

Note: Final version.

Workshop Report

on

**HIV/AIDS and Communication for Behavior and Social Change: Program
Experiences, Examples, and the Way Forward.**

Organized by UNAIDS

in

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by

Arvind Singhal, Ph.D.
Professor
School of Interpersonal Communication
College of Communication
Ohio University
Athens, OH 45701, U.S.A.
Phone: (740) 593-4903
Fax: (740) 593-4810
Email: singhal@ohio.edu

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“The impact of AIDS is no less destructive than war itself, and by some measures, far worse”

U.N. Secretary General Kofi Anan (quoted in UNAIDS, 2000a, p. 39).

“At the moment, education and communication are the only weapons we have against HIV/AIDS”

The late Jonathan Mann, former Director of WHO’s Global Program on AIDS, in an AIDS Conference in New Delhi, India in November, 1992.

Table of Contents

	Pages
EXECUTIVE SUMMARY	05
PURPOSE OF THE WORKSHOP	07
Workshop Activities	08
Organization of the Workshop Report	09
THE ROLE OF COMMUNICATION PROGRAMMING	10
<i>Case: Innovative Home-Based Care Programs for HIV/AIDS in Africa</i>	10
Communicative Challenges for HIV/AIDS	11
<i>Case: The Entertainment-Education Strategy: From Private Closets to Public Discourse</i>	12
THE UNAIDS COMMUNICATION FRAMEWORK: FOCUS ON THE FOREST, NOT THE TREE	13
<i>Case: Local Responses to AIDS: Creating AIDS-Competent Societies</i>	15
Contextual Domain #1: Government Policy	15
<i>Case: Thailand's National Response to AIDS</i>	16
<i>Case: Brazil's Universal Access to Drug Therapy</i>	17
Contextual Domain #2: Socioeconomic Status	17
<i>Case: Barbers as Frontline Soldiers in the War on AIDS</i>	17
Contextual Domain #3: Culture	18
<i>Case: Tapping the Strength of the Nguni Culture</i>	19
Contextual Domain #4: Gender Relations	19
<i>Case: Ethiopian Coffee Ceremonies: AIDS Discussion through Housewives</i>	20
Contextual Domain #5: Spirituality	20
<i>Case: A Spiritual Jihad on AIDS in Uganda</i>	21
NEXT STEPS ON OPERATIONALIZING THE UNAIDS COMMUNICATIONS FRAMEWORK	22
<i>Case: Child Courts in Zimbabwe</i>	24
<i>Case: Sincere Community Centers in Malaysia</i>	25
<i>Case: Buddhist Principles to Cope with AIDS</i>	26

WORKSHOP RECOMMENDATIONS	27
<i>Case: Soul City in South Africa: Where Communication Theory Meets Practice</i>	29
Involving the Private Sector	30
<i>Case: Private Sector Involvement in Brazil's Fight Against AIDS</i>	31
Evaluating the Role of Communications in HIV/AIDS Programs	31
Social Change Indicators for HIV/AIDS Interventions	32
CONCLUDING REMARKS	33
REFERENCES	34
APPENDIX A: Workshop Background Note	37
APPENDIX B: Workshop Participant List	41
APPENDIX C: Workshop Agenda	59

EXECUTIVE SUMMARY

The present report synthesizes the deliberations of a workshop on “Communication for Behavior and Social Change: Program Experiences, Examples, and the Way Forward”, organized by the UNAIDS’ Department of Policy, Strategy and Research (PSR) and the Secretariat of the International Partnership Against AIDS in Africa (IPAA) in Geneva in July, 2000.

The workshop’s objectives were (1) to map out strategies for implementation of communication programs for behaviour and social change, using newly-emerging directions from UNAIDS, co-sponsors, and other organizations, (2) to strengthen linkages between communication programs and priority issues in HIV/AIDS in developing countries, and (3) to increase technical soundness in communication programs, projects, and strategies of organizations working in the realm of HIV/AIDS.

Some 67 participants with responsibility for communication-related programs from UNAIDS, its co-sponsors, other UN agencies, and other international, regional and in-country organizations, including policy-makers, program managers, technical advisors, scholars, and foundation officials, participated in the workshop.

Workshop activities, which broadly centered around a discussion of the role of communication in behavior and social change aspects of HIV/AIDS, included (1) information-sharing sessions, (2) experience-sharing sessions, including group work, (3) a discussion of the UNAIDS’ Communication Framework for HIV/AIDS: A New Direction , and (4) an identification of high priority issues in HIV/AIDS programs, and the role of communication to support such programs.

Workshop participants recognized that communication programming represents a key ingredient in the “social vaccine” against HIV/AIDS, given that AIDS in many respects is a disease of ignorance and intolerance. However, communication was recognized as a necessary but not a sufficient condition for either preventing HIV/AIDS, or for augmenting care and support programs. Workshop participants believed that individual responses to HIV/AIDS are strongly influenced and shaped by societal norms; by one’s gender and socio-economic status; by one’s spiritual values; and by the prevailing governmental and policy environment for HIV/AIDS.

While deliberating on the UNAIDS communication framework, workshop participants stressed the overwhelming importance of having a nationally-driven agenda for HIV/AIDS, one that requires the persistent engagement of the highest levels of government. Further, communication programs need to especially attend to the needs of those individuals and communities that constitute the bottom rung of the socio-economic ladder, who are the most vulnerable to HIV/AIDS. Workshop participants further believed that communication programmers have often viewed culture as being static, and mistakenly looked upon people’s health beliefs as cultural barriers. They emphasized that culture should also be viewed for its strength, and those attributes of a culture that are positive for the conduct of HIV/AIDS prevention, care, and support programs should

be identified and harnessed. Workshop participants also believed that gender relations should be at the heart of any communication strategy for HIV/AIDS prevention, care, and support, especially as women are more vulnerable to HIV, more stigmatized, and the least empowered to control their environment. Finally, workshop participants emphasized that HIV/AIDS communication programs should harness peoples' spiritual domains.

Overall, workshop participants agreed to look at the UNAIDS communications framework not as a readymade prescription, but rather as a flexible guide, that facilitates local ownership in operationalizing and implementing the framework. Workshop participants emphasized the need for communication specialists and program implementers to revisit their current initiatives to see how the five contextual domains of the UNAIDS communication framework could influence their program strategies.

Several recommendations about the role of communication for behavior and social change in HIV/AIDS programs emerged from the workshop deliberations.

Recommendation #1. Communication for behavior and social change should address the full HIV/AIDS continuum of prevention, care, and support.

Recommendation #2. Communication for behavior and social change is most effective when integrated with a cross-disciplinary approach, drawing upon knowledge of epidemiology, anthropology, sociology, information science, psychology, and community development.

Recommendation #3. Communication for behavior and social change should promote provision, access, and use of various services and products.

Recommendation #4. Communication for behavior and social change should be planned and implemented on a sustained, coherent, and long-term basis.

Recommendation #5. Communication for behavior and social change should address regional, country, and community specificity.

Recommendation #6. Communication for behavior and social change need to incorporate aspects of research, monitoring and evaluation.

Recommendation #7. There should be increased advocacy for, and visibility of, communication for behavior and social change initiatives, including their contributions, among UNAIDS co-sponsors and other implementing agencies.

Workshop participants also emphasized that communication programs should make a more concerted effort to involve the private sector in HIV/AIDS prevention, care, and support activities. Further, participants emphasized the need for (1) evaluating the impact of communication programs on HIV/AIDS prevention, care, and support, and (2) to develop new indicators that go beyond the traditional measurement of individual-level behavioral changes to measure changes at the social-systemic level.

HIV/AIDS and Communication for Behavior and Social Change: Program Experiences, Examples, and the Way Forward¹.

By mid-2000, an estimated 40 million people worldwide were living with HIV/AIDS; some 20 million people have died, leaving behind 15 million AIDS orphans (UNAIDS, 2000a). How can this rising tide of human devastation resulting from AIDS be stemmed? What role can communication play in this endeavor?

PURPOSE OF THE WORKSHOP

From 25 to 27 July, 2000, the UNAIDS' Department of Policy, Strategy and Research (PSR) and the Secretariat of the International Partnership Against AIDS in Africa (IPAA) organized a three-day workshop on "Communication for Behavior and Social Change: Program Experiences, Examples, and the Way Forward" in Geneva. This three-day workshop was preceded by a one-day workshop (on July 24, 2000) for communication advisors, officers, and consultants of UNAIDS, and its co-sponsors. The purpose of the one-day workshop was (1) to exchange experiences among UNAIDS communication specialists and consultants, (2) to identify problems and possible solutions in furthering the role of communication advisors and consultants in the fight against HIV/AIDS, and (3) to harmonize the directions of HIV/AIDS communication programs with co-sponsors and other partners. This one-day workshop helped in honing the agenda for the three-day workshop that followed.

The long-term objectives of the three-day workshop (see Workshop Background Note, Appendix A) were to work toward:

- (1) the strengthening of in-country HIV/AIDS communication programs for behaviour and social change within UNAIDS, its co-sponsors (WHO, UNICEF, UNESCO, UNDP, UNFPA, World Bank, and UNDCP), and other UN and international agencies (FAO, ILO, WCC, and others); and
- (2) the strengthening of linkages between high priority in-country programs for HIV/AIDS with the communication activities of other international agencies and institutions in Africa, Asia, Latin America, and the Caribbean such as USAID, Rockefeller Foundation, Ford Foundation, Family Health International, DFID, and such regional institutions as ECA, OAU, ADB, SADCC, ECOWAS, ASEAN, IDB, PAHO, and other regional NGOs.

¹ I thank Dr. Collins O. Airhihenbuwa, Professor of Bio-Behavioral Health at Penn State University, and Bunmi Makinwa, Communication Adviser, UNAIDS, Geneva, for their feedback on a draft version of this report. I also thank each workshop participant for contributing their ideas, experiences, and voices to this report.

The workshop's specific objectives were:

- (1) To map out strategies for implementation of communication programs for behaviour and social change, using newly-emerging directions from UNAIDS, co-sponsors, and other organizations.
- (2) To strengthen linkages between communication programs and priority issues in HIV/AIDS in developing countries, especially in Sub-Saharan Africa and Southeast Asia, to boost effectiveness in implementation and evaluation.
- (3) To increase technical soundness in communication programs, projects, and strategies of organizations working in the realm of HIV/AIDS.

Some 67 participants with direct or indirect responsibility for communication-related programs from UNAIDS, its co-sponsors, other UN agencies, and other international, regional and in-country organizations, including policy-makers, program managers, technical advisors, scholars, foundation officials, and others participated in the workshop deliberations (see Workshop Participant List, Appendix B). Workshop participants represented various regions, countries, disciplines, and points-of-view, stimulating a polylogue.

Workshop Activities

Workshop activities, which broadly centered around a discussion of the role of communication in behavior and social change aspects of HIV/AIDS, included (1) information-sharing sessions, (2) experience-sharing sessions, including group work, (3) a discussion of the UNAIDS' Communication Framework for HIV/AIDS: A New Direction (UNAIDS/Penn State, 1999), and (4) an identification of high priority issues in HIV/AIDS programs, and the role of communication to support such programs through behavior and social change (see Workshop Agenda, Appendix C).

(1) Information-sharing sessions during the workshop covered such topics as (1) the current epidemiological state of HIV/AIDS, (2) the UNAIDS Best Practice Collection and Technical Resource Network, and (3) the socio-economic impacts of HIV/AIDS. In addition, programmatic reports were presented on various UNAIDS priority issues such as (4) greater involvement of people with AIDS (GIPA), (5) focus on young people, (6) HIV/AIDS and human rights, (7) HIV prevention, (8) care, treatment, and access to retroviral drugs, (9) mother to child transmission, (10) International Partnership on HIV/AIDS in Africa (IPAA), and (11) the development of an HIV/AIDS vaccine.

(2) Experience-sharing from countries and regions occurred (1) in the plenary sessions (a) during the various post-presentation discussions and question-and-answer activities and (b) in certain specifically-designated sessions for sharing in-country experiences, and (2) in the small breakaway group sessions, where participants tabled their experiences to strategize about the role of communication programming to

effectively address UNAIDS priority areas (listed above). The breakaway groups also identified key actors and activities with respect to the five contextual domains of the UNAIDS' communication framework (discussed later), including suggestions for its operationalization, and outlining of strategies for program sustainability, coherence, and evaluation.

(3) Undergirding the workshop deliberations was the newly-developed UNAIDS' Communication Framework for HIV/AIDS: A New Direction (UNAIDS/Penn State, 1999), which calls for a reorientation of HIV/AIDS communication programs by moving away from just focusing on individual-level behaviour changes to focusing on bringing changes in five contextual domains (government policy, socio-economic status, culture, gender relations, and spirituality), where HIV/AIDS occurs, spreads, and assails individuals, families, communities, countries, and world regions. The new framework urges communication program managers to realize that individual behaviours are not always rational, volitional, and made under free will; that individuals are often not on a level playing field, for instance, with respect to socio-economic status or gender equity. Workshop participants discussed the implications, challenges, and possibilities of incorporating one or more of the five contextual domains in current and future HIV/AIDS communication programs.

(4) The above-mentioned workshop activities -- information-sharing, experience-sharing, and discussion of the UNAIDS' communication framework -- helped the workshop participants to identify several high priority issues in harnessing communication programs to support HIV/AIDS-related behaviour and social change. These high priority issues are tabled in the present report in the form of workshop recommendations.

Organization of the Workshop Report

The present report is informed by a variety of inputs, including (1) the author's notes as a participant observer during the workshop deliberations, (2) the background reading materials for the workshop (3) and the various rapporteurs' reports from the workshop's breakaway group activities.

The present workshop report is organized as follows. First, the role of communication in HIV/AIDS programming is discussed, highlighting the various communicative challenges to HIV/AIDS prevention, care, and support. Second, the rationale for the new UNAIDS communications framework is provided, followed by suggestions for operationalizing the framework's five contextual domains at the in-country level. The key workshop recommendations are then provided, including some practical guides on how to involve the private sector in HIV/AIDS initiatives, and how to evaluate the "social change" impacts of HIV/AIDS communication programs. Several case studies signifying effective utilization of communication programming for HIV/AIDS are included to provide implementation ideas for communication program managers.

THE ROLE OF COMMUNICATION PROGRAMMING

Workshop participants emphasized that AIDS can be viewed as a disease of ignorance and intolerance. Taboos surrounding HIV/AIDS often prevent recognition, discussion, or acceptance of safe practices. In the absence of a vaccine and therapeutic cure, communication programming represents a key ingredient in the social vaccine against HIV/AIDS (Population Reports, 1989. P. 1).

Workshop participants recognized communication programming as being a crucial factor in the implementation of the various UNAIDS priority areas, including:

- GIPA (Greater Involvement of People with AIDS): For instance, GIPA is an essential communicative tool for community mobilization and advocacy. It makes HIV visible, contributing to the breaking of silence.
- Young people's right to know about HIV/AIDS, especially AIDS orphans, child laborers, street children, young girls at risk for prostitution, and others.
- Drug therapy and vaccines. New challenges are emerging in communication programming in light of the discovery of new antiretroviral combination drug therapies, as also media coverage of efforts to develop an HIV vaccine.
- Prevention, care, and support. Communication programs must now address the entire HIV/AIDS continuum of prevention, care, and support. A holistic approach to HIV/AIDS should go beyond prevention (the previous mantra for communications programs) to also enabling mechanisms for (1) bio, (2) psycho, and (3) socio care and support of HIV/AIDS patients.

Innovative Home-Based Care Programs for HIV/AIDS in Africa

As HIV/AIDS takes a heavy toll on the existing medical services in countries of Sub-Saharan Africa, several innovative home-based care programs have sprung up in South Africa, Zimbabwe, and other countries.

The Tateni Home Care Services was started by a group of retired nurses in Mamelodi, the black "township" of 1.5 million people on the western fringes of Pretoria, the capital of South Africa. In response to the growing needs for care and support among local HIV/AIDS patients, Tateni developed home-based care policy and training materials in cooperation with the local health authorities. Tateni's credo is based on the values of empathy, acceptance, hope, and the removal of discrimination against those infected or affected by HIV/AIDS.

Tateni's program complements existing health care services rather than duplicating or competing with them. The family members of HIV/AIDS patients are trained to enlarge the base of primary care givers, thereby boosting the community's internal capacity to handle HIV/AIDS. Tateni was careful not to copy home-based care models from industrialized countries, where clients usually receive formal home-based health care, mostly in senior citizen homes or nursing home facilities. As African traditions emphasize complex family and community relationships of support, obligation, and consensus, cost-effective family-based home care is provided by Tateni

in a way that is respectful of cultural norms and traditions. While Tateni mainly provides enabling palliative care, HIV/AIDS prevention, education, and surveillance are also an integral part of its work. Tateni's outreach workers teach home care using life-sized dolls made of foam rubber and cast off clothes. They teach caregivers about how to take care of patients while guarding themselves against HIV infections (for instance, by wearing protective gloves, etc.).

The Chirumhanzu Home-based Care project in the central Midlands province of Zimbabwe, grew out of an initiative of hospital health workers, including senior nurses, Dominican sisters, and expatriate doctors. The home-based care project was launched because of three key reasons: overcrowded hospital wards, high costs of hospital care, and the wish of local AIDS patients to stay at home under the care of their families, up until the time of their death.

The Chirumhanzu project works closely with traditional village leaders, who are first invited to visit the local hospital or clinic to meet with the project staff. A video on home-care and HIV/AIDS is shown during this visit. Then the Chirumhanzu staff visits the village, where a public meeting is called by the local chief. The public meeting begins with a skit created by the Chirumhanzu's drama troupe to entertain the public while providing relevant information on HIV/AIDS prevention, care, and support. The drama performance is followed by an interactive discussion on the effect of HIV/AIDS on the local community, usually facilitated by a respected nurse practitioner. The meeting usually ends with the chief, his advisors, and the local people showing interest in beginning home care services locally.

Source: UNAIDS (1999a, pp. 54-55).

Communicative Challenges for HIV/AIDS

There are many communicative challenges to HIV/AIDS prevention, care, and support. A glance at some of the key challenges will show that

- (1) Communication is a necessary but not a sufficient condition for either preventing HIV/AIDS or for augmenting care and support programs.
- (2) An individual's response to HIV/AIDS is strongly influenced and shaped by societal norms; by their gender and socio-economic status; by their faith, beliefs, and spiritual values; and by the prevailing governmental and policy environment for HIV/AIDS.

Communicative challenges to HIV/AIDS exist because (Singhal, 2000):

A. HIV/AIDS is:

- invisible (for several years)
- silent (for several years)
- non-debilitating (for several years)
- infectious
- multiple transmission modes
- non-discriminating (e.g. in terms of age, gender, geography, etc.)

B. HIV/AIDS deals with human behaviors:

- that often involve interaction between unequal parties (e.g. a paying client versus a poor commercial sex worker)
- that are shaped by deep-rooted socio-cultural traditions (e.g. patriarchy, circumcision)
- that are private and personal (e.g. sex, drug use)
- that are recurring
- that are pleasurable
- that satisfy physiological, psychological, and socio-affiliative needs
- whose discussions are considered taboo by society
- that are moralized by society
- that are stigmatized by society
- that are discriminated against by society

C. Efficacious responses to HIV/AIDS involves adoption of behaviors:

- that are dependent on compliance of more than one party (e.g. condom use)
- that are dependent on the availability of products (e.g. condoms) and services (e.g. HIV testing).
- that are preventive in nature (i.e. involve adopting a behavior today to lower the probability of some future unwanted event)
- whose benefits are neither imminent nor clear-cut
- whose execution is a non-event (that is, nothing happens when one adopts; so motivation for maintaining behavior change is low)
- that involve foregoing or reducing pleasure
- that involve foregoing or reducing adventure

D. HIV/AIDS deals with populations (Svenkerud, Singhal, & Papa, 1998):

- that are often hard to reach by conventional media channels
- who are often marginalized (for instance, gays, IV drug users, commercial sex workers) by society
- who are most vulnerable and powerless (for instance, women and children)
- who are of a lower socio-economic status
- who are on the move (migrants, truck-drivers) and not easy to target

The Entertainment-Education Strategy: From Private Closets to Public Discourse

In Japan, the number of HIV tests and the requests for HIV/AIDS counseling more than doubled between July and September, 1998, thanks largely to a popular melodramatic television series, “Kamisama Mo Sukoshidake” (“Please God, Just a Little More Time”), which told the story of a high-school girl who is infected by HIV while she engages in commercial sex work. This highly popular program, which was broadcast over three months, addressed the issues of HIV/AIDS prevention, care and support, as also the issue of teenage prostitution in a culturally-sensitive manner, breaking the media’s silence on the topic. Prior to the broadcasts of

“Kamisama Mo Sukoshidake”, which amplified human emotions in confronting stigma, shame, guilt, fear, and anger, public awareness about HIV/AIDS had declined in Japan for five straight years, primarily because of media’s reluctance to address the taboo topic. The television series earned the second highest ratings of all programs broadcast during the summer of 1998 in Japan, moving a highly stigmatized topic to the domain of public discourse.

Entertainment-education programs, such as “Kamisama Mo Sukoshidake”, represent an effective and viable weapon in the war against HIV/AIDS (Piotrow, Meyer, & Zulu, 1992). Such programs utilize the popular appeal of entertainment formats (such as melodrama) to consciously address educational issues (Singhal & Rogers, 1999; Piotrow et al., 1997). They earn high audience ratings, involve audience members emotionally, and spur interpersonal conversations among listeners on various topics.

Source: Watts (1998).

THE UNAIDS COMMUNICATION FRAMEWORK: FOCUS ON THE FOREST, NOT THE TREE

Most past and present strategic planning for HIV/AIDS communication programming usually begins with ascertaining the problematic knowledge, attitudinal, and practice (KAP) factors among individuals in the target audience. The “new” UNAIDS communication framework (UNAIDS/Penn State, 1999) urges HIV/AIDS program implementers to reorient their approach to instead ascertain the role of socio-cultural influences (socio-economic status, gender relations, cultural norms, and spirituality) and environmental influences (government policy, access to services, occupational risks) in shaping individual behavior. The UNAIDS framework calls for refocusing communication interventions on the basis of five key contextual domains: (1) government policy, (2) socio-economic status, (3) culture, (4) gender relations, and (5) spirituality. These contextual domains, while they lie outside the skin of individuals, have a significant influence on their HIV/AIDS-related health behaviors.

In essence, the UNAIDS framework calls for moving away from individual-level theories and models of preventive health behaviors (health belief models, theory of reasoned action, stages of change, hierarchy of effects model, social cognitive theory, diffusion of innovations, and others) to more multilevel, cultural, and contextual explanations and interventions (McKinlay & Marceau, 1999; 2000). Metaphorically-speaking, the UNAIDS framework urges communication programmers to go beyond analyzing and influencing the bobbing of individual corks on surface waters, but to focus more on redirecting the stronger undercurrents that determine where cork clusters end up along a shoreline (McMichael, 1995).

The UNAIDS communications framework is premised on the notion that past failures of preventive health intervention programs in developing countries have been wrongly blamed on the individual, disregarding the context that shapes the individual. Individuals have been the focus of change of communication programs, assuming, mistakenly, that

- (1) All individuals are capable of controlling the elements and structures of their context.

However, whether or not an individual can get an HIV test, use condoms, be monogamous, or use clean needles is often impacted by cultural, economic, social, and political factors over which the individual may exercise little control.

- (2) All individuals are on an even playing field.

However, women and those of lower socio-economic status are more vulnerable to HIV/AIDS.

- (3) All individuals take preventive health decisions rationally.

However, well-informed rational intentions to use condoms, for instance, often can fall by the wayside in the context of a passionate sexual encounter. In a given time and space, passionate physiological churnings for sexual release, coupled with heightened psycho-biological drives for physical union, may overwhelm previously-conceived rational intentions about “being safe”.

Also, the important role of emotions as a valid form of human experience, which may trigger the practice of preventive health behaviors, is often underestimated, understated, and overlooked. For instance, witnessing the death of a close friend from AIDS, and seeing the grief of his parents, infected widow, and child, can serve as a more powerful trigger to adopting a prevention behavior than rationally-structured media messages promoting condom use (Airhihenbuwa, 1999).

- (4) All individuals take decisions of their own free will

However, whether or not a woman is protected from HIV is often determined by her male partner who may or may not wish to use a condom.

The five contextual domains of the UNAIDS communication framework signify the view that the forest is more important than the tree. Understanding the forest (the context) can allow one to appreciate the ways in which individual trees are shaped, discern the order that exists between these trees, including the roles, connections, and relationships that exist between them (Airhihenbuwa, 1999). An understanding of the forest can reveal why certain trees tower over others, which trees nurture which ones, and other nuances. By focusing on the five contextual domains, communication programmers can create a flexible culture-based holistic strategy where the interventions are located in the social patterns of relationships among individuals -- as may be determined by their age, seniority, gender, socio-economic class, cultural, and spiritual beliefs.

In the next section, the five contextual domains of the UNAIDS communications framework are revisited, especially in the context of the present workshop’s deliberations.

Local Responses to AIDS: Creating AIDS-Competent Societies

The UNAIDS' Local Responses initiative is a community-based, people-driven response to HIV/AIDS. It believes that people need to "own" the problem, and be involved in partnering in socially-acceptable actions for HIV/AIDS prevention, care, and support in places where they live – in their homes, neighborhoods, and workplaces. The goals of the initiative are to facilitate the creation of AIDS competent societies by strengthening the local capacity of people to accept the reality of AIDS, assess how it affects their daily lives, to prevent it, to live with it positively, and to learn from their actions.

The UNAIDS local responses initiatives are presently active in Uganda, Tanzania, Burkina Faso, Thailand, Philippines, and several other countries. In Uganda, for instance, people living with AIDS actively participate in the local decision-making of their villages, parish, and sub-county councils. In Magu, Tanzania, female guardians at schools involve teachers and students to curb unwanted pregnancies, rapes, and sexual exploitation. In Gaoua, Burkina Faso, the struggle against AIDS has become "everybody's business": Members of the local community, the administrative sector (such as education, agriculture, military, and prisons), and the voluntary sector (such as women's, youth, farmers' cooperatives, and churches) collaboratively designed a plan to combat HIV/AIDS, and mobilized resources to achieve their goals.

The local responses initiative believes in both internal and external facilitation. The purpose of facilitation is to create an enabling environment so that local actors can take responsibility for finding solutions to their AIDS problem in a manner that is most suited for them. The premise of the local responses initiative is consistent with the contextual focus of the UNAIDS communication framework for they both believe that "people are the subject of the response to AIDS, not the objects of our interventions".

Source: UNAIDS Local Responses Initiative.

Contextual Domain #1: Government Policy

Workshop participants stressed the overwhelming importance of having a nationally-driven agenda for HIV/AIDS; one that requires "the persistent engagement of the highest levels of government" (Piot cited in UNAIDS, 2000a, p.7). Government policies, laws, and regulations can promote or hinder HIV/AIDS communications programs. The political will and courage of national leaders determines whether or not a country will put the lid on AIDS, or bring it pro-actively to the domain of public discourse. The sustainability of communication programs, including its focus on multi-sectoral partnerships, strategic alliances, and capacity-building are highly dependent on the national policy on HIV/AIDS.

In Uganda, Senegal, and Thailand, the national government, non-governmental organizations, and other civil society institutions dealt with HIV/AIDS issues openly and directly (UNAIDS, 1998a; Phoolcharoen, 1998; Madraa & Ruranga-Rubaramira, 1998). In Uganda, the political will of government to openly address HIV/AIDS, with the charge being led by President Yowiro Museveni, has created a conducive environment to create

and sustain a national response. Many pioneering initiatives were undertaken such as the establishment of the first multi-sectoral commission worldwide to coordinate HIV/AIDS prevention, care, and support efforts, and the first voluntary and anonymous HIV testing and counseling center in Sub-Saharan Africa. Thanks to government policies, in 2000, Uganda probably is the only country in the world where AIDS has “zero stigma” (as noted by the workshop participant from Uganda)..

Thailand’s National Response to AIDS

Thailand’s national response to HIV/AIDS is coordinated by its National Economic and Social Development Board (NESDB), which represents the country’s planning authority. The NESDB coordinates a comprehensive AIDS action plan through 14 different ministries, over two hundred NGOs, and various private sector institutions. Thailand’s government policy with respect to HIV/AIDS prevention, care, and support has been open, timely, and pro-active, at least when compared to its neighbors.

The NESDB assigns various HIV/AIDS program components to appropriate government ministries, offices, or departments. For instance, public relations and mass media activities related to HIV/AIDS are conducted by the Prime Minister’s Office (signifying political support at the highest level); AIDS education in schools by the Ministry of Education; AIDS programs for special target groups (like IDUs, CSWs, etc.) by the Ministry of Interior; medical and counseling services and condom promotion by the Ministry of Public Health; condom distribution and peer education among the military by the Ministry of Defense; and research and evaluation of HIV/AIDS programs by the Ministry of University Affairs

Over 200 Thai development-oriented NGOs work in the realm of HIV/AIDS prevention, care, and support in addition to a 42 member consortium of Thai NGOs Against AIDS. They provide AIDS education and social support services where the government sector has been relatively weak. For instance, NGOs work closely with disadvantaged communities, especially focusing on the empowerment among stigmatized social groups such as CSWs, IDUs, migrant workers, and others.

The Thai Business Coalition on AIDS also provides information, interventions, technical support, and training programs on HIV/AIDS to Thai businesses. It implements non-discriminatory programs in the workplace for people living with AIDS.

Source: UNAIDS (1999a, p. 77).

The Senegalese government also has dealt with HIV/AIDS openly and pro-actively. When the first six AIDS cases were reported in Senegal in 1986, the government immediately established a national AIDS program. Within a year, every unit of blood transfusion was screened for HIV antibodies in all ten regions of the country (UNAIDS, 1999b). In 2000, over 400 women’s groups, comprising some 500,000 members, and 200 NGOs support AIDS-related activities in Senegal. AIDS discussions occur in schools, social and professional associations, religious institutions, recreational areas, football fields, the media, the markets, the bus stations, and the home (Diop, 2000). In essence, everywhere.

Workshop participants felt that a national response to HIV/AIDS calls for political courage to make hard political choices. For instance, how to engage the Catholic Church to endorse the idea of condoms to “prevent a death” as opposed to “prevent a birth”? How to institute needle exchange programs for drug users? How to protect the rights of the most marginalized and vulnerable?

Brazil’s Universal Access to Drug Therapy

In Brazil, the government’s policy of universal access to antiretroviral drugs nearly halved the annual number of AIDS deaths between 1996 and 1999, reducing opportunistic infections among AIDS patients by up to 80 percent.

In the mid-1990s, the Brazilian government initiated local manufacture of non-patent protected antiretroviral drugs for which it had the know-how and the production infrastructure. Local production, supplemented with the government’s bulk purchase of imported antiretrovirals, made drugs affordable to the country’s 85,000 AIDS patients. While the drug program cost the government some \$340 million (U.S.) in 1999; substantial national savings occurred through the tens of thousands of AIDS-related hospitalizations that were averted.

Source: UNAIDS (2000a, pp. 101-102).

Contextual Domain #2: Socioeconomic status

Workshop participants felt that those individuals and communities that constitute the bottom rung of the socio-economic ladder are the most vulnerable to HIV/AIDS: They have the least power, the least access to information, and few resources to fight HIV/AIDS (Melkote, Mupiddi, & Goswami, 2000). They also have poor nutritional status, little access to health care, and are least able to afford medical services (Pasick, 1995).

At the country-level, the developing countries of Asia, Africa, and Latin America are most vulnerable to AIDS, given the prevailing poverty, malnutrition, unemployment, illiteracy, lack of infrastructural and basic primary health care systems, rural-urban migration, poor sanitation, income inequality, knowledge inequality, gender inequality, and other exacerbating factors (Melkote, Mupiddi, & Goswami, 2000).

Barbers as Frontline Soldiers in the War on AIDS.

Many Indian men are too embarrassed to buy condoms at a drugstore or to talk freely about sex with health counselors and family members. But at one place they feel comfortable about “letting their hair down”: At the barber’s shop. The Indian State of Tamil Nadu has trained barbers to be its frontline soldiers in the fight against AIDS. In the poorer and blue-collar areas of Chennai, Tamil Nadu’s capital city, men often trim their hair and beard before frequenting a commercial sex worker. Now they pick up a condom on their way out.

Mr. Mani, a local barber, trims hair and dispenses advice on safe sex, which represents a new dimension to his 20-year old career: He starts by talking to his clients about their family and children. Slowly he gets to women, AIDS, and condoms. The barber program was launched in 1995 and within a year recruited 5,000 barbers, who receive AIDS education and training on Tuesdays, their day off. The barbers are not paid to be AIDS counselors; but they appear to take pride in their new responsibility.

Over centuries, India's barbers have been trusted as traditional healers, trusted advisors, and matchmakers. "To get the king's ears, tell his barber", so goes the popular saying. To reinforce the image of barbers as healers, the local trade group is called the Tamil Nadu Medical Barber Association. Participating barber shops in Tamil Nadu provide free subsidized condoms to its clients; some offer a premium "pleasure pack" at subsidized rates, from which they earn a 25 percent commission.

Source: Jordan (1996).

Contextual Domain #3: Culture

Several workshop participants felt that communication programmers have often viewed culture as being static, and mistakenly looked upon people's health beliefs as cultural barriers. Workshop participants emphasized that culture should also be viewed for its strength. Attributes of a culture that are positive for the conduct of HIV/AIDS prevention, care, and support programs should be identified and harnessed. The metaphorical coupling of culture and barrier needs to be exposed, deconstructed, and reconstructed so that new, positive, cultural linkages can be forged (Airhihenbuwa & Obregon, 2000). For instance, smoking cessation programs among Latino found the cultural strength of the influence of family, a positive Latino cultural norm, and harnessed it to reduce smoking in the community (Airhihenbuwa, 1995; 1999).

Several socio-cultural and spiritual dimensions of Senegalese society have strengthened the nation's response to HIV/AIDS: For instance, the cultural norms with respect to the universality of marriage; the rapid remarriage of widow(er)s and divorced persons; moral condemnation of all forms of sexual cohabitation not sanctioned by religious beliefs; and extended social networks of parents, cousins, relatives, neighbors, and others that serve to control irresponsible sexuality. The fear of dishonoring one's family and the subsequent "what will they say" syndrome exercises a strong check on irresponsible individual behavior (Diop, 2000).

Workshop participants also felt that HIV/AIDS communications campaigns, especially in Africa, Asia, and Latin America have tended to undervalue the importance of utilizing the traditional oral communication channels. In these cultures, the oral tradition is highly rich in visual imagery -- on which learning and imagination are founded (Airhihenbuwa, 1999). Proverbs, adages, riddles, folklore, and storytelling are thus important communication tools. The oral tradition offers the potential to tap into language elasticity, that is, the entire spectrum of cultural expressions, particularly words-of-advice and encouragement, that are often couched in adage, allegory, and metaphor (Airhihenbuwa, 1999).

Tapping the Strength of the Nguni Culture

A cursory analysis of some of the cultural attributes of the Nguni people in Southern Africa reveals various points of entry for implementing HIV/AIDS communication programs.

For instance, among the Nguni,

** the responsibility for providing sexuality education to the young is usually delegated to an aunt or an uncle, especially during puberty.*

** there is a cultural emphasis on sexual abstinence and moderates social behavior*

** there is a strong taboo against bringing one's family name to disrepute.*

** family members of an extended family take turns in looking after the sick, so as to not overly burden one person.*

** there are no orphans as the extended family takes care of orphans.*

** the practice of ukusoma (a Zulu term for non-penetrative sex) is common both to preserve virginity and to prevent pregnancy. The woman keeps her thighs close together where the man finds sexual release. Among other groups, the space between a bent elbow is often used for a similar purpose. Similar non-penetrative sex practices exist among certain groups in Ethiopia (commonly referred to as 'brushing'); the Kikuyu in Kenya, and other groups.*

Source: Rapporteur's notes from the present UNAIDS workshop.

Contextual Domain #4: Gender Relations

Workshop participants felt that gender relations should be at the heart of any communication strategy for HIV/AIDS prevention, care, and support. Women in many developing countries still have to prove their worth by being married, having children, and caring for their families. Women are more vulnerable to HIV, more stigmatized, and the least empowered to control their environment.

Gender roles and relationships play a key role in shaping the HIV/AIDS epidemic. While women sex workers are blamed for the spread of HIV, sex work exists because of the demand from men. "Without men, AIDS would not be an epidemic" (Foreman, 1999). Further, men are involved in sex work and in almost every case of sexual transmission; perhaps one in every 10 cases is the result of transmissions solely between men (Foreman, 1999). Four of every five drug injectors are men. With more sexual and drug-taking partners than women, men have more opportunity to transmit HIV. More often than not, it is men who determine whether sex takes place and whether a condom is used. While both men and women fall sick and die from AIDS, in many ways men are less affected by the disease. Worldwide, women are contracting HIV at a

faster rate than men. Women with virus may pass it to their future children. At home and in hospital, women assume greater responsibility for caring for the sick (Foreman, 1999).

Workshop participants noted that there exists a strong gender bias in HIV/AIDS-related stigmatization, discrimination, and denial. Women are more likely to be blamed, even if they lead a monogamous life, and are infected by their husbands. As a 40-year old HIV-positive widow in Bangalore India noted: “My in-laws do not have a good opinion about me. They say that my husband got the disease from me. I sometimes feel why should I live with insult. It is better to die. But I am living for the sake of my children” (quoted in UNAIDS, 2000b, p. 22). Mothers often tend to suffer blame and stigma when their infants or young adult children become infected with HIV. As a result of this stigma, many women who are offered HIV tests refuse testing because of the dangers and difficulties they will face – partner rejection, social ostracization, and psychological stress -- were they to test positive

Further, women’s economic dependence on men, violence against women, and the generally widespread acceptance of male promiscuity, leaves women especially vulnerable to HIV/AIDS.

Ethiopian Coffee Ceremonies: AIDS Discussion through Housewives

In Ethiopia, coffee ceremonies are common in neighborhoods: Friends and family members, usually in neighborhoods, get together to socialize over a cup of coffee. Some innovative HIV/AIDS programs in Ethiopia have piggybacked on the cultural popularity of these ‘coffee ceremonies’ to initiate discussion about HIV/AIDS among housewives. Unlike the youth, who may have access to AIDS prevention information in schools, and men, who may learn about AIDS in the workplace, housewives are somewhat harder to reach through convention institutional channels.

In one innovative program in Ethiopia, a group of peer educators were recruited from among the housewives and were trained to launch informal discussions (over coffee ceremonies) about HIV/AIDS with their friends and neighbors. These housewives-centered discussions quickly expanded to children and men, who informally joined the group. Such family-based HIV discussions, previously taboo, increased dialogue between husbands and wives and between parents and children about how to reduce HIV risk. Some women now pack condoms for their husband when they are traveling, saying it should be available “for use in an emergency”. To keep these conversations going, many housewives now sell condoms from their homes. In some neighborhoods, these conversations have catalyzed the formation of local AIDS action teams.

Source: Workshop participant, Fekerte Belete of PACT Ethiopia.

Contextual Domain #5: Spirituality

Workshop participants felt that HIV/AIDS communication programs should tap into the spiritual domain of human beings. HIV/AIDS deals with issues of life and death, care and compassion, and hope and support, which represent core spiritual values. The

workshop deliberations clarified that spirituality is a much broader concept than religion, although, sadly and mistakenly, the two have been used interchangeably.

Spirituality includes values and beliefs about love, tolerance, compassion, sacrifice, hope, courage, patience, and faith; reflections on what is right and wrong, fair and unfair, truth and untruth; ponderings on the meaning and purpose of life, the inevitability of mortality, and the relationship between mind, body, and soul (Relv, 1997). Spirituality as a conceptual tool is very powerful as it cuts across age, gender, caste, class, language, religion, culture, geography, and occupation.

A Spiritual Jihad on AIDS in Uganda

Since 1992, the Islamic Medical Association of Uganda (IMAU) has trained over 8,000 Islamic religious leaders and their volunteer teams in 11 districts of Uganda to launch a spiritually-motivated grassroots movement to change HIV/AIDS-related behaviors of Muslim communities. The Muslim community in Uganda accounts for about 20 percent (4 million) of the nation's 20 million population. This spiritual movement taps into the existing nationwide network of Islamic leaders, including the Mufti, who heads the Uganda Muslim Supreme Council. In 1989, the Mufti declared Jihad (a holy war) on AIDS. The Mufti supervises 33 district religious leaders (Khadis), who supervise 6 county religious leaders (Sheikhs), who supervise about 40 Imams, each of whom heads a local mosque, serving as a spiritual leader to some 75 to 100 families.

Among the Muslim community, the Imams are highly respected and trusted local spiritual and moral teachers. They are viewed as role models for appropriate social behavior. The Imams teach about AIDS during congregational prayers, home visits, and at intimate family ceremonies such as marriage, birth, and burials. As Imam Ali noted: "Everyday I visit two homes. I use the teachings of the Qur'an to educate people about AIDS – especially the dangers of promiscuity. My visits are not new. The people here expect me because this is my duty as Imam. People feel free to talk to me" (quoted in UNAIDS, 1998b, p. 17).

The Imams incorporate accurate information about HIV/AIDS into Islamic teachings and discourses, promoting messages of mutual fidelity and moral responsibility. For instance,

*Nor come nigh to adultery:
For it is shameful deed and an evil,
Opening the road to other evils.
(Qur'an 17:32)*

The Imams also educate community members about the risks of contracting HIV through traditional Muslim practices such as male circumcision (when one unsterilized razor may be used for several infants), and ablution of the dead (when body orifices may be cleaned without wearing protective gloves). The preventive aspects of using sterilized razors and protective gloves are especially promoted.

The Imam's work on HIV/AIDS prevention, care, and support is aided locally by a respected male and female assistant, who are strongly committed to the cause and are respected by the neighborhood community. In addition, five male and female community members are

chosen by the local mosque to serve as family AIDS workers. They are also respected by their peers and are perceived as being approachable.

Goaded by the Mufti's call to wage a Jihad on AIDS, the Islamic leaders are highly committed to their HIV/AIDS mission. As Sheikh Mohammed Bukanya noted: "People must be educated about AIDS. Many think it is caused by witchcraft. We have to tell people the truth about how the virus is transmitted. I include AIDS teachings when I conduct prayers, Khutba (Friday sermon), and when I speak to families at birth, wedding, and funeral ceremonies. In fact, I will not perform a marriage ceremony until both people have gone for an AIDS test. Couples usually thank me for this" (quoted in UNAIDS, 1998b, p. 19).

In Uganda, the IMAU reaches Muslim children through another innovative initiative called the Madarasa AIDS Education and Prevention Project (MAEP). In the MAEP, Imams and their assistants teach children about AIDS through a special curriculum designed for Madarasas, the informal schools attached to mosques. The AIDS education curriculum includes 36 short lessons, tailored to be age appropriate for mixed age class groups. In over 350 Madarsa schools all over Uganda, students learn about HIV/AIDS transmission, prevention, and control. They learn about caring for AIDS patients and supporting community initiatives to improving their quality of life.

The experience of the IMAU in Uganda suggests the importance of tapping into existing religious institutional networks, and the power of spiritual discourses, to fight the war against AIDS.

Source: UNAIDS (1998b).

NEXT STPES ON OPERATIONALIZING THE UNAIDS COMMUNICATION FRAMEWORK

At the outset, it was acknowledged that the new UNAIDS communications framework is not an alternative theory, but rather a guided flexible approach to addressing HIV/AIDS prevention, care, and support issues globally, with attention to regional and local specificity. Workshop participants were urged to look at the UNAIDS communications framework not as a readymade prescription, but rather as a flexible guide, a philosophy which would facilitate local ownership in operationalizing and implementing the framework.

Workshop participants noted that the process of operationalizing the UNAIDS communications framework has already begun in Ethiopia, which will likely lead to some further guides for in-country implementation. Also, UNICEF's West and Central African Region (WCAR) has created an HIV/AIDS communication strategy for local responses and partnerships, drawing upon the UNAIDS communication framework. The UNAIDS framework was provided to the program implementers as a "road map", but not with instructions on how to navigate it (This was left to in-country teams). Based on this flexible approach, UNICEF's WCAR has created an integrated communication initiative to address HIV/AIDS issues by incorporating components of media and political advocacy, social mobilization, and communication for behavior change.

Workshop participants provided several useful recommendations as possible next steps in trying to operationalize, unpack, and implement the UNAIDS communications framework:

1. Communication specialists and program implementers should revisit their current initiatives to see how the five contextual domains can influence their program strategies.
2. A new mode of operationalizing is needed for the five contextual domains, going beyond the involvement of communication planners. Most past communication interventions have been designed by communication researchers and planners. For operationalizing the five contextual domains, communication planners must pull together a multi-disciplinary team, create multi-sectoral partnerships, and a plan for multi-institution capacity-building.
3. In operationalizing the five contextual domains, it may be useful to ask (for each of the domains) the following sets of questions: Who are the key actors? Who is the target group? What might be the key activities? What institutional mechanisms are needed to implement the key activities? What resources (human and material) are needed for the activities? How can these resources be raised locally, regionally, nationally, and internationally?

Further, workshop participants provided several suggestions for next steps in operationalizing each of the five contextual domains of the UNAIDS communications framework.

#1. Government Policy: With respect to contextual domain of government policy, it may be useful to understand:

- What is the government's present political stance with respect to HIV/AIDS? What more could it do? How?
- What is the government's present role in establishing the media and public agenda for HIV/AIDS? What more could it do? How?
- What is the government's present role in promoting participation of other civil society institutions in HIV/AIDS prevention, care, and support, including the private sector? What more could it do? How?
- What are the government's policy, laws, and regulations with respect tourism, commercial sex work, domestic violence, and other domains which impact HIV/AIDS prevention, care, and support initiatives? What more could it do? How?

Child Courts in Zimbabwe

The Zimbabwean government deserves credit for modifying its legal and judicial proceedings to protect the rights of sexually assaulted children. Prior to the establishment of the child-friendly courts, children faced hostile questioning in regular courtrooms, face-to-face with their adult abusers. Intimidated by the courtroom atmosphere, they often broke down, refused to speak, or had great difficulty in describing the sexual act. Without their testimony, the accused were often acquitted.

Today, when a sexual offence complaint is initiated on behalf of a child, the Zimbabwean police and social welfare officers work with the child to reduce their physical and emotional trauma. Children now give courtroom testimony sitting in a separate room through close-circuit television, removed from the gaze of their abuser. A trained intermediary relays the court's question to the child in a gentle language that the child can understand. The child can also use male and female dolls to demonstrate the sexual act without describing it.

In 2000, every province in Zimbabwe has at least one child-friendly court. The child-friendly courts represent a culturally-sensitive government intervention to protect the rights of the young people.

Source: UNAIDS (2000a, p. 53).

#2. Socioeconomic Status: With respect to contextual domain of socioeconomic status, it may be useful to understand:

- What role does poverty play in exacerbating local vulnerability to HIV/AIDS?
- What may be certain local mechanisms to alleviate poverty and vulnerability for those at risk for HIV/AIDS?
- What mechanisms may stimulate local income-generating activities?
- What local mechanisms can ensure equal access of all citizens to (1) job opportunities, (2) educational services, and (3) care and support facilities?
- What is the role of key governmental, civil society, and private actors in vocational training, education, and employment generation?

#3. Culture: With respect to contextual domain of culture, it may be useful to understand:

- What is the nature of relationships between people in families (including husband-wife, parent-child, extended kinship networks, and intergenerational dynamics)?
- What is the nature of relationships between people in neighborhood communities?
- What types of oral and visual media that characterize the community, especially traditional media forms?
- What is the role of cultural gatekeepers in community information flows?
- What are the positive and negative cultural attributes of the local community with respect to HIV/AIDS?

Sincere Community Centers in Malaysia

Pink Triangle Malaysia (PTM), a non-governmental organization, operates an innovative outreach program targeted at intravenous drug users (IDUs) in Chow Kit, a poor red-light community in Kuala Lumpur, the nation's capital city.

The use of a culturally-sensitive research protocol to assess the clients' needs, prior to launching the program, strongly pointed to the importance of creating an Ikhlas ("sincere") Community Center (ICC), a "safe space" where the IDUs would feel comfortable dropping-in. The Ikhlas Community Center provides meals to IDUs, medical care and treatment, referrals to hospitals and drug treatment centers, counseling and psychological support, access to condoms and other risk-reduction services, and referrals to job placements. Clean bathroom and toilet facilities are also provided so that IDUS can bathe, wash clothes, and maintain basic hygiene.

The IDUs are involved in running the various ICC activities: They cook and clean, serve as outreach workers and volunteer counselors, and conduct administrative tasks. Such participatory involvement helps them take "ownership" of the project, and builds their self-esteem. The IDUs of the ICC now routinely liaisons with volunteer groups from hospitals, nursing schools, the corporate sector, and colleges, and thus feel more accepted by the general community. Their active involvement also makes the Pink Ikhlas program highly cost-effective and effective.

Source: UNAIDS (1999a, p. 42).

#4. Gender Relations: With respect to contextual domain of gender, it may be useful to understand:

- What are the role, relationships, opportunities, and expectations of both men and women in the family, community, and society?

- What may be some ways in which men and women in the community can be engaged in facilitating more equitable gender relationships?
- What are the men's culturally-driven perceptions of family relationships, spousal relationships, child care, and others?
- What are the cultural strengths of the community which promote men as fathers, husbands, care givers, concerned head of households, and responsible members of the community?

#5. Spirituality: With respect to contextual domain of spirituality, it may be useful to understand:

- What are the various types/denominations of religious, spiritual, and secular organizations in the local community?
- What are the communication channels (mass, interpersonal, and group) used by religious and spiritual organizations to communicate with their audiences?
- What types of influence is wielded by local religious and spiritual leaders (including traditional healers, voodoo priests, and others) in the local communities?
- What are the mechanisms through which spiritual and religious organizations engage with other governmental, private, and civil society organizations: For instance, with educational institutions such as Bible colleges and Islamic Madarsa Schools, and with other women, youth, and other voluntary associations?

Buddhist Principles to Cope With AIDS

Spiritual care is an integral part of the Sanpatong Home-Based Care project in Thailand, where Buddhist principles of kindness, compassion, altruistic joy, and equanimity help the afflicted to cope with AIDS. Buddhist monks teach meditation to help people find tranquility, boosting their mental strength to continue with life. Spiritual guidance is provided on how to protect oneself from suffering and how to see the natural hand in the human cycle of life and death. Discourses cover how to come to terms with one's mortality, or that of a loved one. Those suffering from HIV/AIDS often spend week-long retreats at Buddhist Wats (temples), where they meditate, reexamine their spiritual beliefs, and benefit from a regimen of healthy diet and exercise.

People in six out of the 10 ASEAN (Association of South East Asian Nations) countries subscribe to Buddhist principles, suggesting some important guides for designing communication programs for HIV/AIDS prevention, care, and support in this region. Buddhist principles forbid the taking of life (i.e. do not infect others) or consumption of substances to alter the natural body

state (i.e. do not consume alcohol or inject IV drugs), providing an effective spiritual platform to address high-risk behavior.

Source: UNAIDS (1999a, p. 71).

WORKSHOP RECOMMENDATIONS

Based on the three-days of intense workshop discussions of the role of communication for behavior and social change, including the operationalizing of the UNAIDS communications framework, workshop participants made the following seven recommendations:

Recommendation #1. Communication for behavior and social change should address the full HIV/AIDS continuum of prevention, care, and support. In the past, communication programs have tended to treat these aspects of HIV/AIDS as separate. Thus, the role of communication (1) for those who are HIV negative is to keep them HIV free (i.e. prevention through safe sex practices, usage of clean needles, and safe blood supply), (2) for those who are HIV positive is to promote the provision and use of HIV testing, counseling, antiretroviral drug therapy, and others, and (3) for those who have full-blown AIDS is to promote an environment free of stigma, and the provision and use of care and support services.

In essence, workshop participants felt that communication programming can be immensely more powerful by promoting

- diagnosis and treatment of STDs;
- condom availability, accessibility, and use;
- HIV counselling and testing;
- care and support for those with HIV/AIDS;
- information, education, and training for those that provide care and support;
- communication between health care providers and those living with HIV/AIDS (for instance, about adhering to drug treatment regimen);
- communication with the public about the strengths and limitations of antiretroviral treatments, status of vaccines, and others.

Recommendation #2. Communication for behavior and social change is most effective when integrated with a cross-disciplinary approach, drawing upon knowledge of epidemiology, anthropology, sociology, information science, psychology, and community development. Communication programs should involve multi-sectors and multi-disciplinary actors, including the government, civil society organizations, and the private sector.

Recommendation #3. Communication for behavior and social change should promote provision, access, and use of various services and products. For instance, voluntary counseling testing (VCT) sites can represent a strategic entry point for

communicating about prevention, care, and support. They can facilitate adoption of safe sex practices, counsel on ways to prevent mother-to-child transmission, and provide access to care and support groups.

Recommendation #4. Communication for behavior and social change should be planned and implemented on a sustained, coherent, and long-term basis, especially if it were to suitably address the HIV/AIDS continuum of prevention, care, and support. This sustainability is especially warranted given HIV prevention calls for continuous and sustained action by individuals over a good deal of their adolescent and adult lives.

Program sustainability has various components: technical, managerial, political, and financial. Sustainability of communication programs is often a function of the funding cycles of donor and implementing agencies. Also limited funds tend to foster competition between NGOs rather than cooperation.

Communication practitioners should consider setting project priorities based on how conducive the political environment is to create a sustainable program, rather than solely being driven by epidemiological data. For sustainability, intersectoral coordination within and across governments, civil society, and the private sector is key. Sustainability also can be achieved by working through existing institutional structures of the military, prisons, workplaces, brothels, and others.

Recommendation #5. Communication for behavior and social change should address regional, country, and community specificity. A cookie-cutter approach to HIV/AIDS communication programming is likely to be culturally insensitive and ineffective. Resources should be managed in ways to build institutional capacity at the local, regional, national, and international levels.

Recommendation #6. Communication for behavior and social change need to incorporate aspects of research, monitoring and evaluation. Research should begin in the planning phase to gain a contextual understanding of what shapes the behaviors of individuals in a target audience, to understand the emotional and seemingly irrational reasons why people find themselves at risk for HIV, to identify cultural and spiritual opinion leaders, the appropriate communication channels, and others. Monitoring and evaluation should be participatory, involving the local people in assessing their present conditions and establishing future goals. Evaluation should utilize multiple methods and be able to assess changes at multi-levels i.e. at the level of the individual, family, community, and society. Monitoring and evaluation allows for timely feedback to the programmatic intervention, affording possibilities for mid-course correction. Evaluation also makes possible distillation of lessons learned and gleaning of best practices to strengthen subsequent interventions.

Recommendation #7. There should be increased advocacy for, and visibility of, communication for behavior and social change initiatives, including their contributions, among UNAIDS co-sponsors and other implementing agencies. Increase interagency

coordination and collaboration in the implementation of HIV/AIDS communication programs.

Soul City in South Africa: Where Communication Theory Meets Practice

Soul City is a unique example of communication and social change programming in South Africa. It represents a series of integrated, on-going mass media and interpersonal communication activities. Each year a series of mass media interventions are implemented, including the flagship “Soul City”, a 13-part prime-time television drama series, which runs for three months, and promotes specific health education issues. Next, a 60-episode radio drama series is broadcast daily in eight South African languages. While the story in the radio drama is different, the health issues and topics addressed in it are the same as in the TV series. Once the television and radio series are broadcast, 2.25 million health education booklets, designed around the popularity of the TV series’ characters, are distributed free-of-cost to select target audience groups. Some 12 major newspapers further serialize the booklets.

Four sets of “Soul City” series have been broadcast between 1994 and 2000, focusing on issues such as maternal and child health, HIV prevention and control, alcohol abuse, and domestic violence. The Soul City year-long health campaign reaches over 20 million South Africans, including eight million adults. By using a multi-media approach, Soul City helps build a campaign atmosphere which is sustained throughout the year. Each medium reinforces the popularity of the “Soul City” television series, while appealing to a somewhat different target audience: Such a multi-media strategy facilitates the brokering of media partnerships.

Soul City recognizes that overt behavior change is facilitated when audience members talk to one another. So each year, after the television and radio series are broadcast, several campaign activities are implemented to keep people talking. Examples of such initiatives include the “Soul City Search for Stars” (to recruit talent for next year’s television and radio series), the “Soul City Health Care Worker of the Year” (to recognize outstanding outreach workers), and “Soul Citizens” (recognizing outstanding youth who engage in community development activities).

The total cost incurred by Soul City for one year of multi-media materials, is about 3.5 million dollars (U.S.). Some 25 percent of it is provided by the South African government, 25 percent by international donor agencies such as the European Union and UNICEF, 25 percent by corporations such as British Petroleum and Old Mutual, and the remaining 25 percent by the broadcast media

Interestingly, Soul City is mostly a research and management organization. It coordinates the activities of its various corporate, government, media, and donor partners. Its employees do not directly produce, direct, or publish its health communication materials. They commission them from professionals, and through research, ensure their high quality. Soul City owns the media product that is produced, and they pay the bills.

Soul City represents a “site” where communication theory meets practice, to the benefit of health.

Source: Singhal and Rogers (1999).

Involving the Private Sector

In addition to the above seven recommendations, workshop participants felt that communication programs should make a more concerted effort to involve the private sector in HIV/AIDS prevention, care, and support activities. Governments and other civil society organizations have thus far not adequately tapped private sector resources in the war against AIDS, in part because there exists the mistaken assumption that the private sector is only interested in the bottom line, and has little to gain from being involved in HIV/AIDS interventions.

Workshop participants identified a range of private sector entities that could be involved in HIV/AIDS programs: Corporations, foundations, media organizations, trade associations, private individuals, and others. Private sector involvement may take various forms: Direct monetary contributions, in-kind contributions (for instance, the Bata Shoe Company in Zambia provides shoes to people with HIV); partnering for specific activities; HIV/AIDS workplace policies; and workplace interventions. The private sector might contribute in other creative ways as well: For instance, by training and hiring AIDS orphans, or by partnering in audience research, design of communication materials, media advertising, public relations, and condom social marketing (CSM) projects (UNAIDS, 1998c).

Workshop participants felt that the private sector needs to understand the advantages that can accrue to them by partnering in HIV/AIDS prevention, care, and support activities: For instance, savings in personnel hours lost because of sickness or attending funerals, public relations for the company, and/or enhancement of health within the company. The Volkswagen company in Brazil and the Tata Iron and Steel Company (TISCO) in India have launched exemplary AIDS-workplace programs (UNAIDS, 2000b). To facilitate private sector involvement, governments should create a single point of contact for private companies in the administration, and provide specific, practical, and mutually-beneficial suggestions for partnerships. Tax advantages may be considered for the implementation of HIV/AIDS prevention programs in the workplace.

The workshop participants felt that sustaining private sector partnerships is important; hence the private sector should be involved early, beginning with the planning process. There is a special need to create pro-active partnerships in high-risk workplaces, for instance, in the trucking and mining industry. For instance, the truck drivers association in Malawi openly says: “When we hire a new truck driver, we are signing his death warrant”.

In India, UNICEF struck an innovative partnership with the private media channels – both print and cable television media -- to address HIV/AIDS issues. UNICEF monitored the print media coverage on HIV/AIDS, providing feedback to editors and journalists about the frequency, quantity, and slant of existing HIV/AIDS coverage, and thus pointing out some important gaps. It also prepared press kits and media briefing packages on the vulnerability of children and young women to HIV/AIDS, serving as an

advocate to stimulate coverage of these salient issues. UNICEF also partnered with cable television's Channel V, which broadcasts MTV style-videos and appeals to young audiences. HIV/AIDS messages were inserted in Channel V's broadcasts and were reinforced through Channel V's Veejay (video jockey) road shows in major Indian cities and towns. UNICEF arranged for local AIDS NGOs to have programmatic tie-ins with these road shows, thus reaching a large audience of college students with HIV prevention messages.

Private Sector Involvement in Brazil's Fight Against AIDS

In Brazil, in the early 1990s, the National AIDS Program convinced 10 of the nation's biggest private companies to contribute \$50,000 each to promote HIV prevention. The outcome was a research-based, high quality mass media campaign, which raised awareness about HIV prevention and control. One of the participating companies, an ad agency, made in-kind contributions of \$50,000 by designing the media plan and the creative copy. This private sector contribution to HIV/AIDS has continued in subsequent years, making this an ongoing campaign. As a bonus, it has fuelled other private sector initiatives with respect to HIV/AIDS, notably the launch of several AIDS- in-the-workplace programs.

Source: Workshop participant, Michael Fox of UNAIDS, Geneva.

Evaluating the Role of Communication in HIV/AIDS Programs

Workshop participants emphasized the need for (1) evaluating the impact of communication programs on HIV/AIDS prevention, care, and support, and (2) to develop new indicators that go beyond the traditional measurement of individual-level behavioral changes to measure changes at the social-systemic level.

Further, workshop participants felt that:

- A communication program for behavior and social change should encourage both internal and external evaluation. Community members should be actively involved in assessing how the quality of their community life and environment has changed. Communities should be especially encouraged to propose their own indicators of social change.
- Evaluation research should be conducted before, during, and after the launch of communication programs.
- Skills in conducting various types of evaluation of communication programs need to be strengthened so that the evaluation processes are useful, timely, relevant, practical, and cost-effective.
- Evaluation should serve the function of evidence-based advocacy. That is, evaluation should be able to articulate what role communication programs play in promoting HIV/AIDS prevention, care, and support.

Workshop participants also pointed to the difficulties in assessing the impact of communication programs in HIV/AIDS prevention, care, and support. For instance, how does one compute the impact of communication programs in enhancing the quality of life of those who are afflicted by HIV/AIDS?

Social Change Indicators for HIV/AIDS Interventions

As previously stated, workshop participants echoed a strong need to develop indicators for measuring social and organizational change in the community, going beyond measurement of individual-level changes. A preliminary list of social change indicators for HIV/AIDS communication interventions may include (Singhal, 2000):

Changes in the degree (in terms of frequency, reach, intensity, and quality) to which

1. The workplaces in the community have implemented HIV/AIDS programs.
2. The community has initiated home-based care programs.
3. The local health services offer HIV/AIDS testing and counseling.
4. The local health services ensure and provide access to safe blood supply.
5. The local brothels and commercial sex houses have adopted a condom adoption and HIV testing policy.
6. The local prisons and military establishments have instituted HIV/AIDS programs.
7. The local schools have adopted an HIV/AIDS education curriculum.
8. The dropout rate for AIDS orphans at local schools has decreased.
9. Those who are living with HIV/AIDS are part of the “mainstream” in society (employed in regular jobs, working as counselors, etc.).
10. Those who are living with HIV/AIDS are protected by laws (that are designed to uphold their rights).
11. The quality of life of those living with AIDS, and those taking care of them, has been enhanced.
12. The community members openly discuss and debate HIV/AIDS issues in public meetings.
13. New community-based programs and initiatives have been launched to address HIV/AIDS prevention, care, and support.
14. New coalitions and alliances have emerged among community organizations to address HIV/AIDS issues.
15. The community members have collectively taken decisions or passed resolutions about combating HIV/AIDS.
16. Grassroots leadership has emerged from within the community to tackle HIV/AIDS issues.
17. Religious organizations and spiritual leaders are involved in HIV prevention, care, and support programs.
18. The community has engaged in acts of mobilization and activism for HIV/AIDS related issues.

19. The community has engaged with the local administration, service delivery organizations, non-governmental organizations, and others on HIV/AIDS issues.
20. The community's cultural activities (sports, folk media, festivals, celebrations, songs, etc.) engage with HIV/AIDS issues.
21. The most vulnerable groups for HIV/AIDS in a community have been empowered to take more control of their external environment.
22. The media coverage and media advocacy for HIV/AIDS has increased.
23. The overall rate of STDs, HIV infections have decreased.
24. The community has become AIDS-competent in terms of prevention, care, and support.
25. There exists multi-sectoral involvement at the national level for HIV/AIDS prevention, care, and support.

CONCLUDING REMARKS

In conclusion, the present workshop on “Communication for Behavior and Social Change: Program Experiences, Examples, and the Way Forward” helped to map out strategies for implementation of HIV/AIDS communication programs for behaviour and social change, using newly-emerging directions from UNAIDS, its co-sponsors, and other organizations.

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Phoolcharoen, W. (1998). Experience from Thailand. In A. Malcolm & G. Dowsett (Eds.) Partners in prevention: International case studies of effective health promotion practice in HIV/AIDS (36-48). Geneva: UNAIDS.

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Svenkerud, P., Singhal, A., & Papa, M. J. (1998). Diffusion of innovations theory and effective targeting of HIV/AIDS programs in Thailand. Asian Journal of Communication, 8(1): 1-30.

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APPENDIX A

Workshop Background Note

UNAIDS workshop for agencies and implementing institutions on Communication for Behaviour and Social Change: Programme experiences, examples and the way forward; Geneva, July 25 – 27, 2000.

Background information for participants

Background

In order to work towards a strengthening of in country communication programmes for behaviour and social change, within UNAIDS as well as with Cosponsors, UN agencies and other large international and regional NGOs, a 3 day workshop is being organised by UNAIDS, Dept. of Policy, Strategy and Research, and the Secretariat of the International Partnership Against AIDS in Africa (IPAA), to be held in Geneva from 25 to 27 July 2000.

In 1999, UNAIDS produced a key document on communication for dissemination and implementation in countries in the fight against the spread of HIV/AIDS and STD: *Communication Framework for HIV/AIDS: A New Direction*. This framework, under a project managed by Penn State University, was developed with the participation of international, national and regional organizations and specialists in Africa, Asia, Latin America and the Caribbean, Europe and North America. It has been published and widely disseminated for use in national programmes on HIV/AIDS. Although no inventory has been done, it is known that reorientation of communication programmes in countries has been effected based on the new directions.

Within the framework, communication programmes for HIV/AIDS should aim at not only behaviour change but also at bringing about changes in contextual factors that facilitate individual behaviour change. Whilst experiences may be limited in the execution of programmes that combine the five contextual factors (Government Policy, Socio-economic Status, Culture, Gender Relations, Spirituality), many countries, agencies and organizations have experiences in programming communication that include or focus on one or more of these factors.

The workshop will facilitate the sharing of experiences on implementation, with other agencies and institutions that face equally significant challenges for effective communication for behaviour and social change in other contexts. Many issues, constraints and priorities will probably be found to be common to all and the exchange of experiences, as well as identification of opportunities for future collaboration, will certainly strengthen programmes in behavioural and social contexts.

Documents

Relevant documents including the following are being prepared and will be made available at the workshop:

UNAIDS: *Communication Framework for HIV/AIDS: A New Direction*; and *Peer Education and HIV/AIDS: Concepts, uses and challenges*; and also *Communications*

Programming - an annotated bibliography, in addition to two papers on peer education, a radio manual for journalists, as well as a paper on the roles and uses of community radio.

Agencies and organizations are requested to recommend or forward to UNAIDS other relevant documents and materials which would be appropriate as background materials.

The language of the workshop will be English.

Objectives

A long-term objective is to strengthen the linkage between in-country priority programmes with the communication activities of agencies and institutions in Africa, Southeast Asia, and Latin America, such as UNICEF, UNESCO, World Bank, FAO ILO, UNDCP, USAID, Rockefeller Foundation, Ford Foundation, Family Health International, DFID, and such regional institutions as: ECA, OAU, ADB, SADCC, ECOWAS, ASEAN, IDB, PAHO, and regional NGOs.

The specific objectives of the workshop are:

- i) To map out strategies for implementation of communications for behaviour and social change, using newly emerging directions from UNAIDS, Cosponsors and other organizations;
- ii) To strengthen linkages between communication and priority issues on HIV/AIDS in developing countries, particularly in Africa, aiming at effectiveness and coherence in implementation and evaluation;
- iii) To increase technical soundness among major organizations of communication programmes, projects and strategies in countries.

Outputs

The principal outputs of the workshop include:

- i) A document on key communication programmes of UN agencies, international organizations, funding agencies in developing countries, areas and opportunities for collaboration and support to countries;
- ii) Steps, scenarios and case studies for implementing effective communication for behaviour and social change programmes in developing countries;
- iii) A report that outlines priority, current issues in HIV/AIDS programmes and the role of communication programming for behaviour and social change to support the programmes. This will be published as a UNAIDS Best Practice document.

In addition, and at country level:

- Documentation of case studies and implementation scenarios with examples from countries;

- Identification of current and planned communication programmes in countries and potential areas of collaboration for further discussion amongst funding and implementing agencies.

Participants

A total of 60 participants with responsibility for communication /IEC are expected from UNAIDS, Cosponsors, UN agencies, as well as similar staff of other organizations including large NGOs and foundations. Communications specialists from the constituencies of the IPAA will also participate in the workshop.

APPENDIX B

Workshop Participant List

Marian Amisshah
Deputy Head of Unit
Ministry of Health
Health Education Unit
P.O. Box GP 753
Accra
Ghana

Tel: (233 21) 66 70 81

Fax: (233 21) 23 8256

e-mail:

Collins Airhihenbuwa
Professor of Behavioral Health
Pennsylvania State University
Department of Biobehavioral Health
& Human Development
304 East University Park
PA 16802
USA

Tel: (1 814) 865 1382

Fax: (1 814) 863 7525

e-mail: aou@psu.edu

Sevim Ahmedov
National Program Officer
UNDP
Sofia
Bulgaria

Tel: (359 2) 974 3419

Fax: (359 2) 974 3089

e-mail: sevim.ahmedov@undp.org

Tin Aung
Research Coordinator
Population Services International (PSI)
36 Golden Hill Avenue
Bahan Tovonchip
Yangon
Myanmar

Tel: (951) 514 473

Fax: (951) 527 668

e-mail: psimyan2@mptmail.net.mm

Jacques Boyer
UNICEF
Rue Armand Holly/Débussey
BP 1363
Port-au-Price
Haiti

Tel: (509) 245 3525 / 1424 / 2890
Fax: (509) 245 1877
e-mail: jboyer@unicef.org

David Bridger
Information Support Advisor
UNAIDS Asia Pacific Intercountry Team (APICT)
United Nations Building
Rajdamnern Nok Avenue, Dusit
Bangkok 10200 THAILAND
Switzerland

Tel: +662 288 2179
Fax: +662 288 1092
e-mail: bridger.unescap@un.org

Fekerte Belete
Health Program Manager
PACT – Ethiopia
W17, K23
H. No. 2239
P.O. Box – 13180
Ethiopia

Tel: (251 16) 23 787
Fax: (251 16) 23 789
e-mail: fbelete@pacteth.org

Maurizio Bussi
Programme Officer
Labour Protection Department
ILO
1211 Geneva 27
Switzerland

Tel (41 22) 799 64 56
Fax:
e-mail: bussi@ilo

Kwame Boafo
Programme Specialist
Coordination and Evaluation Unit
Sector of Communication, Information & Informatics
UNESCO
7, place de Fontenoy
75352 Paris 07 SP
France

Tel: (33 1) 45 68 44 95
Fax: (33 1) 45 68 55 81/55 85
e-mail: K.Boafo@unesco.org

Sylvie Cohen
Senior Technical Officer – Technical Branch
Technical and Policy Division
UNFPA
220 East 42nd Street
17 th Fl.
New York, NY 10017
USA

Tel: (1 212) 297 52 38
Fax: (1 212) 297 5145
e-mail: cohen@unfpa.org

Robert Mnthenga Chizimba
Acting Director
Department of Information
Research & Planning Unit
P.O. Box 494
Blantyre
Malawi

Tel: (265) 642 600
Fax: (265) 642 364
e-mail:

Pauline Cassalom
National AIDS Control Programme
Burkina Faso

Tel: (226) 32 41 88
Fax: (226) 31 08 72
e-mail: spcnls@fasonet.bf

James Deane
Executive Director
Panos Institute
9 White Lion St.
London N1 9PD, UK

Tel: +44 (0)20 7278 1111
Direct line: +44 (0)20 7239 7602
email: jamesd@panoslondon.org.uk

Akin Fatoyinbo
Senior Regional Communication Specialist
The World Bank
01 B.P. 1850
Abidjan
Cote D'Ivoire

Tel: (225 22) 44 22 27
Fax: (225 22) 44 16 87/22 44 79 79
e-mail: afatoyinbo@worldbank.org

Sarah Gordon
Director
National AIDS Control Programme
Division of Health Sciences Education
Ministry of Health Annex
Liliendaal,
Greater Georgetown
Guyana

Tel: (59 2) 22 44 14/20 34 39
Fax: (59 2) 22 44 13
e-mail: dhse@sdpn.org.gy

Debbie Gachuhi
Academy for Educational Development
P. O. Box 21529
Nairobi, Kenya
Tel: (254 2) 57 48 06
Fax:
e-mail: dgachuhi@yahoo.com or
dgachuhi@africaonline.co.ke

Doris D' Cruz Grote
HIV/AIDS Programme Advisor
UNICEF/UNAIDS
UNICEF House
73 Lodi Estate
New Delhi, 110 003
India

Tel: (91 11) 469 0401
Fax: (91 11) 462 75 21
e-mail: dgrote@unicef.org

Roman Gailevich
UNTG Projects Coordinator
UNDP
UN Office
Kirou Str. 17
G.P.O. Box 103
220050 Minsk
Belarus

Tel: (375 17) 227 7822
Fax: (375 17) 226 0340
e-mail: roman.gailevich@undp.org

Kristine Greenaway
Director, Communication
World Council Of Churches
Room Lac-323
WCC
Geneva
Switzerland

Tel: (41 22) 791 61 68
Fax: (41 22) 798 13 46
e-mail: kg@wcc-coe.org

Treven Hendricks
National Council of YMCAs
P. O. Box 31045
Braamfontein 2017
South Africa

Tel: (27 11) 339 1385
Fax: (27 11) 339 7184
e-mail: treven@global.co.za

Rana Ibrahim
IEC Officer
National AIDS Control Programme
Beirut
C/o WHO Office
Glass Bldg – Musueum
P.O. Box 5391
Beirut
Lebanon

Tel: (96 1) 156 6100/1
Fax: (96 1) 156 6102
e-mail: wholeb_nap@inco.com.lb

Jack Jones
School Health Team Leader
Department of Health Promotion,
Noncommunicable Disease Prevention & Surveillance
WHO
20 Avenue Appia
1211 Geneva 27
Switzerland

Tel: (41 22) 791 2582
Fax: (41 22) 791 4186
e-mail: jonesj@who.int

Mary Wanjiku Kairu
IPPF/Africa Region
Madison Insurance House
1st Floor, Ngong/Upper Hill Road
P.O. Box 30234
Nairobi
Kenya

Tel: (254 2) 720 280
Fax: (254 2) 712 819/712 853
e-mail: mkairu@ippfaro.org

Theresa Lethu
Tobacco Free Initiative
Division of Noncommunicable Diseases & Mental Health
WHO
20 Avenue Appia
1211 Geneva 27
Switzerland

Tel: (33 6) 1037 3090
Fax:
e-mail: lethul@who.int

Silvia Luciani
Acting Senior Advisor – Communication
UNICEF HQ
PCSM/Programme Division

Tel: (1 212) 824 6608
Fax: (1 212) 824 6484
e-mail: sluciani@unicef.org

Laurie Liskin
Chief
Europe and New Independent States Division
Johns Hopkins University /
Center for Communication Programs
111 Market Place
Baltimore, MD 21202
USA

Tel: (1 410) 659 6300
Fax: (1 410) 6596266
e-mail: lliskin@jhuccp.org

Paul Kaggwa
Assistant Commissioner for Health Education
Ministry of Health
P.O. Box 7272
Kampala
Uganda

Tel: (256 41) 234 591/2 or (256 41) 77 50 77 99
Fax: (256 41) 259 146 / 256 41 258 173
e-mail:

G. Kiangi
Ministry of Health
Health Education Unit
P.O. Box 65219
Dar es Salaam
Tanzania

Tel: (255 22) 215 03 08
Fax: (255 22) 215 03 08
e-mail

Emelyn Q. Libunao
Staff Director
Philippine Information Agency (PIA)
Programme Development Division
Visayas Avenue
Quezon City
Philippines

Tel: (63 2) 921 7941 ext. 4259
Fax: (63 2) 920 4348
e-mail: pdd@pia.gov.ph

Jordi Lozano
Honorary President & Coordinator
Gay and Lesbian Coordination Group
& Democracy is Equality Campaign
Barcelona
Spain

Tel: (34 93) 298 0029
Fax: (34 93) 298 0618
e-mail: jpetit@pangea.org

Ana Lopez
Communication Adviser for the Latin American International
Center for Communication Professional Studies
Av. Diego de Almagro N. 32-133 Y Andrade Marin
Quito
Ecuador

Tel: (503 2) 506 151
Fax: (593 2) 502 487
e-mail: formprof@ciespal.org.ec

Kurian Manoj
Program Executive Health and Healing
World Council Of Churches
Room Lac-323
WCC
Geneva
Switzerland

Tel: (41 22) 791 6323
e-mail: mku@wcc-coe.org

Aida Mahomed
IEC Adviser
National AIDS Control Programme
Ministério da Saude
Av. Eduardo Mondlane
Salvador Allende
CP 264
Maputo
Mozambique

Tel/Fax: (258 1) 430 970
e-mail: aidamid-63@hotmail.com

Narcisse de Medeiros
Regional Adviser Programme - Communication
UNICEF - W&C Africa
Immeuble Alliance-EcoBank-Paribas
Rue Lecoœur, Quartier Plateau
04 BP 443 Abidjan 04
Côte d'Ivoire

Tel: (225 20) 20 81 02
Fax: (225 20) 22 76 07
e-mail: ndemeiros@unicef.org

Andre Oliver
Associate Director, Communications
The Rockefeller Foundation
420 5th Ave.
New York, N.Y. 10018
USA

Tel: (1 212) 852 84 88
Fax.: (1 212) 852 84 41
e-mail: aoliver@rockfound.org

Dan Odallo
Communication & Community
Mobilization Adviser
ICT Eastern & Southern Africa
UNAIDS
Metropark Bldg, 351 Schoeman Street
P.O. Box 6541
Pretoria 0001
South Africa

Tel: 27 12 338 5080 (direct)
Fax: 27 12 338 5310
dodallo@un.org.za

Festus Oyiade
Press Officer
National Action Committee on AIDS (NACA)
Federal Secretariat Complex
Abuja, Nigeria

Tel: (234 9) 523 4253
Fax:
e-mail: naca@inet.global.com

Pok Panhavichetr
Executive Director
Khmer HIV/AIDS NGO Alliance (KHANA)
13 St 302 Boeung Keng Kang I
P.O. Box 2311
Chamcarmorn
Phnom Penh 3
Cambodia

Tel: (855 23) 211 505
Fax: (855 23) 214 049
e-mail: khana@bigpond.com.kh

Arletty Pinel
Associate Director, Behavior Change Interventions
Family Health International
HIV/AIDS Prevention and Care Department
2101 Wilson Blvd., Suite 700
Arlington, VA 22201
USA

Tel: +1 703 516-9779 Ext. 133
Fax: +1 703 516-9781
e-mail: apinel@fhi.org

Julia Ross
Writer/Researcher
The Synergy Project
1101 Vermont Ave NW
Suite 900
Washington, DC 20005
USA

Tel: (1 202) 842 2939 ext. 101
Fax: (1 202) 842 3646
e-mail: julia@

Cho Kah Sin
Assistant Director
Association of Southeast Asian Nations (ASEAN)
Bureau of Economic and Functional Cooperation
70 A Jl. Sisingamangaraja
Jakarta 12110
Indonesia

Tel: (62 21) 726 2991//734 3372 ext. 341
Fax: (62 21) 739 8234/724 3504
e-mail: cho@aseansec.org

Mary Simat
P.O. Box 388
Narok
Kenya
Tel:
Fax:
e-mail: atmuriu@inconnect.co.ke

Arvind Singhal
Professor, College of Communication
School of Interpersonal Communication
206 Lasher Hall
Ohio University
Athens, OH 45701
USA

Tel: (1 740) 593 4903
Fax: (1 740) 593 4810
e-mail: singhal@oak.cats.ohiou.edu

Anton Schneider
Director
The Change Project
Academy for Educational Development
1825 Connecticut Ave, nw
Washington, DC 20009
USA

Tel: (1 202) 884 8730
Fax: (1 202) 884 8454
e-mail: aschneid@aed.org

Tall Cheick Tidiane
AFRICASO/WANASO
WANASO, ENDA Tiers Monde
BP 3123
Bamako
Mali

Tel: ((223) 225 564
Fax: (223) 23 25 93
e-mail: end-bko@spider.toolnet.org or
tidiane.tall@caramail.com

Anne Wilson
PATH
1990 M Street, NW
Suite 700
Washington, DC 20036
USA

Tel: (1 202) 822 0033
Fax: (1 202) 457 1466
e-mail: Emurphy@path-dc.org

Hany Ziady
Officer UNAIDS Project
AIDS Information Center
WHO/EMRO
Alexandria – 21511
Egypt

Tel: (203) 48 20 223
Fax: (203) 48 38 916/ 48 24 329
e-mail: ziadyH@who.sci.eg

UNAIDS Geneva:

UNAIDS
20 Avenue Appia
CH-1211 Geneva 27
Switzerland

Kathleen Cravero
Deputy Executive Director
Office of Deputy Executive Director

Tel. (41 22) 791 4716
Fax. (41 22) 791 4187
craverok@unaids.org

Werasit Sittitrai
Associate Director
Department of Policy, Strategy and Research

Tel: (41 22) 791 4457
Fax: (41 22) 791 4165
sittitrai@unaids.org

Robert Hecht
Associate Director
Department of Policy, Strategy and Research

Tel: (41 22) 791 4355
Fax: (41 22) 791 4741
hechtr@unaids.org

Joanna Adusei
Graduate – Intern from Columbia University
Department of Policy, Strategy and Research

Tel: (41 22) 791 4523
Fax: (41 22) 791 4165
aduseij@unaids.org or
joa2@columbia.edu

Soji Adeyi
Technical Resource Networks
Department of Policy, Strategy and Research

Tel: (41 22) 791 4231
Fax: (41 22) 791 4165
Adeyio@unaids.org

Tina Boonto
Best Practice Officer and Programme Review Committee Secretary
Department of Policy, Strategy and Research

Tel: (41 22) 791 4699
Fax: (41 22) 791 4741
Boontok@unaids.org

Jose Esparza
Vaccine Team Leader
UNAIDS/WHO

Tel: (41 22) 791 4392/3484
Fax: (41 22) 791 4865
Esparzaj@unaids.org

Nina Ferencic
Programme Development Officer
Department of Country Planning and Programme Development (CPP)

Tel: 41 22 791 4812
Fax: 41 22 791 4162
Ferencicn@unaids.org

Michael Fox
Technical Officer
Department of Policy, Strategy and Research

Tel: 791 4523
Fax: 791 4165
Foxmp@unaids.org

Meskerem Grunitzky-Bekele
Associate Director and Manager, International Partnership Against AIDS
Department of Country Planning and Programme Development (CPP)

Tel: (41 22) 791 4412/4612
Fax: (41 22) 791 4162
grunitzkybekelem@unaids.org

Andrew Doupe
World AIDS Campaign Focal Point
Communication and Public Information
Department of External Relations

Tel: (41 22) 791 4765
Fax: (41 22) 791 4188
e-mail: doupea@unaids.org

Peter Ghys
Senior Epidemiologist
Department of Policy, Strategy and Research

Tel: (41 22) 791 4251
Fax: (41 22) 791 4741
Ghysp@unaids.org

Lorna Guinness
Economist
Department of Policy, Strategy and Research

Tel: (41 22) 791 4917
Fax: (41 22) 791 4741
guinnessl@unaids.org

Aurorita Mendoza
Health Promotion and Gender Adviser
Department of Policy, Strategy and Research

Tel: (41 22) 791 4508
Fax: (41 22) 791 4746/4741
Mendozaa@unaids.org

Bunmi Makinwa
Communications Adviser/Focal Point, Condoms
Department of Policy, Strategy and Research

Tel: (41 22) 791 4552
Fax: (41 22) 791 4165
makinwab@unaids.org

Miriam Maluwa
Human Rights Adviser
Department of Policy, Strategy and Research

Tel: (41 22) 791 4675
Fax: (41 22) 791 4784
maluwam@unaids.org

Jean Mason
Technical Adviser
Department of Policy, Strategy and Research

Tel: (41 22) 791-4423
Fax: (41 22) 791-4165
masonj@unaids.org

Salvator Niyonzima
Focal Point GIPA
Department of Policy, Strategy and Research

Tel: (41 22) 791 4448
Fax: (41 22) 791 4741
niyonzimas@unaids.org

APPENDIX C

Workshop Agenda

Final Agenda
UNAIDS workshop for agencies and implementing institutions :

Communication for Behaviour and Social Change: Programme experiences, examples and the way forward

Geneva, July 25-27, 2000
Salle B, WHO Main Building

Day 1

Tuesday, 25 July

8:30 – 9:00	Registration	Chair: Silvia Luciani
9:00 – 9:15	Opening remarks	Werasit Sittitrai
9:15 – 9:45	Workshop objectives and expectations	Bunmi Makinwa
9:45 – 10:30	Review and approval of workshop agenda Introduction of participants	
10:30 – 11:00	Break	
11:00 – 11:40	Communication for HIV/AIDS: Examples from countries, regions: Strategies, implementation, monitoring, evaluation	
11:40 – 13:00	Discussion: Issues, challenges and strategies in communication for behaviour and social change	Lead discussants: Jacques Boyer, M. Bussy
13:00 – 14:00	Lunch	Chair: Akin Fatoyinbo
14:00 – 14:30	Epidemiological update: The current state and future trends of HIV/AIDS	Peter Ghys
14:30 – 14:45	Introduction to group work	Arvind Singhal
14:45 – 15:15	Divide into groups	Collins Airhihenbuwa
15:15 – 15:45	Break	
15:45 – 16:30	Group work:	
16:30 – 17:00	Group presentations	
16:50 – 17:00	Intoduction	Rob Hecht
17:00 – 17:30	UNAIDS Best Practice Collection and Technical Resource Network	Tina Boonto, Soji Adeyi
17:30 – 18:00	Socio-economic Impact of HIV/AIDS Discussion	Lorna Guinness Lead discussant: G. Kiangi

Day 2

Wednesday, 26 July

	Priority issues in HIV/AIDS:	Chair:
9:00 – 9:30	Greater Involvement of People living with AIDS	Arletty Pinel Salvator Niyonzima
9:30 – 10:00	Young People	Silvia Luciani
10:00 – 10:30	Human Rights	Miriam Maluwa, Jordi Lozano
10:30 – 10:50	Break	
10:50 – 11: 20	Prevention	Aurorita Mendoza
11:20 – 12:00	Care, Treatment and Access to Drugs, Mother to Child Transmission	Noerine Kaleeba Silvia Luciani
12:00 – 13:00	International Partnership on HIV/AIDS in Africa	Meskerem Grunitzky-Bekele
13:00 – 14:00	Lunch	Chair: Kwame Boafo
14:00 – 15:00	Development of Vaccines / Communication	José Esparza, Bunmi Makinwa
15:00 – 15:15	Introduction to group work	Arvind Singhal, Collins Airhihenbuwa
15:15 – 16.15	Divide into groups Group work: Implications of the HIV/AIDS priority areas for communication programming	
16:15 – 16:30	Break	
16:30 – 17:30	Group presentations, discussion	Lead discussants: Robert Chizimba, Emmelyn Libunao
17:30 – 18:00	“Communication Framework for HIV/AIDS: A New Direction: 5 contextual domains” Discussion	Dan Odallo Lead discussants: Debbie Gachui, Rana Ibrahim

Day 3

Thursday, 27 July

		Chair: Andre Oliver
8:30 – 9:00	Operationalising the Framework	Akin Fatoyinbo
9:00 – 11:00	Roundtable: Thematic issues and discussion Communication and: Government Policy, Socioeconomic status, Culture, Gender, Spirituality	M. Bussy, Andrew Doupe, Doris Grote, Silvie Cohen, Manoj Kurian Kwame Bofo
11:00 – 11:30	Break	
11:30 – 12:00	Indigenous people and HIV/AIDS: The case of the Masai of Kenya	Mary Simat Lead discussant: Sarah Gordon
12:00 – 13:00	Introduction to group work Divide into groups Group work: Implications for communications programming	Arvind Singhal, Collins Airhihenbuwa
13:00 – 14:00	Lunch	Chair: James Deane
14:00 – 14:45	Group work contd.	
14:45 – 15:30	Group work: Shared experiences and challenges, opportunities for collaboration, identification of potential case studies	
15:30 – 16:30	Group presentations, discussion	
16:30 – 17:00	Conclusions	Arvind Singhal, Collins Airhihenbuwa, Bunmi Makinwa
17:00 – 17:15	Closing remarks	Kathleen Cravero