a psychosocial evaluation to determine mental health status may be appropriate.

The representatives from Philadelphia, Amsterdam, and San Francisco felt that adolescent peer educators, in particular, should have opportunities during both their recruitment and their training to explore their feelings about sexuality and decision making before they work with others. This may help avoid the "do as I say, not as I might do" problem. In certain instances, it may be more effective to have an adult facilitator participate with the adolescent peer educator.

Having a standardized training program is crucial both for making sure that the information being shared is accurate and current and for evaluating the program. The training should also be specific in addressing the concerns and issues of the target population. For example, in developing a training program for sex workers, understanding the various subpopulations within

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Strategies for Using Culturally Specific Modes of Communication for Education

Abdelkader Bacha, MD

Effective AIDS prevention and treatment education involves making sure that people understand the issues, especially when we expect changes in both individual behavior and community norms. To improve this understanding, we must find the best way to communicate with people about the HIV/AIDS epidemic. This communication must be a real exchange of ideas and information between AIDS field workers, including medical providers, social workers, and educators, and the population at risk for HIV/AIDS. Since each community has its own specific modes of communication, which are linked to its culture, history, and traditions, we must use these channels to provide effective HIV/AIDS prevention and treatment education.

SUCCESSFUL EDUCATION EFFORTS INVOLVE SPEAKING WITH PEOPLE IN THEIR LANGUAGE, RESPECTING THEIR LEVEL OF UNDERSTANDING, AND USING THE IMAGES THAT ARE COMMON IN THEIR CULTURE.

The participants at our table met to share their extensive experience in the fight against AIDS, and their work with populations and communities that are very different in terms of race, ethnicity, religion, culture, sex, and sexual orientation. The US participants described their outreach efforts in African American, Asian, Native American, and Mexican American and other Latino communities. Educators from East and West Africa brought to the discussion their experience with women's groups and associations, people living with HIV/AIDS, widows and orphans from AIDS, youth movements, community-based associations, and rural groups.

Major Barriers to Effective Education

One of the major barriers to HIV/AIDS education is that communities and individuals do not perceive themselves to be at risk for the disease. One participant commented that, in the United States, AIDS has been perceived as a disease that affects gay white men. A homosexual black man may not identify as "gay," and therefore may not consider himself to be at risk.

Poorly crafted educational messages on HIV/AIDS disseminated through dramas and videos may increase the stigmatization and marginalization of people with HIV/AIDS or those who are in the epidemiologic risk categories. For example, early messages on HIV/AIDS prevention in Africa were focused on prostitutes. One participant commented that, because she is HIV-positive, her 8-year-old daughter believes she works as a prostitute. On the other hand, women who may occasionally work as prostitutes, but do not identify as prostitutes, are more likely to be unconcerned about AIDS and to continue to practice high-risk behaviors.

Beyond convincing individuals and communities of the risk of HIV disease, educators face the challenge of drawing attention and resources into their communities. For example, in some African American communities in the United States, and especially in the African American gay male community, early AIDS prevention efforts were very difficult. One participant explained that his community was interested in and concerned about HIV/AIDS several years before the appearance of the first basic prevention messages directed to African Americans. Educators working with women's associations in Senegal have found that their members need clear information to understand how they may be exposed to HIV and what behavior changes are necessary to prevent the infection.

For many African women, illiteracy, cultural oppression, and economic dependence are major factors in the dramatic spread of AIDS. Minorities and the poor worldwide are at increased risk of HIV infection, because of the difficulty in reaching them with educational messages. Access to information, support services, and healthcare is often limited, especially in rural areas.

In terms of treatment for HIV disease, the relatively high costs of western medicines limit their availability in developing countries, and people must rely on traditional remedies for AIDS-related medical problems. One participant learned from her grandmother that flour water, rice water, and cornstarch all work well to soothe skin irritated from diarrhea. Participants from both the United States and Africa expressed concern that HIV antibody testing was not always being conducted properly. In some cases, people are tested but are not given the results, while in others people are being told only that they are HIV-positive, with no explanation of prevention and treatment issues.

Strategies for Culturally Specific Education

Because of the cultural specificities of different groups and minorities, successful education efforts involve speaking with people in their language, respecting their level of understanding, and using the images that are common in their culture. One participant commented that many people in the United States do not understand the differences among the various Asian communities or among the different Spanish-speaking communities. For example, distributing educational materials written in Chinese to a Korean community would be futile. HIV/AIDS educators must provide information campaigns that use local languages within the local cultural context.

POLITICAL AND CULTURAL EVENTS, SUCH AS RELIGIOUS MEETINGS IN WEST AFRICA, RURAL POLITICAL CAMPAIGNS IN ZIMBABWE, AND NATIVE AMERICAN TRADITIONAL CEREMONIES ARE POTENTIAL OUTLETS FOR EDUCATION.

To provide effective HIV/AIDS prevention and treatment programs, educators must conduct focus groups or other research to determine what information a specific community needs. Once a culturally sensitive message has been shaped, it should be disseminated through local groups, such as women's associations, labor syndicates, and youth-sport movements. Political and cultural events, such as religious meetings in West Africa, rural political campaigns in Zimbabwe, and Native American traditional ceremonies are potential outlets for education.

Many educators have found that spiritual aspects play an important role in people's lives. Spirituality and religious tradition can be a great source of strength, and many people are regaining their inspiration, and going back to their roots and to their spiritual motherhood. Linking HIV/AIDS education messages to local religious beliefs may increase acceptance and understanding of the information.

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Strategies for Using the Mass Media as an Educational Tool

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Television, radio, and the print media have already had a large impact on how the public image of AIDS has been built. The media were the first to alert us that a hitherto unknown immune deficiency syndrome existed, but at the same time they have provided a forum for a large variety of healers, right-wing politicians, and all sorts of "AIDS specialists." In addition, the media have contributed to the expedited flow of information on treatments for HIV infection and AIDS and on the evolution of the epidemic.

In using the mass media to disseminate information, there are several inherent principles and challenges for HIV/AIDS educators to be aware of. Specialization for particular audiences is a well-established feature of the mass media; different target groups must be addressed in different, specific ways. In addition, the mass media in general aim to make a profit, so information has to be made "news" even if it is not new. Mass access to the media means that information distributed through the mass media has to use language and images that appear to be acceptable to a general audience. The standards for what is acceptable vary, but often exclude sexually explicit messages.

Even though mass-media messages are generally perceived as coming from an anonymous, unanimous body, they are in fact produced by individual journalists who are pursuing their own goals. At times, their ethical conduct can be influenced by profit-oriented economic pressure. Furthermore, the messages disseminated through the mass media are basically unidirectional. Communication is often limited and, once spread, information is difficult to revoke.

"You need to think like a reporter. You have to know what is attractive as a news story to reporters and also have to deliver it in a way that they can use."

These conditions make the mass media an important but difficult-to-handle tool for HIV/AIDS educators. This summary focuses on models of using the mass media and describes the discussants' experience in introducing important prevention and treatment education messages into existing mass communication systems.

Building a Media Network

One of the keys to using the media effectively lies with the individual journalists. One participant commented that "you need to think like a reporter. You have to know what is attractive as a news story to reporters and also have to deliver it in a way that they can use."

If a community-based organization (CBO) or an AIDS service organization (ASO) is considering using the mass media for an educational campaign, it has to aim at becoming the most reliable source of AIDS information, the first source a reporter would think of. To be perceived as a reliable and useful source, the organization's involvement with both formal bodies (eg, governmental advisory boards) and with those communities that are directly affected by the disease must be publicly recognized. Organizations should not misuse their status as reliable and useful resources if they lack expertise in a certain topic, but may refer media questions to other groups and sources.

Reporters want to be known and be treated well. One way of doing this is to remember that AIDS is but one of 10 or 20 or more different topics that they cover, and they don't know as much about it as HIV/AIDS educators or service providers. In a proactive effort to build a useful network of reporters, one participant took a phone book, looked up the addresses of the local media, and called and identified the journalists who cover AIDS issues. She created a filing system, adding bits and pieces such as press clippings and announcements, in order to establish and maintain communication. When various AIDS-related issues arise, this file is a useful tool for addressing them with reporters.

Press releases should always be focused properly (ie, cover only one topic), and they should also include a glossary of words and phrases.

It should also be taken into account that there are times of "low tide" in the news business. For example, issuing press releases on Mondays or Tuesdays or after public holidays can help ensure the best coverage.

Providing Information to the Media

There are some easy-to-supply services that can help CBOs and ASOs get to know different reporters and be considered a reliable source. For instance, press releases should always be focused properly (ie, cover only one topic), and they should also include a glossary of words and phrases. This glossary can be of utmost importance if, for instance, the difference between an "AIDS test" and the HIV antibody test needs to be explained. Often these definitions or explanatory lines can introduce such delicate matters as using the preferred term "person living with HIV or AIDS" rather than "AIDS victim."

Providing background material may also help to refocus issues when an organization is asked to comment on dramatic events, such as the case of HIV transmission during dental procedures.

The latest epidemiologic data should also be included in a press kit. Providing background material may also help to refocus issues when an organization is asked to comment on dramatic events, such as the case of HIV transmission during dental procedures. Professional handling of the media in this instance could contribute to a message that reinforces standards of care and universal precautions rather

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Educating Gay Men

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transvestites and transsexuals—must be listened to carefully and responded to appropriately. Research and education among these groups is complicated by distrust, fear, and anger, which are often the only things shared by marginalized people, be they gay men in Moscow, transsexuals in Los Angeles, or the very poor of Manila.

Providing Education to Subgroups Within the Gay Community

While accepting that particular difficulties exist in gaining access to many gay and bisexual men, and in particular men who have sex with other men but do not identify themselves as gay, the participants agreed that it is vital not to forget the general majority of gay men who are relatively easy to reach. Conducting ongoing HIV/AIDS prevention and treatment education in this core group of men with a strong gay identity has often been neglected, and yet it is vital to the success of any HIV education program. After all, this core group of men is often involved in sexual encounters with gay and bisexual men on the periphery; this core group has access, however tenuous, to all the important

IT IS VITAL NOT TO NEGLECT OR UNDERESTIMATE THE NEEDS OF GAY MEN LIVING WITH HIV DISEASE.... CLEARLY, THERE IS AN IMPORTANT ROLE FOR TREATMENT AND "HEALTH-ENHANCING" EDUCATION, IN CONJUNCTION WITH SAFE-SEX CAMPAIGNS.

subgroups with special needs. In effect, the general population of gay men will always be important, because they serve as educators to other groups and also because they need ongoing safe-sex support for themselves.

It was further noted that it is vital not to neglect or underestimate the needs of gay men living with HIV disease. Whereas among the population as a whole people with HIV disease are a small minority, among gay men they are a very substantial minority. Clearly, there is an important role for treatment and "health-enhancing" education, in conjunction with safe-sex campaigns.

Finally, the importance of assessing and targeting particular situations (rather than sociological groupings) that inhibit safe sexual activity was emphasized. For instance, research shows that the pressure to abandon safe sex is often most intense in loving relationships, regardless of the social backgrounds of those involved in the relationship. Maintaining safe sex in a relationship that has evolved, changed, and grown over two, three, or more years is always more difficult and complex than insisting on safe sex in a casual encounter.

In conclusion, the participants strongly endorsed the relevance of the "STOP AIDS" type of community development strategies, adapted for local use through a comprehensive needs assessment. The continually changing relationship between the needs of individuals and couples and the general social context in which they live must also constantly be debated and responded to. The "tools" of safe sex must be easily available, user-friendly, and cheap. The messages of safe sex should be kept simple, clear, and positive. Last, our work must be assessed and evaluated, not only so that we can be sure that we are responding to the full range of ever-changing needs, but also so that successful programs are adequately documented for use by others. In the current climate, this documentation is of fundamental importance in ensuring that this vital work receives the long-term government funding it deserves but has so far been denied. ■

Educating People in Non-urban Settings

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Prevention and treatment education may also be effectively conducted by using outreach workers. These workers are most effective when they are chosen from within the community at risk with input from members of that community. An outreach worker's effectiveness is enhanced through interactions with community leaders, focus groups, and formal or informal groups of advisors. Outreach workers must be able to overcome internalized AIDS-phobia or homophobia. They must develop their intrinsic understanding of the local population and their perspectives.

Despite the large amount of information to convey, outreach educators should use the KISS principle for their messages: Keep It Short and Simple. Also, outreach educators should borrow ideas that have already proved successful for others and that can be adapted to fit their communities. Outreach workers cannot expect or demand anything in return. After long efforts at trust-building, local people may or may not "buy into" the problem and its solutions.

Evaluation

The group stressed the importance of effective program evaluation, and also the difficulty of designing and conducting it. They agreed on the wisdom of including professional evaluation as part of a grant request or from other sources. They also emphasized that funding agencies should help devise and fund evaluation mechanisms and provide support and technical assistance to newer community-based organizations to develop and implement effective evaluation.

Programs should be designed with realistic, measurable objectives, and a baseline evaluation should be done before the intervention. It is important at the beginning of a project to create and use evaluation instruments such as reports and checklists and to fine-tune measures as the project progresses. These may be as simple as keeping a log of phone inquiries or donations to a program or agency before, during, and after the outreach effort. Other useful

OUTREACH EDUCATORS SHOULD USE THE KISS PRINCIPLE FOR THEIR MESSAGES: KEEP IT SHORT AND SIMPLE.

evaluation measures may include the number of referrals, the level of volunteer participation, and the percentage of people who return for HIV test results or more information. It is also important to recognize, however, that some program effects are not easily measured and that the results of others may not be immediately apparent.

As discussed above, there are a number of obstacles to delivering HIV/AIDS prevention and treatment information in non-urban settings. There are, however, positive characteristics of these communities, including strong family and cultural support, less-crowded hospitals, more-individualized healthcare, and long-term relationships with family doctors or caseworkers, that represent advantages over urban settings. HIV prevention and treatment messages for non-urban settings must fit and reflect the economic and cultural realities of the intended audience. The messages must be delivered by a person the audience can trust and with whom they can identify. Just as a musician can evoke the best from a seasoned musical instrument, a sensitive outreach worker or peer counselor can add to the effectiveness of an oft-used message about HIV. ■

Educating Women

(continued from page 6)

distributed them at lesbian and bisexual night clubs. Several participants described successful programs in which beauty-salon staff are trained to talk to their customers about HIV and are given condoms to distribute. Another way of educating groups of women is to have women in the community host safe-sex-information parties in their homes. For women who are injection drug users, syringe- and needle-exchange programs can be a contact point for HIV/AIDS educators to provide not only clean needles, but also prevention information, condoms, and treatment referrals.

In some developing countries, gaining access to social networks is more difficult. In Islamic countries, for example, prostitution is illegal and its existence is officially denied. In these countries, outreach educators have conducted surveys of knowledge, attitudes, and beliefs among sex workers and have begun distributing condoms to them. Because many women in developing countries have limited reading skills, and many do not have access to the evening television broadcasts, HIV/AIDS educators are producing an audiotape in which sex workers discuss AIDS prevention; the tape will be distributed to other sex workers. As the trust between outreach educators and sex workers strengthens, additional services can be approached, like HIV testing. The educators find that discussing antibody testing with sex workers now only frightens them, but feel that, eventually, as these women come to trust them more, this service may be accepted.

The participants agreed on the need to create social climates in which people need not fear identifying themselves as HIV-positive, or being labeled as being at risk simply by asking for information. The epidemiologic term "risk groups" (as opposed to "risk behaviors") and the moral judgments associated with AIDS can prevent people both from coming forward for help or information and from believing that they are at risk. Not all women who are at risk for HIV infection are in a "risk group" or knowingly engage in "risk behavior."

DELIVERING PREVENTION AND TREATMENT INFORMATION EFFECTIVELY DEPENDS ON USING MESSAGES TAILORED TO DIFFERENT GROUPS OF WOMEN, USING PEERS TO DELIVER THOSE MESSAGES, AND GAINING ACCESS TO A VARIETY OF DIFFERENT SOCIAL NETWORKS.

The need to reach women with HIV/AIDS prevention and treatment information, and to support both those with HIV disease and those at risk for infection is immediate and growing. In the face of social, political, and religious obstacles, advocates have succeeded in making women a more visible group and a militant force. Educators must continue to aggressively devise creative and culturally sensitive strategies to disseminate education, to build and strengthen support networks, and to advocate and lobby for attention, political influence, and funding. While specific programs are shaped to suit the local context, these needs and these goals are universal. ■

Educating Children, Adolescents, and Young Adults

(continued from page 8)

Ongoing programs in Atlanta, Georgia, USA, include Latino street outreach teams that go door-to-door providing information to families, a program for young African Americans with no visible male role models that helps facilitate positive interactions and helps provide culturally relevant HIV prevention education, and public service announcements on the local rock station that are aimed at sexually active heterosexual teenagers.

Program Evaluation

Every program discussed included some form of evaluation, from the traditional pre- and post-test surveys to follow-up visits, in which the staff return to where they have conducted educational sessions to ask about not only changes in knowledge but also changes in behavior and whether they have been maintained. Some of the programs used client satisfaction forms, and others were part of a formal research project and had evaluative components built into them from the start. Some participants used a formative evaluation plan and others used a third-party evaluation model to determine the efficacy of their programs.

IN BOGOTÁ, COLOMBIA, THE PARENTS AND ADULTS OF THE COMMUNITY ARE THE FIRST TO BE EDUCATED ON HIV/AIDS ISSUES.

Providing HIV/AIDS education for children, adolescents, and young adults is a multifaceted challenge that involves delivering programs to diverse target populations as well as to parents and teachers. The participants shared successful strategies—including media campaigns, peer education, curriculum development, and community outreach—and identified ideas and elements from one another's programs that can be adopted and shaped for their own communities. As described above, effective programs are those that take into account not only the specific needs, interests, and characteristics of a particular group of young people, but also the cultural, political, and religious contexts. ■

Using Peer-to-Peer Education to Change Community Norms of Behavior

(continued from page 10)

this group is very important. In this instance, there are those who prostitute for drugs or money to buy drugs and those who prostitute to earn a living. The distinction here is that some are engaging in high-risk behavior to support an addiction—itself an unhealthy behavior—whereas others are using sex as a product to sell to earn their daily sustenance. The latter are much more likely to be concerned with and interested in techniques and information that will keep business going in a safe and healthy way for both themselves and their customers than are those whose basic motivation is supporting an addiction.

Evaluation

Various methods are used to evaluate the effectiveness of peer education, including pre-tests and post-tests, which are conducted from one hour to six months after the workshops. In other instances, studies of broad community knowledge, attitudes, and risk behavior can be conducted to determine the effectiveness of peer education on a community level. Peer education is just a part of the entire community education effort. There must be a continued "bombardment" of the community to sustain behavior change over the years.

In summary, peer education is an effective strategy for providing HIV/AIDS prevention and treatment information to populations at risk. By training and supporting individuals who have an integral role in and commitment to a target community, peer education programs provide a means to deliver culturally appropriate messages from within. ■

MAINTAINING BEHAVIOR CHANGE

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same context for understanding long-term behavior maintenance if diffusion is to succeed.

A clear implication of this holistic approach is that more attention should be paid to ensuring that the HIV prevention message is specific to the locality and the culture. While it is sometimes possible to transfer certain programs from one population or community to another, it may also be necessary to significantly redesign the message's "packaging" to make it look like it was developed specifically for that new audience. Several of the participants noted that communicating the risks of HIV to populations that are already overburdened with problems, including other health problems, seems like a nearly insurmountable task. Some of the educators noted that these difficulties are compounded for those who work with populations that, because of legal and cultural taboos, are hard to locate even in their own countries. All agreed that an aggressive approach is sometimes necessary, but also acknowledged that such an approach could prove dangerous (ie, resulting in legal or physical harassment) both to the affected population and to the HIV educator.

It is never too early in a program to begin discussing the long-term need for behavior change. The sooner people can incorporate information in the context of their lives, the more successful the effort will be. The need to address the entire experience of HIV will lead us to offer fewer programs that are didactic, and more that are participatory, interactive, and belief-oriented. In keeping with this holistic approach to help integrate information into people's lives, HIV educators should also be open to designing diverse

THE NEED TO ADDRESS THE ENTIRE EXPERIENCE OF HIV WILL LEAD US TO OFFER FEWER PROGRAMS THAT ARE DIDACTIC, AND MORE THAT ARE PARTICIPATORY, INTERACTIVE, AND BELIEF-ORIENTED.

interventions. Using nontraditional approaches alongside the usual efforts will result in access to more people. Small group sessions can involve dance or art as well as discussion. Placing ads in the "personal messages" section of a newspaper's classified advertising can sometimes be as effective as using traditional display advertising.

There must also be an understanding that people do not magically transform when HIV enters their lives. People carry the same barriers in their lives before and after they learn about their HIV status. Low self-esteem is a barrier for many people, and more complex messages are not likely to have a significant impact on it. The comprehensive approach, however, allows people to cope directly with self-esteem issues. As with so many other issues, people will be most receptive to addressing personal barriers when the situation of their life has set them up for listening to something new. This may be at a crisis point or crossroads for some people, or may be at a time of calm and simplicity for others. We need to be in contact with people when they reach these turning points, and that may mean working in jails and detoxification clinics, and with religious and support communities.

In keeping with the emphasis on the importance of interpersonal relationships to maintenance efforts, the participants felt that effective evaluation is based on personal contact with the target audience rather than on using questionnaires. The evaluation should be part of the relationship that the person has with the educational program, and a phone call will maintain this relationship better than a mailed survey form will. There was also concern that evaluation should be not a control tool, but an incentive for improvement. Many people avoid evaluation, fearing that it will result in criticism or less funding. We must develop the attitude that all evaluation is valuable and that knowing what does not work is as valuable as knowing what does. ■

USING THE MASS MEDIA AS AN EDUCATIONAL TOOL

(continued from page 12)

than one that causes unfounded panic among dental patients. Another way to refocus this issue would be to discuss not only one woman's dying of complications of AIDS and how she contracted the disease, but also the larger context of how women are affected by the disease.

USING ADVERTISEMENTS AND PUBLIC SERVICE ANNOUNCEMENTS

An entirely different approach to using the mass media is for CBOs and ASOs either to invest in paid advertisements or to use public service announcements (PSAs), which radio and television stations in certain countries are required to broadcast as part of their program interruptions for commercials. The Belgian government asked that one PSA be broadcast for every advertisement for alcoholic beverages or tobacco products.

Producing materials for video or broadcast PSAs requires a lot of experience and cultural and political sensitivity. One Dutch PSA on safe-sex education explicitly shows gay sex; this would not be legally possible in other countries. One American PSA showed a park as seen by a passing driver. The viewer hears the driver thinking about AIDS—"Am I at risk? Is it really here? Did I do anything?" The scene was not startling or offensive to anyone unfamiliar with gay life in that region. But for some gay men, the location was easily recognized as the one park in the area where men have sex with other men.

Posters produced for display in certain settings can also be used as advertisements in magazines to raise awareness on certain issues (eg, safe sex, solidarity, or charitable organizations that need donations). Organizations can create cooperative relationships with certain magazines by offering material for stories in exchange for free or reduced-price advertising space.

Where a close relationship exists between ASOs and government bodies, the mass media can be a means of reinforcing messages and creating a behavioral norm. One participant described an AIDS prevention education campaign in Barbados where youths are asked to sign a commitment to refrain from sex before becoming an adult, and to engage only in monogamous relationships thereafter. These individual commitments are reinforced through the mass media.

In summary, mass media can be an important and powerful tool for disseminating information on HIV/AIDS prevention and treatment, raising awareness, and promoting solidarity and compassion. ASOs receive a lot of feedback on their mass media campaigns, and, to be more effective, should use this feedback in regularly evaluating their strategies and, if necessary, refocusing their strategies. A mass media campaign that efficiently and effectively targets the communities most affected by AIDS reflects positively on the ASOs or CBOs involved and may serve to attract increased financial resources. CBOs and ASOs should be proactive and aggressive in working within existing media networks, and in mounting educational media campaigns. ■

EDUCATING INJECTION DRUG USERS

(*continued from page 7*)

programs (see table). Gaining their trust, getting their input, and facilitating their involvement in designing and implementing various interventions is essential. Putting community members in positions of leadership is particularly effective, as are peer-facilitated programs. To gain the community's trust, it is usually effective to begin working one-on-one, and then in groups.

Providing access to services and care is a key to successful HIV education programs. As stated above, the members of these communities need numerous services. Whenever possible, it is also important to link services such as drug treatment, counseling, financial assistance, child care, and settling immigration status to HIV and healthcare services. There was a great deal of concern expressed in this group about the lack of continuity of care. Too often, outreach workers are successful in getting people into the healthcare system, but once in, they get lost in unconnected bureaucracies. When outreach workers have the resources to facilitate continuity of care and follow-up (case management), people are more likely to stay in the healthcare system.

Many practical suggestions were given about how to deliver messages, such as using simple handout materials written in street language or in cartoon or picture format, using short and simple consent forms, giving out matchbooks or pocket cards with important and practical information (eg, the hours of the STD clinic), making available free condoms along with bleach, and making widespread use of audiovisual materials. Many HIV prevention and treatment educators have successfully delivered important messages by incorporating them with essentials such as toothpaste, soap, tampons, clothing, and food. One example given was that of getting the local church youth group to make up hygiene bags that were handed out along with important HIV-related information.

STRATEGIES FOR HIV EDUCATION AT THE COMMUNITY LEVEL

- Access subgroups of the population by "culturally typical" activities where people gather (eg, neighborhood social clubs)
- Run rap sessions in the housing projects
- Invite community members to participate in an advisory group to discuss local issues
- Develop a peer newsletter that community participants control and that can be distributed to community hangouts as well as to the offices of local officials and policymakers
- Use the pharmacists from whom needle users must get their syringes to help provide access to and gain the trust of the community (notes this example was from India)
- Establish a mobile care unit in the neighborhood that provides a range of services or access to services

Emphasis was placed on ways of empowering individuals. One participant made reference to Paolo Freire (*The Pedagogy of the Oppressed*) and commented, "The way that you educate the masses and develop literacy is to have them deal with social dilemmas . . . and come up with solutions applicable to their own lives." She described an HIV intervention in which people become actors in a theatre piece. At a certain point, the action is stopped and they are asked to identify interaction barriers, to come up with solutions, and to act out possible alternative scenarios. This theatre piece has also been transferred to video. The benefits of this interactional approach are that it overcomes the obstacle of illiteracy, identifies barriers, and offers empowering, realistic solutions.

Finally, we discussed the importance of caring for ourselves as workers on the front lines of the HIV epidemic. One suggestion for providing support was that outreach workers should always work in pairs. Other ways to support HIV/AIDS educators include having on-site weekly support groups and acknowledging outreach efforts and successes, as well as having regular vacations and breaks from front-line activities. ■

USING CULTURALLY SPECIFIC MODES OF COMMUNICATION FOR EDUCATION

(*continued from page 11*)

One successful strategy is the use of "image magic," especially moving images like video. Some educators believe that people do not understand the importance of the HIV/AIDS messages or the danger of the disease and the human tragedy it has wrought. In Senegal, educators use the term "AIDS shock" to describe people's first direct contact with the disease, such as discovering that they or a member of their family is HIV-positive. Relating these strong personal experiences is an effective strategy for educating others. Because it is capable of conveying powerful emotion, of personalizing HIV/AIDS issues, and even of "shocking" people with images, video is often the most useful means to convey these messages.

Effective education strategies also need to take into account the socioeconomic environment; poverty is a major obstacle to effective HIV/AIDS prevention and treatment education programs in many areas. Some educators have found that including food in HIV/AIDS prevention activities is important because it addresses economic need and serves to attract people. One participant commented that her program reserves a part of its financial support for a survival fund.

It is also important to encourage poor people to undertake microeconomic fund-raising activities. In one instance, a group of women, some of whom work as full-time or occasional prostitutes, decided to educate one another and their communities about sexually transmitted diseases, AIDS, and contraception through drama and local music. Because of their daily survival activities, they lacked the time and money. One of the solutions they found was to organize shows and events that incorporated HIV/AIDS information in their villages and districts; the money they made from these events was used to finance a small restaurant. Their efforts increased knowledge and understanding about HIV/AIDS in a culturally sensitive manner and led to improved economic status.

Educators from Senegal shared a videotape with the group covering some of their HIV/AIDS education activities. Strategies portrayed included disseminating brochures in a car painted by local artists with messages on how to prevent HIV/AIDS and holding social/educational events such as district sports competitions, dances, plays, and parties. At some of these events, physicians answered questions about HIV/AIDS prevention and treatment issues. Films about HIV disease followed some evening events. To create a vivid image of AIDS, physical symbols representing the virus were decorated and burned after prevention-education sessions.

In summary, HIV/AIDS education programs are more effective when information is delivered through culturally specific channels of communication. Focus groups can provide valuable insight into the characteristics and needs of different communities. Using common images, appropriate language, community activities, and local networks is essential in designing programs to reach people at risk for HIV/AIDS. ■

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