



Uniformed Services Programming Guide

A guide to HIV/AIDS/STI programming options
for uniformed services



Joint United Nations Programme on HIV/AIDS
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Foreword

We know from experience that AIDS is more than a health issue: it is now a global security concern. Where it reaches epidemic proportions, AIDS can devastate whole regions, knock decades off national development and destroy what constitutes a nation: our communities, our economies, our political institutions, and even our military and police forces. In many countries the pandemic has affected uniformed personnel far more than civilian populations. Where this is the case, AIDS debilitates command structures and compromises the readiness and capacity of the military sector to respond to threat and instability.

The uniformed services, especially young men and women, are highly vulnerable to HIV/AIDS because of their work environment, mobility, age and other factors that expose them to higher risk of infection than their civilian counterparts. This was first recognized by the Security Council when it adopted Resolution 1308 in July 2000 expressing concern over the potentially damaging impact of HIV/AIDS on the health of international peacekeeping personnel. This concern was further emphasized through the adoption of the UN Declaration of Commitment on HIV/AIDS (June 2001), in which the international community and UN member states committed themselves to address HIV/AIDS among uniformed services personnel.

Young recruits are particularly important in view of their potential role as future leaders and decision-makers and as peacekeepers in their own countries and elsewhere. Young people in the uniformed services have to contend with loneliness and other challenges away from their families and familiar cultural norms. The behaviour of young recruits and the services and information they receive determine the quality of life of millions of people.

As a response to this, and as a concrete follow-up to the guiding instruments outlined above, the UNAIDS Secretariat, through its Office on AIDS, Security and Humanitarian Response, has been tasked to take a leading role in developing a coordinated and integrated approach to address and respond to HIV/AIDS among uniformed services, with emphasis on young recruits.

Many uniformed services have found that a systematic approach to addressing HIV/AIDS/STIs is more effective than an ad hoc approach with a few uncoordinated activities. This document has been developed by UNAIDS to support uniformed services that want to respond to the epidemic in a way that will make a difference to the lives of their own personnel, and their partners and families.

Ulf Kristoffersson

Director

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Targeting young recruits

Young people are at the centre of the HIV/AIDS epidemic. Half of all new HIV/AIDS infections are occurring among young people between the ages of 15 and 24: the most sexually active age group. Their behaviour, the extent to which their rights are protected, and the services and information they receive determine the quality of life of millions of people. This is the case among youth in general and young recruits in particular, who face new and challenging environments where they are often detached from their accustomed community and family environment, are increasingly mobile and are the most influenced by their professional ethos and training.

In the same way, young people offer the greatest hope and opportunity to change the course of the epidemic. Among uniformed services, youths and young recruits have strong influence among their peers, within and outside the service. They are also the future officers, leaders and decision-makers in their country.

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1. Introduction

1.1 What is the purpose of this guide?

Provides programme options

This guide is designed to provide an overview of HIV/AIDS/STI programming options for uniformed services programme planners (HIV: human immunodeficiency virus; AIDS: acquired immune deficiency syndrome; STI: sexually transmitted infection). The guide stresses the importance of planning strategically so that all efforts are well targeted and guided by research. Emphasis is placed on inspiring behaviour change and not simply increasing knowledge. Please note that this generic guide has been developed to address target audiences that may have different cultural requirements: readers should adjust the terminology and the programming approach to suit the specific needs of their uniformed services.

Focused on behaviour change

The guide presents a vision in which all efforts are focused on inspiring positive behaviour change. Experience tells us that such change is not usually achieved through information alone. Particular emphasis is given in this guide to developing interventions for the largest at-risk population: uniformed services personnel between the ages of 15 and 24.

Key issues to consider in the uniformed services environment that raise the risk of HIV infection

Most personnel are in the age group at greatest risk of HIV infection: the sexually active aged under 25 years.

The professional ethos of the uniformed services tends to excuse or even encourage risk-taking.

Uniformed services personnel and camps, including installations of peacekeeping forces, attract sex workers and those who deal in illicit drugs.

Uniformed service often includes lengthy periods spent away from home, with the result that personnel are often looking for ways of relieving loneliness, stress and the build-up of sexual tension.

1.2 What is HIV/AIDS/STI programming?

Component parts

HIV/AIDS/STI programming is a coordinated effort to deal with the impact of HIV/AIDS/STIs. Programming options include: bio-medical services including STI diagnosis and treatment; voluntary counselling and testing; condom services and promotion; training; peer education or peer leadership; behaviour change communication; advocacy

and policy development. Most programmes find a balance between advocacy and policy development, medical services and prevention activities, and adjust programme size to the resources available. Those countries with relatively low incidence may allocate more resources to prevention and establishing STI programmes while those with higher incidence may focus on care and treatment, and demobilization.

1.3 Why establish a programme?

Increased effectiveness

Many uniformed services have found that a systematic approach is more effective than an ad hoc approach with a few uncoordinated activities. A programme allows for a framework within which services and activities can be established. It ensures that the response is balanced, available funds are used to good effect and the elements are coordinated and work effectively together.

Prevention and services links

The link between prevention and accessible affordable services is particularly important. Peer educators may encourage condom use or the rapid treatment of STIs, but if no condoms or STI treatments are available, little progress will be made. Uniformed services, like other sectors, want to respond to HIV/AIDS/STIs with a planned approach that makes a difference to the lives of their personnel, and their partners and families.

Protect comrades

There is a long-established ethos in most uniformed services of loyalty to comrades and of officers looking out for the well-being of those under their command. This supports efficiency, which is paramount in the uniformed services. There is also an increasing awareness that meeting the challenge of HIV/AIDS is every bit as important as providing cover during battle, and that prevention is cheaper than providing services to those who become infected.

1.4 Are uniformed services particularly vulnerable?

Casual sex

Men make up the vast majority of personnel in most uniformed services around the world. Young men between the ages of 15 and 24, who are either not married or who are stationed far from their regular partners, are the largest and most vulnerable group. Like their civilian counterparts they are the most likely to become infected with HIV and to infect others. The fact that they are often away from home makes them more likely to use sex workers, become infected with STIs, contract HIV and, in turn, infect their wives and girlfriends or casual partners when demobilized or on leave.

Sex work

In countries with economies destabilized by conflict, the presence of large numbers of uniformed men is an important factor for the local sex industry. This may translate into trafficking of women for prostitution or women offering sex for survival. Largely because of unprotected sex with many different casual partners, uniformed services have, in general, much higher STI and HIV prevalence rates than the national average.

Civilian rates lower

According to UNAIDS, STI rates among armed forces are two to five times higher than among the civilian population, and even higher in times of conflict. Latest figures suggest that in certain parts of the world the difference may be even greater than this. A French study found its uniformed services who had tours of duty overseas were five times as likely to be infected by an STI, including HIV, than those who stayed within the country. In many non-industrialized countries, AIDS is the leading cause of death among uniformed services personnel.

Working with local communities

The interaction between members of the uniformed services and the local community can have both positive and negative effects. Relations between members of the forces and local women including sex workers have been identified as one of the conduits through which HIV/AIDS enters surrounding communities. However, both civilian and uniformed services personnel, if properly trained, could work as advocates in raising HIV/AIDS awareness among the local communities and sex worker networks that often appear near barracks and similar establishments. In all aspects of HIV/AIDS programming, including peer education, the local community, including sex workers, should be involved. This civilian-uniformed services approach will ensure the sustainability of any activity to address HIV/AIDS.

1.5 Why are HIV/AIDS interventions important for the uniformed services?

Impacts on readiness

If left unchecked, HIV/AIDS will impact on the readiness of personnel and compromise national and internal security. Mortality and morbidity can reduce total troop strength, deployment strength and the recruitment pool for enlisted personnel.

Increased costs

Turnover in personnel not only creates a loss of continuity of command but increases the costs of recruiting and training replacements. The increased health-care costs alone can be substantial, including additional health-care staff, medical insurance, life insurance premiums and disability payments. Absenteeism increases and productivity decreases as more people infected with HIV become ill.

Civilian infection vector

Uniformed services can also have an impact outside their own ranks. HIV/AIDS tends to be more prevalent in countries during times of instability. Personnel stationed overseas as peacekeepers or who are a part of a military force can become infected and bring the virus back with them to their own country where infection is less prevalent. In the early 1980s, Tanzanian armed forces invaded neighbouring Uganda. The forces crossed a border area that had the highest incidence in Africa at the time. After the action, the soldiers, many of

whom were infected, were demobilized uniformly around the country, greatly increasing the vulnerability of the people living in every town and province.

1.6 What can happen if effective HIV/AIDS/STI programming is not developed?

Inadequate programming

Many uniformed services around the world still have no HIV/AIDS/STI programming. Others have added some bio-medical facts to existing briefing and training of recruits. By and large, uniformed services, especially those in non-industrialized countries, have made programming less of a priority than the civilian sector. Some uniformed services in countries with high incidence are finding that HIV/AIDS/STI prevalence is impacting negatively on the ability to provide health services.

A military or civil defence force that is sick and dying will not be as effective or as disciplined as one that is healthy

Uniformed services, including defence and civil defence forces, are highly vulnerable to sexually transmitted infections, including HIV, mainly due to their work environment, mobility, age and other factors. High prevalence rates among uniformed services will weaken national defence. Combating HIV/AIDS in the uniformed services is not a moral issue but a question of achieving maximum effectiveness. HIV/AIDS impairs readiness, valuable experience and skills will be lost, a shortage of officers and troops may result, and less experienced personnel may have to take on more responsibility. Raising awareness of HIV/AIDS and encouraging behavioural change among members of the uniformed services will save lives and improve effectiveness.

Increasing problem

Uniformed services in countries with a low incidence of HIV/AIDS today should note that some countries with as many as a third of their uniformed services personnel infected today also had a low incidence as recently as 15 years ago. Countries less affected today should learn from the experience of the more severely affected countries and take immediate action to avoid a spiralling epidemic.

2. Components of a programme

2.1 Why are STI services needed?

STI early indicator of HIV vulnerability

The same factors that make uniformed services personnel vulnerable to HIV infection, such as separation from regular partners, thus increasing the likelihood of sex with sex workers, also increase the chances of contracting STIs. One study revealed that 10% of US navy personnel contracted an STI during missions in South America, West Africa and the Mediterranean.

STI cofactor for HIV infection

If a person has contracted an STI, that person is up to 50 times more likely to become infected as a result of unprotected sexual intercourse with an HIV-infected person. The establishment of reliable STI diagnosis and treatment services or a system of referrals to public services should be a high priority for uniformed services' HIV/AIDS programmes. Especially in countries with relatively low levels of HIV infection, high levels of STIs among uniformed services personnel are an indication of risk-taking behaviour and potential vulnerability to HIV infection.

STI diagnosis and treatment

Training existing uniformed services medical professionals to diagnose and treat common STIs can be a first step. Syndromic case management, where all important causes of the syndrome are treated, is effective in the prevention and treatment of STIs, and no expensive laboratory procedures are required. It can be achieved by using a combination of responses.

Essential components include:

- classification of the main causative agents by the clinical syndromes they produce
- treatment for all important causes of the syndrome
- promoting the treatment of sexual partners.

Syndromic case management cost-effective

For example, in syndromic case management a man complaining of urethral discharge would be treated for both gonorrhoea and chlamydial infection, while for a person with a genital ulcer, the treatment would most likely be for chancroid and syphilis. The syndromic approach offers accessibility and immediate treatment. A disadvantage is over-treatment in some patients. Studies have shown that syndromic case management of STIs is more cost-effective than diagnosis based on either clinical examination or laboratory tests.

Reduce self-treatment

Self-treatment of STIs is a common problem among uniformed services personnel who may be too embarrassed to seek reliable treatment, have no appropriate services available or are concerned that having an STI on their service medical record will be a disadvantage to them. Strategies can be developed to collaborate with pharmacies near uniformed services facilities to encourage referrals to public STI services. The establishment and promotion of anonymous services within the uniformed services facility also increases their use.

Ensure medicine is available

Increasing the skills of health staff to diagnose and treat STIs or establishing new STI clinics is of little use unless other support is widely available including condoms and medicine for treatment of common STIs.

Integrate prevention

To decrease the likelihood of repeated infection, condom promotion and prevention counselling should be part of the treatment. STI services that effectively and systematically conduct contact tracing also reduce the chances of repeated infections. For example, organizing STI prevention activities with sex workers located near uniformed services facilities can impact on the STI rates of uniformed services personnel.

2.2 What role do condoms play?

Responsibility to protect personnel

Condoms, both male and female, are the principal line of defence for most uniformed personnel. New recruits in particular are less likely to be married or have regular partners, less inclined to abstain from sex and more likely to engage in unprotected sexual relations with casual partners. Responsibility for protecting the safety and health of personnel is part of the uniformed services' tradition.

Make condoms part of kit

AIDS is a major cause of death among uniformed services personnel in many countries. Condoms should therefore be considered an essential part of the kit. In fact, some uniformed services have made carrying condoms mandatory and provide leather belt pouches to hold them. Personnel are expected to show their condoms during the routine daily inspections and are disciplined if they do not have them.

Awareness card

UNAIDS, in partnership with UN Department of Peacekeeping Operations (DPKO), has developed an HIV/AIDS awareness card strategy for peacekeeping operations. The awareness card contains basic facts about HIV/AIDS, a code of conduct for peacekeeping personnel, prevention instructions and a pocket to carry a condom. Based on the success of this awareness card, UNAIDS has produced a similar card for national uniformed services. This awareness card, with similar messages and a pocket to carry a condom, can form an integral part of an HIV/AIDS awareness campaign and should ideally be viewed as a part of the required uniform. For more information contact Awarenesscards@unhcr.org

Guarantee supplies

Uniformed services have a responsibility to ensure that personnel have access to regular supplies of reliable and affordable condoms. These condoms can be sold at subsidized prices on or near facilities at canteens, pharmacies or by individuals like peer educators.

Arrangements can be made with existing condom social marketing projects to establish sales points near uniformed services facilities or at locations where risk-taking behaviour is likely to occur such as bars, night clubs or brothels.

Problems with free condoms

As a rule, the distribution of free condoms by uniformed services can be problematic. Distribution may be erratic or unreliable. The “value” of the condom may decrease if it is seen as a free commodity. However, in cases where personnel are assigned to isolated locations or locations where the incidence of HIV/AIDS is particularly high, consideration might be given to supplying free condoms.

Condoms need promotion

Making male and female condoms available and affordable is one challenge. Strongly promoting condom use is equally important. It is necessary to identify common obstacles to their use and help personnel overcome them. Demonstrations of putting on condoms using wooden models, or good user instructions placed in men’s lavatories, for example, can result in increased skills for proper use. Social marketing of condoms to sex workers can also be promoted.

What is VCT?

Voluntary HIV counselling and testing (VCT), also referred to as voluntary HIV counselling and confidential testing (VCCT), is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential. HIV counselling has been defined as “a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour.”

The objectives of HIV counselling are the prevention of HIV transmission and the emotional support of those who wish to consider HIV testing, both to help them make a decision about whether or not to be tested, and to provide support and facilitated decision-making following testing.

2.3 What role does voluntary counselling and testing play?

Mandatory testing prevalent

Mandatory HIV testing before recruitment, for those going on peacekeeping missions or before new assignments is common among uniformed services around the world. A survey of 43 armed forces found that almost all tested personnel before foreign assignments and about half tested new recruits.

Mandatory testing violates human rights

UNAIDS believes mandatory testing without informed consent is a violation of human rights. It must also be remembered that most infection of uniformed services personnel occurs after recruitment and not before. In cases where uniformed services conduct mandatory testing but offer little psychosocial or medical support, there is little or no benefit in the testing. UNAIDS recommends voluntary counselling and testing, which is most effective when strongly promoted and fully financed.

Choosing to test

VCT revolves around choice and communication. People need to understand that they are at risk. Even then they may reject the idea of testing for fear of finding out they are infected. If they can be made aware of the benefits of early testing and the fact that many more people are found to be HIV-negative than HIV-positive when tested they will be more likely to volunteer. Personnel will also be more willing to be tested if uniformed services are not seen to have policies that discriminate against those who are HIV-positive. It is important to ensure that VCT services are available to meet the demand.

Counselling aspect essential

A trained counsellor can help the person being tested to understand the implications and deal with the related fear and anxiety. If the person tests HIV-positive the counsellor helps him or her cope and facilitates links to services. When a trained counsellor offers emotional support, progress can be made in helping the individual avoid further risk or infecting others. Those who have undergone VCT are also more likely to use services and take other steps that can extend their life expectancy. Trained counsellors do much more than offer information. They should be empathetic and understanding and have skills for listening and helping the client manage stress and anxiety.

Confidentiality

Making VCT confidential and anonymous increases the number of people who are interested in being tested. Some uniformed services allow those wishing to be tested to be identified by a number (anonymous testing) or to be referred to public sector VCT services located on or near service facilities. Another way of making testing more discreet is locating it in places where other services are being conducted, such as STI clinics.

Promoting VCT

VCT is most effective when the benefits are well promoted. Getting tested ends worry about being HIV-positive or not. A person who has engaged in risk-taking behaviour in the past who is found to be negative can start with a clean slate and avoid such behaviour in future. For those who are found to be HIV-positive, VCT has proved to be effective in extending the lives of those whose infection is detected early enough. VCT enables people to make links to services and encourages lifestyle changes. Knowing one's status allows planning for the future, including getting finances in order, preparation of a will and protecting the security of the family. Making testing easily accessible by opening many sites and maintaining convenient hours also increases use. Senior officers can show courage and leadership by volunteering to undergo VCT.

2.4 What about care and support?

Medical and psychosocial needs

Care and support services usually cover three important elements: psychosocial services such as the creation of people living with HIV/AIDS (PLWHA) support groups; bio-medical services such as the treatment of opportunistic infections like tuberculosis or pneumonia; and extension services such as support to home-based care. UNAIDS believes that uniformed services should ensure that care and support for personnel and family members living with HIV/AIDS is provided, including continuity of care as they return to civilian life.

Links to civilian services

If uniformed services are unable to provide services themselves, they should ensure that links are made with civilian services. This can involve negotiating to have civilian services established near uniformed services facilities or training uniformed services medical and psychosocial staff to make referrals.

PLWHA support groups

The formation of groups of individuals who are HIV-positive has proved to be one of the most cost-effective means of offering support to those dealing with the challenge of living positively with the virus. Besides offering psychosocial support and a setting for inspiring and maintaining positive changes in behaviour, the groups can be used to participate in prevention activities and provide inputs into policy development.

Antiretroviral plans

Access to antiretroviral drugs enhances length and quality of life for HIV-positive people. Some uniformed services in non-industrialized countries have developed programmes that allow personnel to obtain affordable antiretroviral drugs. Therapeutic solidarity funds are established which function like insurance schemes in which many people contribute but only a few end up needing the benefits. Personnel pay as little as 5-15% of the cost of the drugs.

2.5 What is behaviour change communication?

Planned approach

Behaviour change communication (BCC) is a gradual process consisting of several stages in which individuals gain self-confidence through trying out new behaviour. The process is inspired by communication strategies that are specifically designed to support the decision to change. BCC reinforces the process by helping individuals develop skills for HIV/AIDS prevention and creating a social climate to support the change. BCC can also contribute to changing social and societal environments that may encourage negative behaviour. For example, BCC can help counteract prevailing uniformed services' attitudes that place social pressure on men to drink too much alcohol and have casual sexual relations. It can also be used to reduce the stigmatization of people living with HIV/AIDS.

Evolved from health education

BCC has evolved from health education and health promotion as well as IEC (information, education and communication). BCC has many different, but related, roles to play in HIV/AIDS programming. Effective BCC should:

- *Promote advocacy.* Through advocacy, BCC can ensure that those in positions of power understand the need to actively support HIV/AIDS/STI programming. Advocacy takes place at all levels, from the national down to the local unit level.
- *Stimulate dialogue.* BCC should encourage discussion on the underlying factors that contribute to the spread of HIV/AIDS, such as risk-taking behaviour and the environments that encourage it. BCC should create a demand for information and services, and should encourage action to reduce risk, vulnerability and stigma.
- *Increase knowledge.* BCC should ensure that people have the basic facts in a language, visual medium or other media that they can understand and relate to.
- *Change behaviour.* Perhaps most importantly, BCC should motivate people to change their behaviour in positive ways.
- *Reduce stigma and discrimination.* Communication on HIV/AIDS should address stigma and discrimination and attempt to influence social responses to them.
- *Promote services for prevention, care and support.* BCC can promote services that address STIs, orphans and vulnerable children, voluntary counselling and testing for HIV, mother-to-child transmission of HIV, support groups for people living with HIV/AIDS, clinical care for opportunistic infections, and social and economic support.

2.6 What is the role of training?

Build management skills

Uniformed services staff may need to build skills for planning and implementing an HIV/AIDS/STI programme. Skills in advocacy, seeking and managing civilian technical assistance, monitoring and evaluating may be needed. These and other skills are important to develop truly effective programming that does more than fill information gaps but results in positive behaviour change.

Train health staff

The first step taken by most uniformed services after starting an HIV/AIDS/STI programme is to train the health professionals within the service. This should be done by adding an HIV/AIDS/STI component to existing medical staff in-service training, and ensuring that medical personnel are included in training organized by any national programmes. It may also be possible to negotiate with international donors, non-governmental organizations (NGOs) or existing projects to obtain technical assistance to conduct such training.

Add HIV/AIDS to basic training

All uniformed services conduct basic training for new recruits. Adding content on HIV/AIDS is cost-effective in increasing awareness about the issue. However, it is less effective in inspiring changes in risk-taking behaviour.

Special skills training

Trainers and supervisors of peer educators will require skills development when VCT or behaviour change communication strategies are implemented. Other essential elements such as supervision of trainers and support for activities conducted by peer educators must also be budgeted for.

2.7 What is peer education?

Peer educators encourage looking at risk

A peer is a person who is of equal standing or rank with another person. A peer educator is a member of a group of people sharing the same background, experience and values. The peer educator is trained to facilitate discussions on behaviour that carries a risk of contracting HIV and to lead his or her peers in the examination of solutions. The peer educators are the link between the programme and the target population, and usually share the same age, gender and status as their peers. They can facilitate discussions, answer questions, give lectures, conduct advocacy, provide counselling, lead dramas, distribute materials, make referrals to services, and sell or give out condoms.

Peer leadership versus education

In a uniformed services setting, the term “peer leader” may be considered more appropriate than “peer educator”. Leadership implies setting a positive example and inspiring others to follow that direction. The peer leaders are expected to help others from their peer group to go through the process of examining and, ultimately, changing behaviours that put them at risk of HIV infection. Peer leadership is a type of non-formal education that can be established with little cost. It has also proved to be effective for delivering culturally sensitive messages that come from, as well as work for the benefit of, a specific group.

Advantages of peer education

Peer educators can be available and accessible to the target personnel at all times, and use can be made of the down time when personnel are confined to base. Other advantages include:

- low cost
- sensitive matters may be more easily discussed in a peer setting
- brings about sustainable behaviour change
- more likely to maintain confidentiality
- most effective and informal way of sending the required message to a specific target population such as recruits
- less time consuming than more complex interventions.

Peer education kit available

In recognition of the importance of addressing HIV/AIDS among uniformed services and recognizing the advantages of peer education as outlined above, UNAIDS has produced a Peer education kit directly targeting the young men and women in the national uniformed services. This kit provides comprehensive guidelines on how to establish, coordinate and evaluate peer education processes and helps the educator and his/her peers understand issues such as personal risk factors and HIV/AIDS, condom use, alcohol abuse and HIV/AIDS, sexual violence and HIV/AIDS. The Peer education kit is available by contacting the UNAIDS Office on AIDS, Security and Humanitarian Response. For more information contact unaids@unaids.org

3. Dealing with gender issues

3.1 Why are gender issues important?

Women less powerful

In much of the world, women are at a disadvantage economically and socially. They are vulnerable to the neglect and abuse of men as a result. Gender inequity can limit women's income-earning capacity, which can drive them to sex work. Women and girls can also lack negotiating power resulting in unwanted sex or lack of condom use.

Women more vulnerable to infection

Women are especially vulnerable to HIV infection because of their physiological make-up and because of inequalities in status and power between men and women. Women are more likely to acquire any kind of STI, including HIV, from a single exposure than men. They also have more asymptomatic STIs that are difficult to diagnose.

Increased vulnerability in times of conflict

During times of conflict the situation of women worsens. Rape and sexual violence can be used as weapons of war, whereby the attacking forces target woman to either intimidate the enemy or as a form of ethnic cleansing. With the displacement of refugees and the degeneration of health services including HIV and STI prevention, women's likelihood of being infected increases. Disintegrating economies also increase the number of women offering sex for money. The arrival of large contingents of uniformed services have constituted an important factor for the sex industry, which may include the illegal trafficking of woman for sex work. Often intimidated by violence from their pimps these women who work as sex slaves have little power to negotiate condom use.

Spouses vulnerable

The wives and regular girlfriends of men in uniform can be particularly vulnerable to infection from their partners. A common pattern is that men who are away on assignment have unprotected sex with casual partners. While on home leave they can then unknowingly pass the virus to their regular partners. Many couples only find out about the arrival of HIV in the family when the woman transmits the infection to her baby at birth.

Women in uniform face challenges

Uniformed services have a responsibility to ensure that female personnel are protected from sexual abuse and STI/HIV infection. These women are usually working in a male-dominated environment and can be vulnerable to sexual harassment from colleagues and superior officers.

Teenage dependants vulnerable

Young girls living on military and police facilities are vulnerable to coercion by men in uniform to have sex. This may include sex for money or rape. Young girls are particularly vulnerable as some men believe (wrongly) that young girls are less likely to infect them with HIV. Parents need to protect their daughters by empowering them and ensuring they are aware of how to protect themselves if sexually active.

3.2 What can be done to reduce vulnerability?

Increase negotiating and communication skills of women

The empowerment of women and girls through increasing their self-esteem and negotiating power can impact on the behaviour of men. If women are more confident in their relationships with their sexual partners, the chances that they will be able to protect themselves and their families from infection with HIV are increased. Women can develop skills for talking with their partners and negotiating condom use. In some settings, wives of men in uniform have been encouraged to discuss condom use by their husbands in sexual relations outside the marriage.

Increase respect for women

Men in uniform need to increase their understanding of the vulnerability of women to sexual abuse and HIV infection. Lack of gender sensitivity extenuated by the perceived power that goes with wearing a uniform can increase the risk of abuse for women. A gender component, dealing with these issues, is an integral part of STI/HIV/AIDS programming for uniformed services.

4. Substance abuse

4.1 What is the link between alcohol abuse and HIV?

Alcohol increases sexual risk-taking

Abuse of alcohol can have a direct impact on HIV and STI transmission. Consumption can increase the desire to have sex with casual partners and reduce the will to use a condom. Sex workers are more likely to be found in places where alcohol is consumed. Excessive consumption of alcohol can also increase sexual violence towards wives, regular girlfriends, sex workers or women that uniformed services personnel may meet in the course of their work.

4.2 What can be done about alcohol abuse?

Alcohol treatment programmes

The establishment of alcohol abuse support groups within the uniformed services can support those seeking help. As is the case with all behaviour change, the first step in dealing with an alcohol problem is accepting there is behaviour that needs to be changed. Some uniformed services have encouraged the “buddy system” which involves getting

Non-injecting drug use and HIV/AIDS

A psychoactive substance is any substance that people take to change the way they feel. It can then affect the way they think or behave. Such substances include alcohol and tobacco as well as natural and manufactured drugs. In the past, most drugs were made from plants, such as the coca bush for cocaine, opium poppies for heroin and cannabis for hashish or marijuana. Now drugs such as ecstasy or LSD are produced by synthesizing various chemicals.

The major problem with psychoactive drugs is that when people take them they focus on the desired mental and emotional effects and ignore the potentially damaging physical and mental side-effects that can occur. No illicit drug can be considered “safe”. In one way or another, the use of psychoactive substances alters the normal functioning of the human body, and in the long run it can cause serious damage.

The risk of HIV transmission is not just associated with drugs that are injected. Drugs normally alter people’s judgement, and can lead to risky sexual behaviour such as sex without a condom. Injecting drugs greatly increases the risk of HIV transmission through the sharing of contaminated needles. However, drugs such as ecstasy, LSD, marijuana or cocaine which are taken orally or inhaled may also put people at risk.

Drugs can:

- make you forget what is important
- alter your mind and affect your judgement
- make it more difficult to say “No”
- make it harder to negotiate the use of a condom.

men on leave to stay in pairs and ensure that excess alcohol is not consumed or that at least risky sexual relations are avoided or condoms are used.

4.3 What is the problem with injecting drug use?

Injecting HIV into veins

Those who share equipment used to inject drugs are at high risk of HIV infection especially when they end up injecting directly into their veins the blood of another injector mixed in with the drug. Countries with high rates of injecting drug use, particularly among young people generally, can expect that young people recruited into the uniformed services may also use injectable drugs. This is especially the case if personnel are conscripted into the services.

Illegality drives problem underground

For uniformed services, responding to the challenge of injecting drug use is further complicated as drug use is usually illegal and those who are found to be users are likely to be court-martialled and forced out of the service.

4.4 What can be done about injecting drug users?

Identify extent of problem

Since injecting drug use is usually illegal and hidden, especially within uniformed services, gaining insights into the extent of the problem and the behaviour patterns of users can be a challenge. Engaging civilian groups used to working with injecting drug users (IDUs) can assist in uncovering the realities.

Harm reduction

Ending injecting drug use may be too ambitious a goal. Reducing HIV infection by promoting the cleaning of injecting equipment or the provision of sterile injecting equipment can be a more realistic step towards reducing HIV transmission.

Demand reduction

The provision of social, education and medical services and the promotion of a healthy lifestyle free from drugs have been proved to reduce demand for injectable drugs.

Join with civilian groups

Uniformed services can establish anonymous drug treatment programmes or they can assist civilian groups to establish treatment programmes near bases. Uniformed services can encourage users to voluntarily seek drug treatment in the civilian programmes. Civilian self-help organizations, often run by former users, can provide peer support among IDUs and people living with HIV/AIDS who were infected through drug use.

Harm reduction “hierarchy”

There are a series of steps drug users can be encouraged to take to reduce the chances of HIV infection. Ultimately, harm reduction programmes collaborate with drug demand reduction efforts to assist drug users to stop taking drugs.

- If the overall goal of getting a user to stop using drugs is not achieved for a specific individual, the drug user should be encouraged in an alternative way of using drugs to avoid using needles. The message is: “If you do not inject drugs, you cannot catch infections through sharing drug preparation or injection equipment”.
- If this goal is not achieved, the drug user should be encouraged to inject with new or sterile injecting equipment every time and not to share preparation equipment. “If you use new equipment every time, you cannot catch viral infections such as HIV.”
- If this goal is not achieved, the drug user should be encouraged to reuse his/her own injecting/preparation equipment every time. “If you reuse your own equipment every time, you cannot catch viral infections such as HIV (unless someone else has used your equipment without your knowledge).”
- If this goal is not achieved, the drug user should be encouraged to clean needles/ syringes and other equipment by an approved method. There is some risk of HIV transmission after equipment cleaning, but cleaning in an approved manner will reduce the likelihood of transmission.

5. Establishing an HIV/AIDS/STI programme

5.1 Who develops the programme?

Senior leadership needed

It is usually the medical staff who are assigned the task of developing a particular service's response to HIV/AIDS/STIs. However, it is not necessary that a medical corps professional be put in charge of the programme. In fact, those who already have good skills in conducting advocacy, management, and identifying and contracting diverse expertise can also make good programme managers, even if they have little or no medical background. In some cases, the responsibility is placed at the highest level of command. This is done to ensure that programming extends effectively beyond medical corps structures. It also is an indication of the priority the service assigns to developing a response.

Involve people living with HIV/AIDS from start

People living with HIV/AIDS have a special perspective on HIV/AIDS/STI programming at every level. They can provide insights on risk-taking behaviour and what motivates behaviour change. They can provide feedback on the effectiveness and responsiveness of services. They can also act as persuasive advocates with their peers and with those in command. The testimony of people living with HIV/AIDS adds a human and often emotional dimension that helps others develop deeper understanding of the issues and creates support for programming. Community groups, NGO groups, relatives of uniformed personnel who have died, as well as infected personnel themselves, may all be willing to help.

5.2 What support is needed?

Once a programme head is nominated it is necessary to have a professional and secretarial support staff, office space, communication services like telephone, fax and e-mail, and the financial resources to plan and conduct activities. Uniformed services that have not taken the challenge of HIV/AIDS seriously have assigned a single person to be in charge of their programme, severely limiting the potential impact. In other cases, the head of the programme has limited progress by taking on too much individual responsibility and not delegating tasks to others.

Criteria for selecting peer educators

Language

Participants should be fluent in the specific mission language (both spoken and written).

Gender

In selection of participants, gender balancing is important.

Profession

Those with a medical background have an added advantage but this is not mandatory in selection. The same consideration applies to religious leaders. Changing the opinions of

religious leaders through training can have a huge positive impact in areas where religion still influences the behaviour of its followers.

Rank structure

Since this training involves peer education and interactions, selection should focus on representation of all ranks/levels particularly in institutions with pronounced organigrams like the uniformed services. This facilitates the breaking of sexual barriers among peers. The more senior officers attend the better. Senior officers often influence policy decisions and changing their attitudes supports the sustainability of the peer education.

Aware of own behaviour and ability to change

Those making nominations are encouraged to select only those participants who are willing to change their own behaviour.

Volunteers

Those who offer themselves for the training not only end up doing well but usually become instrumental in promoting the programme.

Representation

The more varied (in countries of origin, institutions, culture, religion, professions, defence forces) the course composition, the more the interactions and lessons will be enriched through sharing different experiences.

In peacekeeping missions

A balance in the selection of the course participants should be drawn between the contingent representatives, military observers, military staff officers and civilian staff (both international and local defence forces of the host nations). Neighbouring communities should also be considered.

Numbers

The number of potential peer educators chosen to participate in a training of trainers largely depends on the size of the target contingent. However, the criteria set out above, i.e. representation, gender and profession, should be taken into account.

Motivating and rewarding peer educators

One of the major challenges for any peer education intervention is sustaining the interest of the peer educators. The tendency is for them to be motivated and interested immediately after their training but gradually lose interest over time. This is especially true if there are no incentives of any kind or little support such as supervision and refresher training.

Some suggestions for motivating and rewarding peer educators:

- Allow peer educators to conduct their sessions as part of their work day.
- Provide quality support materials that encourage participation to make their task easier, and train them in their use.
- Offer badges or certificates of merit for peer educators who complete a period of service such as a year.
- Have senior officers officially recognize the contribution of individual peer educators who are particularly dedicated.
- Let it be known that doing volunteer work as a peer educator is greatly appreciated by the uniformed service and will increase the chances of gaining promotion when the time comes. (Make sure those approving promotions agree that working as a peer educator is a factor in making promotions and know who the peer educators are.)
- Provide peer educators with caps, t-shirts, polo-shirts, armbands, badges or other clothing items which identify them as being peer educators and potentially increase their status and pride in doing the job.
- Provide incentives such as per diem allowances for training or subsidies for travel when appropriate.

5.3 Where are resources found?

Advocacy linked to funding

When uniformed services decision-makers are aware of the HIV/AIDS challenge and the price to be paid further down the line if it is ignored they are more inclined to support programmes. Advocacy has an important role in ensuring adequate resources are made available to support effective programming. Financial resources are built into medical services budgets or reallocated from other areas considered less of a priority.

Civilian funds available

Uniformed services have traditionally been reluctant to seek funds from civilian sources, but the gravity of the HIV/AIDS/STI epidemic is changing that. In countries where the national AIDS control programme has developed a sectoral response, the ministries of national defence and interior are usually included and resources provided by international donors are allocated to them. The UNAIDS country coordinator (CCO) can be instrumental in linking uniformed services HIV/AIDS/STI programmes with donors within the United Nations. The CCO is also in contact with the UNAIDS Office on AIDS, Security and Humanitarian Response. It has the responsibility of assisting

uniformed services and can provide some seed funding as well as help make links with other donors.

Piggyback onto existing projects

In most non-industrialized countries a wide variety of civilian HIV/AIDS/STI programmes and projects have been established. International organizations and bilateral donors support NGOs, academic institutions, government ministries and the private sector. It is possible to make links with those existing projects and take part in training, obtain BCC materials and negotiate the establishment of services near uniformed services facilities. Collaborating with an existing donor-funded condom social marketing project would be an example of this.

Military-to-military assistance

There is a long tradition of uniformed services in industrialized countries offering technical assistance to their counterparts in non-industrialized countries. Assistance with HIV/AIDS programming has been added to the arsenal of areas of support.

5.4 How are partnerships developed?

Join national committees

By becoming an active member of any national AIDS control programme technical committee, uniformed services representatives can get to know what programmes, projects and donors exist. Visiting uniformed services that have been successful in establishing effective HIV/AIDS/STI programmes at home or in other countries can provide insights on how to find partners, access outside funding and obtain technical assistance from donors.

5.5 Why seek support from decision-makers?

Top-level approval needed

The sensitization of decision-makers to the current and potential impact of HIV/AIDS is crucial to convincing them to support programming. The senior leadership in any organization has the power to allocate resources, establish priorities and make or break any initiative. Advocacy is the term used to describe the process of actively seeking the support of those in positions of power for HIV/AIDS/STI programming.

5.6 How is advocacy organized?

Strategy needed

The first step is to prepare background information on the epidemiological situation and the vulnerability of personnel to new infection through risk-taking behaviour. It is also possible to analyse the cost-effectiveness of developing an effective programme compared to the cost of retraining, lost work-hours, reduced productivity, and providing care and support services. Advocacy can be done quietly through individual meetings with key decision-makers. It can also be done by holding large meetings with the senior leadership to which civilian HIV/AIDS specialists are invited to outline the challenges. In either case, people living with HIV/AIDS can be a particular help in personalizing those challenges and leading a call to arms in the battle against the virus.

Tips for conducting advocacy

- *Compile health data.* It is important to be armed with information that shows the profile of HIV and AIDS in the uniformed services. Data such as levels of cases of STIs, treatment of opportunistic infections, tuberculosis, reported AIDS deaths or other information collected by the medical corps can be compiled into a short paper for commanders. Good resources include a report entitled *Combat AIDS: HIV and the world's armed forces* published by PANOS and Healthlink Worldwide (available at <http://www.healthlink.org.uk/>) and the International Crisis Group report *HIV/AIDS as a Security Issue* (available at <http://www.intl-crisis-group.org/>).
- *Prepare studies of risk-taking behaviour.* Research risk-taking behaviour, such as visits to sex workers, and patterns of health-seeking behaviour such as condom use and use of STI and VCT services. If studies of risk-taking behaviour are not available specifically for uniformed services personnel, conduct them or present selected data on men from existing studies such as national sexual behaviour studies.
- *Develop advocacy strategy.* Develop a specific step-by-step advocacy strategy to gain broad support among the leadership including a list of individuals to meet, support documents to produce, meetings to be held over the course of time.
- *Prepare advocacy information document.* Point out the urgency of responding, disadvantages of not responding, projections on the weakening of forces, cost of retraining, cost-effectiveness of prevention, stress on medical services, insurance, widow benefits, etc.
- *Seek support from top.* Show data and behaviour studies to senior command, including the defence minister, and ask for endorsement of the need to take urgent action to develop effective programming.
- *Involve head of medical corps.* Have the senior medical person approach senior command to stress the urgent need for effective action. Have the head of the medical corps send a letter to all the medical corps ranks inviting them to commit to supporting HIV/AIDS programming.
- *Introduce civilian partners to senior command.* Get senior civilian HIV/AIDS leadership to communicate directly with senior command on the importance of developing effective programming. Get a letter from the president's office endorsing the establishment of effective HIV/AIDS programming for reasons of national security.
- *Invite bilateral partners to meet with senior command.* Representatives of international or bilateral organizations interested in supporting HIV/AIDS programming can meet with senior command to discuss the challenge of HIV/AIDS in the uniformed services and options for effective responses.
- *Get senior command approval.* Get commitment for developing effective HIV/AIDS programming including, if possible, peer education during working hours and reform of discriminatory rules and regulations.
- *Communicate senior command support.* Have senior command send official orders to all commanders requiring them to support HIV/AIDS programming. Have commanders send out personal letters to regional commanders inviting them to

show leadership in protecting their personnel and the integrity and strength of the service by actively supporting HIV/AIDS programming. Make public announcements endorsing the HIV/AIDS programme.

- *Explain programming options.* Point out the different HIV/AIDS programming options and their costs, advantages and disadvantages. Also explain why it is to the advantage of the forces to allocate resources to HIV/AIDS.
- *Speak about HIV/AIDS at regular command meetings.* Make a call to arms to respond to the HIV/AIDS menace at regularly scheduled meetings of senior officers.
- *Identify commanders who are reluctant, indifferent or opposed.* Meet individually with commanders who have been identified as being reluctant, indifferent or opposed to HIV/AIDS programming. Have senior commanders contact them and urge them to offer their support.
- *Engage regional HIV/AIDS coordinators.* Provide regional coordinators with training in how to conduct advocacy. Provide them with advocacy support documents and materials. Urge them to hold regular meetings with regional commanders and their staff to explain HIV/AIDS programming and get endorsement. Encourage coordinators to set up meetings with regional commanders and regional civilian HIV/AIDS officials to discuss the specific challenge of HIV and AIDS in the region.
- *Involve people living with HIV/AIDS who are officers.* Personalize HIV/AIDS by having people living with HIV/AIDS who are officers meet with senior command personally or speak at meetings of commanders or other senior officers to tell their stories and make the case for effective HIV/AIDS programming.

5.7 Why engage the regional leaders?

Need broad support

Not all senior officers may be convinced of the value of permitting personnel under their command to participate in HIV/AIDS activities. For example, one uniformed service sensitized senior leadership in the national capital on the urgency of establishing effective HIV/AIDS programming. But the regional commanders were not convinced which severely limited the level of activities outside the capital. They did not allow staff to be released to undergo training or allow trucks to be used to transport condoms.

Case study: Successful use of advocacy in South-East Asia

Military vulnerability to HIV/AIDS felt at command level

Four years ago the national defence ministry and a US-based nongovernmental organization (NGO) teamed up to develop an HIV peer education programme in a South-East Asian country. The ministry was becoming increasingly alarmed by the levels of infection among its personnel. In fact, the data on prevalence proved to be a powerful advocacy tool. The top military leadership feared that HIV/AIDS had the potential for weakening its capacity to respond to security challenges. For many of the regional and

provincial commanders it was not only the high prevalence rate of more than 5% that created a sense of urgency for them. Many of the commanders knew fellow commanders who had died from AIDS.

In the initial phase of the programme, less attention was paid to gaining the support of the regional and provincial commanders. In the second phase, greater attention was paid to advocacy and hundreds of “sensitization” meetings were held with the commanders. This proved to be effective in getting the leadership on board. Their support was vitally important since the regional and provincial commanders possessed the power to make or break the programme.

Another factor that contributed to the success of the advocacy efforts was the strong commander-level concern for the welfare of men serving under them. This solidarity can be considered part and parcel of military ethos since all ranks depend on each other in the life-and-death reality of battle. Commanders often referred to their men as “family” and showed much sympathy for the men and their families who had been affected by the virus.

One general who conducted the advocacy said that he used the power of his rank to get the attention of commanders under his command. He said he and his team went straight to any commanders who they heard did not support the programme fully and explained what the programme was about and why it was important. The commanders were told HIV/AIDS was a real problem and that it was their role to protect soldiers.

Reluctance quickly overcome

Since peer education is a new concept for the military leadership in most countries it is understandable that there may be some reservations about the approach among some commanders. The representatives of the medical corps in the field played a key role in identifying commanders who had doubts about peer education and were not convinced that HIV/AIDS should be a priority. Since the medical corps also housed the HIV/AIDS unit, it was able to report any difficulties with uncooperative commanders. Those commanders with doubts received visits from the defence ministry’s HIV/AIDS unit as well as orders from superior officers compelling them to support the peer education programme.

As part of the process of engaging the regional and provincial commanders the ministry’s HIV/AIDS unit and the NGO team met with the commanders to map the personnel under their command and develop plans for the peer education. This process is credited with increasing their commitment, since the plans were developed collaboratively. Another motivator for the two dozen regional commanders was a study tour that took them to a neighbouring country where the impact of the epidemic was more pronounced and the response more diverse than in their own country. The commanders also observed participatory training at first hand, which helped them better understand the peer education concept. ⇨

One of the participants of the study tour admitted that he had doubts about the participatory approach but once he saw for himself the potential impact of the virus he started to trust and support all the programme activities, including financially.

Commander-level support obtained

One of the most evident successes of the programme was its generation of a high level of support and commitment from the senior leadership at the national level, as well as from the regional and provincial commanders. Almost all the senior officers were highly motivated and their level of awareness about the programme and commitment to it were impressive. There was evidence that the commanders had made time to attend coordination meetings as well as permit the trainers to spend as much as half their time on programme activities. Commanders had provided in-kind donations, had spent discretionary funds and had arranged for transportation, all in support of peer education.

6. Legal, ethical and human rights

6.1 What can happen to people living with HIV/AIDS?

People living with HIV/AIDS need protection

Unlike most other health conditions, being infected with HIV/AIDS often brings with it loss of employment, prejudice and scorn by co-workers, public stigmatization and even rejection by family and friends. As a result, attention needs to be paid to ensuring that the human rights of people living with HIV/AIDS are protected and that legal and ethical frameworks are put in place to protect them.

6.2 Why protect human rights?

Protect HIV-positive personnel

Uniformed services have a responsibility to protect their personnel. That includes ensuring that rules, regulations, policies and laws are in place so that people living with HIV/AIDS do not suffer needlessly from discrimination and are allowed to live with dignity and respect. As a rule, uniformed services are relatively slow to create new policies regarding HIV/AIDS and to revise harmful ones.

6.3 How can official discrimination be reduced and harmful policies be changed?

Policy assessment

The first step in improving the policy environment is to review the human rights situation and identify the key policy issues that impact negatively on people living with HIV/AIDS. The next step is to develop strategies to revise them. For example, in some Asian countries widows were not given widows' pensions when their husbands died of an AIDS-related illness because AIDS, being a relatively new cause of death, was not listed on the official list of causes of death that entitles a widow to a pension. As a result, medical staff often listed malaria as the cause of death, distorting the mortality statistics of both AIDS and malaria.

Give stakeholders a say

People living with HIV/AIDS are in the best position to know what policies are unfair to them and what changes would be welcome. Some uniformed services have included people living with HIV/AIDS on advisory committees, planning commissions and other planning structures. Others regularly meet with support groups formed by uniformed services personnel.

Seek outside advice

Uniformed services may not have experience with developing policies to protect human rights. In many countries there are NGOs or lawyers with expertise in this area that can be consulted.

Announce policy changes

Once policies have been put in place it is important to announce their existence. This can be done by sending messages through the command structure, posting notices and holding meetings with PLWHA groups advising people of their rights.

7. Establishing and changing policies

7.1 What kind of policies need to be changed?

Confidential VCT

Full confidentiality for HIV testing is important. People will come for testing more readily if they are confident the service is discreet and confidential. Lack of confidentiality can compromise the use of services like VCT and care, services which can extend lives and improve the quality of life of those who are infected.

Asymptomatic right to work

If personnel fear that they will suffer discrimination in terms of career advancement if found to be HIV-positive they will reject testing. One of the most common areas of discrimination in operational settings is restricting the assignments of those who have been found to be infected but are asymptomatic. There is no valid medical reason for such restrictions considering the risk of infecting others through non-sexual casual contact is next to zero. Some uniformed services where the percentage of infected personnel is very high cannot afford to impose restrictions since it would reduce strength and manpower. UNAIDS believes people living with HIV/AIDS within uniformed services should be given every opportunity to do the tasks for which they were trained and which they are still fit to perform.

Ensure benefits protected

It is important that uniformed services ensure continuity of care for people living with HIV/AIDS and their families. This should also include ensuring home-care services and support for widows and orphans in places where civilian social services are inadequate. The following services and benefits may come under stress and need good planning and management to ensure their continuity:

- in-service or civilian medical services
- pension and other retirement schemes
- disability and medical discharge benefits
- funeral and survival benefits
- sick leave
- compassionate leave.

Support families

Separation from wives and regular girlfriends increases the chances that personnel will engage in sexual relations with casual partners. A destabilized family unit and increased use of sex workers increases HIV infection rates. A prime policy challenge for uniformed services is to rethink the traditional operational practice of posting personnel far from their partners for long periods of time. Even when policies intend families to be united, housing is often insufficient or poorly managed. Some specific steps that can be taken to support stable romantic and family relationships:

- increase resources spent on housing especially outside national capitals
- clarify housing policies
- shorten tours of duty away from home

- shorten the length of time between visits home for personnel stationed at remote border posts.

Change oppressive laws

Sex work is illegal in many countries, though it tends to thrive anyway. Uniformed services have a role to play in ensuring that the enforcement of laws controlling prostitution is not, in fact, making the HIV situation worse rather than better. For example, if a uniformed service wishes to target its men who frequent brothels, a collaborative relationship with the brothel owners would be more constructive than one that drove the sex work underground.

Change the mentality within the uniformed services

Recruits are taught from the first day of training to be brave and take risks. Accepting risk is highly important in combat but is harmful when applied to sexual relations. The value of the “macho” mentality within the uniformed services is being increasingly questioned. The military ethos of solidarity between comrades often encourages excessive alcohol consumption and sex with sex workers. There is the potential to use the existing ethos to encourage the men to protect each other from alcohol abuse and unprotected sex with sex workers.

Change attitudes to civilian populations

Personnel on patrol find themselves increasingly confronted by complex situations that require more contact with civilians and judgements that require subtle and measured responses. To be able to calculate risks and judge responses there is an increasing need for individual initiative. This new ethos of taking personal responsibility can also be applied to HIV prevention.

7.2 Why does stigma have to be dealt with?

Defining stigma

Stigmatization involves the creation of a hostile and fearful environment concerning everything related to HIV and AIDS. It results in the condemnation of people living with HIV/AIDS. Fear and prejudice may cause people to react to HIV/AIDS by blaming those infected for their infection, and seeing them as shameful.

Stigma handicaps effective programming

Fear of suffering from stigmatization and discrimination discourages people from finding out if they are HIV-positive or not. Stigma and discrimination also result in people living with HIV/AIDS not getting encouragement and support at a time they need it most.

Stigma distorts reality

People living with HIV/AIDS, if rejected, feel alone and isolated. They can be driven from their jobs, homes and communities. They can end up living in poverty. Their lives may be shortened if they are not able to look after themselves or benefit from access to health services. The stigmatization of HIV/AIDS increases the likelihood that young recruits will continue to deny they have a problem since it is often seen as being limited to those who are perceived to be “immoral people” or to be “someone else’s problem”. Stigmatization can

also create exaggerated fears of infection from casual contact like sharing eating utensils or touching those who are infected.

7.3 How can stigma be reduced?

Gain insights into stigma

The first step in creating a non-stigmatizing, non-discriminatory environment is to understand better what prejudices are held and what impact they have. Health providers may alienate people living with HIV/AIDS if the latter feel they are being judged. Families may drive infected relatives out of their houses from a mistaken fear that they themselves could become infected through casual contact. Behaviour change communication can play a role in reducing unwarranted fears and promoting human rights and respect for people living with HIV/AIDS.

Policy changes on stigma

New codes of conduct are being developed requiring respect for the human rights of all people, whether they are vulnerable populations like refugees and sex workers or people living with HIV/AIDS suffering from prejudicial attitudes. Greater emphasis needs to be placed on protection of vulnerable civilians, providing security, communication and understanding. Such policies would also need enforcement and punishment for violators.

Men having sex with men within the uniformed services

Men having sex with men is not an issue many talk about in the context of the uniformed services. Indeed sexual relations between men are forbidden in many countries and grounds for dismissal from many uniformed services. Within uniformed services, men who identify themselves as heterosexual may experiment with male-to-male sexual activity (for example during periods of isolation from female companionship). As sex between men frequently involves anal intercourse, which carries a very high risk of HIV transmission, HIV prevention programmes addressing men who have sex with men (MSM) are vitally important. However, they are often seriously neglected because of the relative invisibility of MSM, stigmatization of male-to-male sex, or ignorance or lack of information.

8. Collaborating with the civilian sector

8.1 Why collaborate with the civilian sector?

Uniformed services stronger if not working alone

Close collaboration with the civilian health and other authorities can increase the effectiveness of programming. The traditional separation of the military medical services from civilian inputs is unproductive in meeting the challenge of HIV/AIDS/STIs. There are no simple solutions to the HIV/AIDS epidemic and uniformed services can benefit from sharing the state-of-the-art approaches and innovations developed in the civilian sector, and vice versa.

Demobilization requires collaboration

When large numbers of uniformed services personnel are demobilized, good collaboration with the civilian sector is called for to reduce any potential impact of increased HIV infection at the community level.

8.2 How can collaboration be organized?

Full participation by uniformed services as members of the civilian national HIV/AIDS programme is essential. Civilian health-system officials can also participate directly in training, prevention activities and the provision of care for uniformed services personnel. This can be done by inviting civilian HIV/AIDS specialists to participate in training, arranging for uniformed services medical staff and others to participate in national training, and the establishment of civilian HIV/AIDS/STI services near or on uniformed services facilities.

9. Problem identification

9.1 Why start by examining basic data?

Insights needed to be effective

It is important to know the current risk-taking behaviour patterns of the target groups and what things influence that behaviour in order to plan effectively. Some examples of types of insights that might be considered:

- patterns of sexual activity (commercial sex workers, casual partners, wives)
- frequency that risk-taking behaviour is practised
- acceptability of preventive behaviour (condom use, mutual fidelity and abstinence)
- identification of behaviour most likely to be changed
- focus on changing behaviours with widest impact
- identification of obstacles to change (e.g. misconceptions about condoms)
- define communication objective (e.g. increase use of military STI services).

9.2 What circumstances are unique to uniformed services?

Personnel at risk

In some countries uniformed services have the same levels of infection as occur in the rest of the country. In others the infection rate is higher, even as much as twice as high. In all countries there are a number of factors that render uniformed services vulnerable to infection. Factors include:

- the encouragement of risk-taking behaviour as part of the job
- personnel often located away from regular sexual partners
- their work often requires long periods of isolation and boredom
- they often consume large amounts of alcohol and engage in casual sexual relations
- sex workers may target men in uniform
- women may provide sex to avoid arrest or fines.

Young recruits are like other “youth”

By and large, young recruits, who are a major target group, will not be different from other young people in the country. The first step in problem identification is to benefit from information that is usually already collected in countries on youth sexual behaviour, with particular emphasis on young men.

10. Managing a programme

10.1 What resources are needed?

Ensure adequate resources available

In order to develop effective programming, human and financial resources must be committed from government ministries or from outside sources. This means getting health budgets increased to cover HIV/AIDS programming, taking on staff dedicated to the programme and getting in-kind commitments of office space, equipment and communications, as well as transport. (See also Section 5 Establishing an HIV/AIDS/STI programme.)

10.2 What is the role of monitoring and evaluation?

Keep track of what is being done

Monitoring involves the periodic observation of what has been accomplished by the programme. It measures what has been done against what was planned, and the process of accomplishing it.

Keep track of what has been accomplished

Evaluation takes account of whether the programme has achieved its goals and objectives. In other words, it measures to what degree behaviour has changed and what influenced that change.

Sample uniformed services HIV/AIDS programme plan for one year

Enabling environment

- *Advocacy at regional level*
Promote the importance of rapid response to HIV/AIDS crisis to senior and middle-ranking officers.
- *Strategic planning and management training*
Conduct training of national AIDS committee members to improve their organizational capacity.
- *Advocacy of community leaders*
Promote the importance of HIV prevention to community leaders in the civilian population including religious leaders, wives' associations, youth association leaders, school leaders, business leaders and others.

Prevention

- *Condom promotion*
Purchase condom pouches for all personnel (e.g. UNAIDS awareness cards), provide resources for all peer educators, and promote condom use through stickers, pamphlets and comic books. Collaborate with local social marketing project to ensure condoms widely sold near or on uniformed services facilities. ⇨

- *Behaviour change communication (peer education)*

Conduct training for peer educators to get them to focus on risk assessments and on overcoming obstacles to condom use. Provide with support materials including flip charts, pamphlets and videos.

- *Improve STI services*

Integrate STI services into regular clinic services in all health facilities, including training in diagnosis and treatment and improved testing facilities. Work towards setting up VCT services on-site, and refer personnel to civilian services in the meantime. Promote improved services through peer educators and media such as pamphlets, posters and billboards.

Care and support

- *Treatment of people living with HIV/AIDS*

Train services health personnel nationally in treating AIDS-related illnesses.

11. Behaviour change communication strategic planning

11.1 How is BCC different from other strategies?

Information alone does not work

Filling information gaps is necessary but it is not enough on its own. BCC is not just about imparting information: it focuses specifically on inspiring behaviour change.

11.2 How does it fit in with other programming?

Link to services

BCC planners work closely with uniformed services or public health planners to ensure that STI, condom, VCT and other services are available before they are promoted.

11.3 How does BCC work in a uniformed services context?

Homogeneous target population

There are advantages in having a largely homogeneous, relatively easy to reach, literate target population. Some uniformed services leaders may be concerned that their personnel are perceived by the public as being more at risk than others are. They will prefer that BCC efforts be discreet and internal. It is important, in any case, that they reflect uniformed services culture.

11.4 What is unique about BCC in the uniformed services?

Advantages of BCC for uniformed services

Identifying and getting the attention of target populations is one of the biggest challenges when conducting BCC in the civilian sector. Uniformed services are highly structured and their personnel highly disciplined which facilitates the implementation of BCC strategies.

Other advantages include:

- uniformed services are a closed community, which reduces the chances that the public will be offended by frank and open discussion of sexuality
- BCC is easier to conduct when the target population is homogeneous
- there is usually little opposition to open condom promotion and distribution
- target populations tend to be more literate than the general population
- BCC is relatively easy to organize since target populations can be found at barracks and in the workplace
- BCC materials can be easily distributed through existing distribution networks.

Challenges for BCC for uniformed services

BCC is a new approach for many uniformed services and not all those in positions of power are convinced that it is suitable. Participatory processes, basing strategies on socio-behavioural research and establishing communication lines between peers rather than from the top down are usually new and foreign to uniformed services. Approval for BCC materials is needed from senior officers who will not be familiar with BCC strategies or methods.

11.5 How do you inspire behaviour change?

Behaviour change not easy

Inspiring behaviour change is often a slow process. It is not just one input that inspires the person to change. It is usually a series of different influences that reach the individual. It could be a pamphlet handed out at a training session discussed later in the barracks, a heart-to-heart talk with a sexual partner after hearing a radio spot advertisement or an order by a superior officer to always carry condoms. There are a number of common reasons why people change their behaviour. Some examples follow:

- *Expected outcomes.* When those with risk-taking behaviour see the positive benefits of making change they are closer to adopting the new behaviour. For example, if personnel are very worried about being infected with HIV, they can be encouraged to undergo voluntary counselling and testing, and plan to avoid future risk-taking behaviour after the test.
- *Intention.* The person decides that making the change is worthwhile. For example, many think they are not personally at risk but through BCC they can assess and accept their own risk, which is a step in deciding to change their behaviour.
- *Self-image.* BCC can create an environment that makes it acceptable and even fashionable to practise prevention. If people feel good about practising the behaviour, it is more likely they will practise it.
- *Skills.* BCC can help the person develop skills that enable them to practise the positive behaviour. For example, if people are not using condoms because they do not know how or they are experiencing frequent breaks, they can be taught how to use them properly.
- *Self-efficacy.* Adopting new behaviour can increase confidence. For example, BCC can enable people to take control of their health by learning negotiation skills or correct condom use.
- *Emotions.* BCC can solicit emotional feelings among high-risk personnel, which can lead to self-examination. For example, people with risk-taking behaviour may not be motivated to protect themselves, but they may have strong feelings about leaving their children orphans.
- *Perceived social norms.* BCC can contribute to the creation of an environment which gives the people at risk the impression that there is a social movement or momentum towards adopting a particular behaviour. For example, the pressure of peers who have already adopted the behaviour can be very influential in the context of a peer education programme.
- *Services availability.* Awareness that services are available, accessible and affordable increases the chances that they will be used. BCC can promote services, and overcome obstacles to their use.
- *Knowledge.* BCC can fill in knowledge gaps and overcome misinformation and ignorance. For example, if researchers find that those with risk-taking behaviour are not aware of the link between STIs and HIV infection, BCC can point that fact out as well as promote rapid use of reliable services.
- *Behavioural compatibility.* BCC is most effective when it is consistent with existing lifestyles. Promoting abstinence among young unmarried soldiers who frequently visit bars, for example, will have less impact than promoting condom use.

11.6 What is the process of BCC?

Road to behaviour change is not straight and clear

The behaviour change process does not follow a sequential order or a fixed pattern. There can be detours, stops and starts and even the loss of ground gained. The behaviour change continuum outlined in the box describes the levels of change that people often go through from becoming aware they have a problem to making and sustaining positive change.

Behaviour change continuum

1. *Unaware*

- Need to recognize that there is a problem with current behaviour that puts them at risk.
- May know of the problem but may not be linking it to themselves.
- May not know that their own behaviour is risky.
- Basic information on HIV/AIDS/STIs can be provided.
- Risk assessments can be done for those at risk to better understand the effects of their behaviour.
- Myths, misconceptions and misinformation can be corrected.

2. *Aware/concerned*

- Once there is understanding that there is a problem the next step is recognizing a solution to it.
- Interest in examining risk-taking behaviour increases.
- People need to understand why they are vulnerable.
- Denial is overcome as people decide something must be done.

3. *Knowledgeable and skilled*

- Now seriously considering the problem.
- Seeking more information by talking with peers, friends and family.
- Skills for discussing sexual issues and negotiating safe sex can be built.
- Increased awareness of availability of related services.

4. *Motivated and ready to change*

- Starting to make a commitment to change.
- Serious about need to protect self and others from infection.
- Tired of anxiety and guilt about risk-taking behaviour.
- Want to avoid consequences of infection.
- Need access to services such as STI clinics, condoms or VCT.
- Believe that peer group and others are practising safe sex.
- Can be shown role models, positive messages and supportive environment. ⇨

5. Trial change of behaviour

- Provision of condom-use instructions useful.
- Ensure STI clinics are user friendly and offer warm welcome.
- Willing to try out the new behaviour.
- May not try again if it is found to be awkward (e.g. condom breaks).
- Need positive reinforcement and praise for behaviour change.

6. Maintenance/adoption of new behaviour

- Assessing and reinforcing the action taken.
- New habit established and positively supported.
- Continued communication to reinforce.
- Report success and benefit to others.
- Reassess personal risk.

11.7 How do we know that it works?

Difficult to measure

Since many different things influence behaviour change it is hard to know what exactly has brought about any particular change. The change may have been inspired by BCC or it could have been brought on by unrelated family circumstances. It is possible to see if BCC messages have been heard and understood. It is possible to see the impact in ways such as increases in condom use, growth in requests for services or drops in STI rates. But pinpointing exactly what brought about the change is not easy.

Many concurrent influences

BCC efforts are often the trigger mechanism to get people to think through their behaviour choices. They may read a pamphlet or have a talk with a peer educator on the topic of condoms. They may then hear a spot advertisement promoting a condom brand and be given a free sample at a bar. Finally, it might be a discussion with his regular sexual partner about mother-to-child transmission that finally convinces the person to try the condom in his next casual sexual relation. It is impossible to say that it was the pamphlet or the advertisement that resulted in the changed behaviour. In reality it was the combination of many influences, some programmed and some spontaneous.

12. Selection of target populations

12.1 What are target populations?

Groups with common features

A target population is a group of people who share the same demographic characteristics and behaviour patterns. The common demographic characteristics that define target populations might be gender, age, geographical location, ethnic group, language or occupation. Common behavioural patterns, also called “psychosocial” characteristics, might define your target population, e.g. they are clients of sex workers or repeat users of STI services. Young men between the ages of 15 and 24 who have been employed by a uniformed service for less than five years often make up the largest population as well as being the most at risk of HIV infection.

12.2 What are “primary” target populations?

Main groups needing attention

Targeted populations are divided into “primary” and “secondary” populations. The primary target population is the main group whose knowledge, attitudes or behaviour must change to help solve a given problem. Typical primary populations in HIV/AIDS programming include clients of sex workers, youth, migrant workers, injecting drug users and well-defined segments of the larger population.

12.3 What are “secondary” target populations?

Groups which influence first group

Secondary target populations are those groups that can help change the behaviour of the primary population. For example, a uniformed services HIV/AIDS programme may seek to increase condom use among non-commissioned officers (NCOs) (a primary target population) in their sexual relations with sex workers. But, to achieve this objective, it may be important to target bar owners as well as the sex workers.

12.4 Can target populations be segmented?

Best to focus on largest, most at risk

Segmenting a target population means dividing the group into parts. Focusing on those with the highest risk of becoming infected and infecting others makes BCC more effective. For example, there is a tendency to focus on all ranks and both sexes equally while it is the young, male, non-commissioned officers or lower ranks who make up the largest percentage of all uniformed services. If men and women, all services, and both officers and other ranks are all targeted with BCC at the same time, this will reduce effectiveness. If 70% of a country’s service personnel are young men in the army who tend to have frequent unprotected sexual relations with casual partners, then they should be the primary target population.

12.5 Why focus resources on specific groups?

Unfocused BCC effort is a blunt instrument

If the same messages are sent to several different target populations, none will think the messages address them specifically. Untargeted BCC is like a shotgun: most of it hits

nothing and it only inflicts superficial damage when shot off at long range. A well-targeted intervention has a sniper's precision in reaching its mark. Targeting specific groups is also much more cost-effective.

These steps might be followed in deciding what the primary target populations should be:

- Which groups are the most at risk of being infected and infecting others?
- Which groups are the most likely to change their risk-taking behaviour?
- Which groups have the most common characteristics such as the same patterns of behaviour, age, language and culture?

Example: Targeting the largest common denominator

A draft of a pamphlet is being prepared for the armed forces in a West African country. If the purpose is to have the largest number of personnel in the armed forces identify with the pamphlet the best choice of cover picture would be an enlisted army man between the ages of 18 and 25, who represents 80% of armed forces personnel. A naval officer in a white uniform, who represents less than 1% of all armed forces personnel, would not be a good choice.

Example: Different sexes have different needs

Male and female armed forces personnel in an Asian country were targeted in the same materials, though the messages were very different for each. The men were more likely not to be married than the women and were much more at risk because of their relationships with sex workers. But condom promotion was only a minor feature in the materials, which also covered abstinence, fidelity and family planning services for women.

Example: Prioritizing target populations

The armed forces HIV/AIDS programme in one African country decided to prioritize its target populations and over a five-year period develop BCC strategies to reach all of them. The list:

- lower-ranked male army personnel about to be assigned to a mission within the country
- decommissioned army personnel
- male armed forces personnel before leaving and after returning from international peacekeeping assignments
- enlisted men of other services (navy and air force)
- regular girlfriends and wives of armed forces personnel
- sex workers and casual girlfriends located near armed forces camps and bases
- youths living in armed forces facilities.

13. Conducting a formative assessment

13.1 What insights into target populations are needed?

Behaviour, motivation, media habits

The first step, once target populations have been selected and prioritized, is to gain insights into the behaviour, motivation, media habits and preferences of each. The research does not have to be done all at once in one large study. In fact, a series of small studies, such as focus groups discussions, is often more successful. Some suggestions for developing studies are:

- involve the target population in the planning process
- define current behaviour and ideal behaviour after the behaviour change
- identify factors influencing behaviour
- look for those who have already adopted new behaviour to understand what motivated them to change
- pretest messages and materials.

13.2 What is formative assessment?

Find existing studies, conduct new ones

Formative assessment involves reviewing existing data and conducting new studies aimed at establishing the levels of knowledge, attitudes and behaviour of given target populations. These studies might include key informant interviews, in-depth interviews and focus group discussions. To develop an effective BCC strategy, it is important to see individuals within their broader social context. This also means looking beyond an individual assessment to the environment in which the individuals live. In the uniformed services context this could include gaining insights into communities located around uniformed services facilities. It may also include understanding the behaviour at bars and night clubs used by uniformed services personnel. It is important to gain insights into the social setting for risk-taking behaviour and the structural, societal and environmental risk factors that are present.

13.3 What insights are needed?

Risk-taking behaviour patterns

BCC planners need to understand patterns of risk-taking behaviour. This involves gaining insights into who engages in what risk-taking behaviour with what partners. Insights are also needed into whether they are aware of their risk or why they chose to deny it. Insights into media habits and preferences for styles and images to inspire the development of materials are also needed. An effective BCC strategy requires an understanding of:

- perceptions of risk and risk-taking behaviour
- settings for risk-taking behaviour
- key views of opinion leaders on issues related to sex, sexuality and (in some cases) drug abuse
- services and facilities used by the target population and their opinions about them
- target population's hopes, fears and goals for the future (this will help capture their attention)
- media habits
- entertainment habits
- health-care-seeking behaviour.

13.4 What studies can be done?

Secondary research

The first step in conducting research is to gather secondary data or existing studies. Too often research is done without taking into consideration that similar research already exists. For example, many countries have done extensive behavioural studies of youth as well as sex workers. Those kinds of study results would be applicable if the primary target population is young men aged 15–24 who have sexual relations with sex workers.

Focus group discussions

This is one of the most cost-effective forms of research. It involves selecting representatives of the target population and stimulating an open-ended focused discussion by asking questions. This is a form of qualitative research because no attempt is made to quantify the results in terms of percentages or other numbers.

KABP studies (knowledge, attitude, behaviour and practice studies)

A form of qualitative research, this method involves asking a series of questions to individuals usually using the multiple-choice format. This is a relatively cumbersome form of research in that samples are usually quite big, interviewers need to be trained and the results have to be analysed using sophisticated computers and painstaking tabulation.

In-depth interviews

This is similar to focus group discussions in that it is a form of qualitative research and involves getting representatives of a target population, one at a time, to talk about their risk-taking behaviour, perception of their own risk and perspective on prevention.

Observation

Going to environments conducive to high-risk-taking behaviour and watching behaviour and the interactions between people is a simple, yet very revealing form of research.

13.5 Which is better: qualitative or quantitative research?

Research methods complementary

This is an on-going debate that has no right or wrong answer. Certainly, quantitative research has more credibility because it usually has larger sample sizes and looks very impressive with everything neatly arranged in columns of digestible numbers. On the other hand, qualitative research, like focus group discussions, often provides intimate insights that cold statistics cannot. It is also cheaper, easier and quicker to plan and finish. Ideally, research budgets should be large enough to accommodate both. The most useful insights are those based on both qualitative and quantitative research.

Example: Need representative sample

It is important when selecting representatives of target populations that they are truly representative. There were major problems with the selection of participants in focus group discussions carried out in two different countries. In one country, the armed forces HIV programme planners had a lot of difficulty finding senior officers willing to release their men to participate in the research. As a result they were obliged to use the medical corps which,

relative to the rest of the personnel, had a very high level of knowledge about HIV/AIDS and STIs. The results were of little use since they were untypical of the rest of the service. In another country, the results of focus group discussions with senior and junior officers were given equal importance with those of the enlisted men, though the latter group is much larger and more at risk. The officers cited “high blood pressure” and “gout” as their more pressing health problems, reflecting the fact they tended to be middle aged.

13.6 Who conducts the studies?

Develop capacity or outsource

Most services recognize that their capacity for conducting socio-behavioural research is limited and seek to contract out the work. One advantage of this approach is that uniformed services personnel may feel more comfortable discussing intimate matters like their sexual behaviour with neutral third parties who are used to conducting this kind of research. University social science departments, consulting firms with experience working for international aid agencies and commercial advertisers who do consumer research are among the groups who can be approached.

13.7 How can researchers be engaged?

Identifying researchers

It is possible for uniformed services to develop skills for conducting socio-behavioural research and pretesting prototype materials with representatives of target populations. In some cases, they may already employ personnel with these skills. In most cases, the services will look to the civilian sector for assistance in conducting research. Some suggestions for identifying researchers:

- Look for researchers who have experience preparing socio-behavioural research for other organizations.
- Ask to look at the studies done previously.
- Contact the other organizations and find out if they were satisfied.
- Ask for a plan to conduct the research from several different research groups.
- Offer background information on the particular needs and culture of uniformed services.
- Establish with the researcher that the uniformed services are in charge and no external use can be made of the results.
- Involve the target population in planning, including reviewing questionnaires and focus group discussion guides.

13.8 How much should be spent?

Some is better than none

As a rule of thumb it is appropriate to spend 10% of the total BCC budget on research. Developing and implementing BCC without research is like driving a car blindfolded, and even a small amount of research is better than none. Those who are put off by the complexity and cost of a large quantitative study can gain some useful insights with a few focus group discussions.

14. Behaviour change communication within HIV/AIDS programming

14.1 How does BCC fit into overall programme planning?

A support and a critical element

The BCC part of the overall uniformed services HIV/AIDS programme is both a support and a critical element of the programme. Behaviour change communication works best when it is a carefully planned process that is built into uniformed services HIV/AIDS programmes from the start. Interpersonal communication strategies such as peer education, events organized in communities around uniformed services facilities and barracks, and internal media within uniformed services structures can all be included in the BCC component.

14.2 What are the different levels of goals and objectives?

Attempting to achieve change

The planning process is often seen as being more complicated than it is or has to be. Essentially it involves calculating what the programme wishes to accomplish and how that fits into a national HIV/AIDS programme, and then defining desired changes in behaviour and specific plans for achieving those changes. “Goals” and “objectives” are the terms most often used to describe what HIV/AIDS programmes plan to achieve. Different levels of planning may include:

- *Level one.* Review the general “goals” or “objectives” which have been established by the national HIV/AIDS programme. These are usually very broad and offer general direction on what is expected to be accomplished within the whole country. An example of a national HIV/AIDS programme goal might be to reduce HIV infection rates among youths.
- *Level two.* Establish uniformed services HIV/AIDS programme goals. These are general statements that describe what the programme wishes to accomplish. They should correspond with the national HIV/AIDS programme goals and objectives. They take into consideration the goals of establishing services and of changing behaviour. An example of a uniformed services HIV/AIDS programme goal might be to reduce HIV infection rates among uniformed services personnel aged 15–24.
- *Level three.* Establish behaviour change objectives. These are more specific than the programme goals. They suggest how the uniformed services programme goals will be achieved. These objectives are usually measurable so that progress can be seen. An example of a behaviour change objective might be to increase condom use among uniformed services personnel aged 15–24 from 20% to 70%.
- *Level four.* Develop specific behaviour change communication strategies for selected target populations that are designed to meet the behaviour change objectives. An example of a behaviour change communication strategy might be to increase confidence in the reliability of condoms and skills for using condoms.

14.3 What other examples of uniformed services HIV/AIDS programme objectives are there?

BCC meets programme objectives

The uniformed services HIV/AIDS programme objectives cover all aspects of intervention including behaviour change. Experience shows that BCC works best when it is coordinated with the development of services. It is important to establish objectives that set out a complete and coherent plan for attacking the problem. Some other examples of objectives:

- increased safer sexual practices (more frequent condom use, fewer partners)
- increased incidence of health-care-seeking behaviour for STIs and tuberculosis (visits or calls to facilities, for example)
- increased access to and use of VCT
- increased use of universal precautions to improve blood safety
- increased blood donations
- improved compliance with drug treatment regimens by providers and clients
- increased use of new or disinfected syringes and needles by injecting drug users
- decline in attitudes associated with stigma around HIV/AIDS
- reduced incidence of discriminatory activity directed at people living with HIV/AIDS.

15. Developing messages and materials

15.1 What is a message?

Carefully crafted piece of information

Messages are the contents you want your target population to receive and respond to. Messages work best if they are in the language and reflect the culture of the target population. The message must also clearly address members of the target population specifically. It is designed to catch their attention, stimulate discussion and action, and meet behaviour change objectives. If it addresses a product, such as condoms, it must provide information on where to get that product and how to use it. If it promotes skills development or specific services, those services and training programmes must exist. Messages should be simple and, where possible, able to be acted upon.

15.2 How do you develop messages?

Based on target population insights

The better the target population is understood, the greater the chance the messages will be understood and appreciated. That understanding is then used to clearly define the risk-taking behaviour and the behaviour to be changed, as well as what it might take to inspire change. The creative process is then started to develop several different messages which are shown to representatives of the target population to find out which ones work best. The messages are developed collaboratively between HIV/AIDS programme planners and those who specialize in developing messages and materials.

15.3 What different approaches are used?

A variety of styles are frequently used when developing BCC messages. Here is a list of approaches and their advantages and disadvantages.

Creating an atmosphere of fear

This approach is designed to overcome complacency or denial that HIV is a real problem. It was extensively used at the beginning of the pandemic, but was found not to be subtle enough to inspire behaviour change. In fact, it often had the opposite effect to the one intended. Creating an atmosphere of fear can end up alienating those who are most at risk and scaring others, as well as creating prejudice against people living with HIV/AIDS.

Blaming victims in specific target populations

When too much importance is given in the mass media to sex workers and their clients, injecting drug users and other high-risk groups, other groups can develop prejudice against them and get a false sense of their own lack of vulnerability to risk.

Moralistic tone

Some BCC planners prefer to promote abstinence and fidelity rather than deal with issues they feel less comfortable with like condom use and commercial sex work. Messages with a moralistic tone are especially ineffective with younger people. Abstinence is a behaviour that is very difficult for those who are sexually active to accept.

Rational appeal

Messages that stress personal responsibility and present convincing reasons and benefits for adopting positive behaviour have enjoyed more success than telling people to change.

15.4 How are messages developed?

Offer reasons to change

Messages should try to convince target populations to change. Simply telling them they should change has not proved to be very effective. For example, HIV testing can be promoted as a means of reducing worry about a future with or without HIV. Pointing out that STIs are a cofactor for HIV infection or a major cause of infertility can encourage rapid treatment of STIs.

Include emotional tone

HIV/AIDS issues can stimulate an emotional reaction, but BCC materials are often technical and emotionless. Addressing fear, worry, concern, anger, love and patriotism can make messages more effective. A father might not be concerned about being infected himself but he might be reached by the idea of leaving his family with no support or having babies born with HIV. There is no more compelling emotion than the real-life situation of a uniformed services family that has been affected by the virus.

Use credible message carriers and information

Different target populations find different types of people featured delivering messages to be credible. Some might find a doctor to be credible. For others it might be a sergeant or the father of a young family. Young people, in particular, tend to prefer their peers to be the message carriers. The information included must also be believable and truthful.

Have messages in language and culture of the target population

To increase the chances that the target population identify with the message, it is essential that the language used in the materials is easily understood and the target population identifies with the images and situations presented.

Pretest thoroughly with target population

Pretesting means trying out drafts of messages and materials before they are finalized to ensure they are well understood, appropriate and having their intended effect. Pretesting is usually done at several different stages in the process and revisions made each time.

Examples of messages to overcome obstacles to condom use

Research in one country identified several obstacles to condom use among uniformed services personnel. In response, a number of messages were developed to be pretested with male personnel.

Problem:

Reduction of sensation

Key messages:

- *Don't risk a lifetime of future problems for a moment's pleasure of sex without a condom.*
- *Helmets and combat boots can be uncomfortable but a soldier would never consider going into combat without the protection they provide.*

Problem:

Delay of orgasm

Key messages:

- *Most people find that condoms do not delay orgasm once they are used to using them.*
- *Even if orgasm is delayed it is not necessarily a bad thing since it can mean a pleasurable sex act lasts longer.*

Problem:

Misinformation, such as HIV able to penetrate condoms

Key messages:

- *If used properly condoms provide almost perfect protection against STIs, HIV and unwanted pregnancies.*
- *The protection condoms provide is as high as 98% when properly used. The small percentage of condoms that break is usually caused by users who manipulate them incorrectly rather than due to manufacturing defects.*
- *The condom has been proven scientifically to be 100% impervious to STIs, HIV and sperm.*

16. Producing materials and selecting channels

16.1 What are materials and channels?

Different media formats available

Materials and channels are the formats in which the messages are presented and delivered to the target population. Usually BCC strategies try to select the best combination of materials and channels to reach a particular target population. A list of options includes the following.

Print materials

A combination of words and images that are either distributed or used to support interpersonal communication with individuals or groups:

- flip charts
- picture books
- flash cards
- booklets
- pamphlets
- comic books
- calendars
- newsletters.

Mass media

Electronic broadcasts and printed publications with broad reach to the general public:

- radio
- television
- newspapers and magazines.

Public displays

Words and images placed to be seen by the public outside, in health service points, commercial sales establishments, public toilets, offices and meeting locations. Internal displays could also be set up. Consider:

- billboards or hoardings
- posters
- stickers
- wall paintings
- displays
- exhibits.

Audio-visual materials

Electronic productions that can be circulated in their own right, used for group viewing or to support training and interpersonal communication:

- audio and video cassettes
- slide shows
- filmstrips.

Community channels

Existing creative arts that incorporate messages into their work. The performances are used to reach groups of people particularly in rural areas, but could be adapted for a uniformed services setting. Consider:

- traditional theatre
- events
- music
- poetry.

Interpersonal communication

The interaction between a trained specialist and individuals and groups which stimulates a discussion or the exchange of information. It works best when it encourages participation and support media are used. Some examples:

- *Peer education or peer leadership.* Use of trained personnel to facilitate discussions on HIV/AIDS risk-taking behaviour with their peers in order to stimulate an examination of risk solutions.
- *Voluntary counselling and testing.* Interaction between a trained counsellor and a person seeking HIV testing which has the person being tested examine his or her risk-taking behaviour, explore prevention options and understand the implication of the test results.
- *Training.* Formal instruction in issues related to HIV/AIDS.

16.2 Is interpersonal or mass media communication better?

Complementary media best

BCC planners often think they have to choose between interpersonal communication and media communication. An example of interpersonal communication would be a peer educator conducting a session with five people using a flip chart. Circulating an audio cassette or a radio broadcast could be an example of using communication media. The discussion should not be in terms of either/or. BCC works best when communication media, interpersonal communication and services are coordinated.

16.3 What are the advantages of interpersonal and media communication?

Mass media biggest reach

The communication media, especially mass media like radio and television, can quickly and efficiently increase awareness of issues and services. When calculated in terms of the number of people reached, the communication media are usually cost-effective.

Personal contact expensive but effective

Interpersonal communication is usually considered less cost-effective than media communication because it is costly in terms of numbers reached. On the other hand, interpersonal communication is very effective in supporting those who are trying out and adopting new behaviour. A well-trained communicator can tailor messages to meet the needs of small groups and provide instant feedback.

16.4 How are materials and channels selected?

Consider cost-effectiveness

It is important to think about how particular media can help achieve certain goals, and to know which channels can most effectively reach the target population. Different media have distinct advantages and disadvantages and are best used at different times. It may be possible to experiment with different media and find out which ones have the greatest impact.

16.5 Why use a combination of channels?

Different channels, different capacities

Capacities and effectiveness in delivering messages are different for each channel. Mass media like radio and television have a very broad reach. In some countries the armed forces have their own radio show. It could be used to rapidly make large numbers of people aware of a new sexually transmitted infection treatment service, for example. More detailed information about the service might be included in a pamphlet which could be read several times and be shared and discussed by a number of people.

Same message, different channels

The impact is greatest when the same message is communicated through different channels. For example, if a police service is promoting voluntary counselling and testing services, a combination of media could be used such as posters, radio advertisements, pamphlets distributed in stations and stickers placed beside urinals. Experience shows that a considered mix of materials and channels works best.

16.6 Is cost-effectiveness important?

Careful selection saves money

A BCC strategy should calculate what materials and communication channels are best for reaching particular target populations. But the strategy should also consider the cost-effectiveness of each one. For example, filmed messages can be very effective in reaching people but they are expensive to produce and broadcast. In contrast, music and dramas containing the same messages widely circulated on audio cassettes would be much cheaper to produce and end up being more cost-effective.

Need diffusion plan

At times, materials are produced but little thought is given to how they will be used. Flip charts are produced but no one is trained in how to use them. Calendars are printed but they are placed in the offices of senior officers and the rank and file rarely see them. Some materials have the potential to be effective but end up reaching only a tiny fraction of the target population. For example, 1000 comic books may be printed but there may be 10 000 employees in the uniformed service. Additionally, most may be distributed in the capital and few reach the rest of the country.

Some suggestions for developing materials and selecting channels:

- Look at the cost of each medium available.
- Printing tends to be expensive in terms of numbers reached. Printed materials with a

multiplier effect such as those used in training or peer education sessions like flip charts and picture books have more value.

- Any printed materials need to be accompanied by a clear plan for how they will be used and distributed.
- Radio is cheaper than television in terms of reaching large numbers of people.
- Black-and-white printing is cheaper than colour.

Examples of cost-effectiveness

- Producing a larger number of black-and-white booklets is more cost-effective than having a smaller number of glossy, colour booklets which is insufficient to reach more than a small percentage of the target population.
- A sticker promoting condom use placed in all men's toilets used by a uniformed service will be seen by many people and lasts more than a year. This is more cost-effective than producing calendars that may end up in the offices of senior officers and then get taken down after a year.
- A drama is recorded on an audio cassette and copies sent to each company in a uniformed service. This is cheaper to produce and copies cheaper to make than if video-cassette format had been chosen. For the same resources, more people receive their own copy to listen to. Also, more people have audio-cassette players than video-cassette players.
- Resources might be well spent on pouches for carrying condoms that are made an official part of the uniformed services kit. Novelty items like key chains, t-shirts, hats and buttons are very popular but have a limited capacity for carrying a message and inspiring behaviour change.
- Flip charts that are designed to be used in training or peer education sessions should be produced only after sufficient attention has been given to those who are going to use them and how they should be used.

16.7 Who develops the messages and materials?

Outside help may be needed

Some uniformed services HIV/AIDS programmes may have the capacity to develop messages and materials on their own. Others will find it necessary to identify outside help to work with them to develop and pretest the prototypes. Communication consultants, commercial advertising firms, government agencies with experience in message development such as information, education and communication units of ministries of health can all provide help with the development of BCC strategies, messages and materials.

17. Pretesting messages and materials

17.1 What is pretesting?

Verifying potential impact of drafts

It is important to ensure that the message you intend to send is being received properly and having the desired effect on the target population. Pretesting involves trying out prototype ideas in the form of messages and materials with representatives of the target population before they are finalized.

17.2 Why pretest?

Reduces chance of wasted effort

Pretesting does not guarantee that strategies, messages and materials will work, but it greatly increases the chances that they will. It is cost-effective in the sense that it helps avoid costly errors. Producing materials without pretesting is like shooting in the dark. If a poster is misunderstood or a radio spot is profoundly offensive to the target population the cost of printing or production is wasted.

17.3 What do you pretest?

Drafts and prototypes

Materials are pretested when they are far enough along to convey the idea of the content but not so far along that it would be too expensive to change them. Drafts in the form of rough sketches or drawings with hand lettering can be used. Radio advertisements can be read instead of recorded, television advertisements or dramas can be presented in the form of storyboards (a series of drawings representing the images that will be filmed later). It is also possible to pretest the different parts separately such as the messages, music to be used, artistic styles, and the characters and actors to be featured. Several different versions can be pretested to compare reactions.

17.4 Who does the pretesting?

Specialists can help

Communications specialists often develop skills that enable them to pretest the materials they produce. Some social science researchers or others who carry out focus group discussions are also able to conduct pretesting. Since the technique was developed by the advertising industry, there are private sector advertising agencies and media consultants with skills for pretesting. As a rule of thumb, it is generally better that those who created the work do not also pretest it.

17.5 When is pretesting done?

Periodically throughout process

Ideally pretesting is done at every stage. At the start, ideas for BCC strategies, such as to what degree dreams of the future are a motivating factor, can be pretested. Different messages, images, spokespeople or even colours and music can all be pretested. In general, pretesting should occur when BCC planners are in doubt about an approach, message or material. Major differences of opinion on what will work best can be settled by pretesting.

Pretest drafts not finished products

Materials are pretested at draft stage (see 17.3, above).

17.6 Who do you pretest with?

Representatives of target population

Carefully selected representatives of the target population should be used for pretesting: a sample of those for whom the messages and materials are intended. The sample size depends on the resources available but a total of 10–50 is average. The pretesting could be conducted with individuals, small groups of 3–5 or focus group size (12–15).

Make sure truly representative

The key to successful pretesting is ensuring that those who are pretesting are truly representative of the target population. If those chosen are more literate than the rest of the target population, they may understand the content more easily and give a false impression of how well it will work with the majority. As a rule the larger the sample, the more reliable the results will be.

Pretesting with stakeholders

Although it cannot substitute for pretesting with members of the target population, pretesting should also take place with key stakeholders. This is not always possible, but programmers should try to do so to minimize controversy, which can derail or compromise the programme. In the context of uniformed services, chaplains, spouses or senior officers might be consulted.

17.7 What questions should be asked?

Keep questions simple

Open-ended questions that get at what the target population thinks, likes, feels or to what degree it is inspired by the messages and materials are needed. The questions can be very simple and do not need to be specific. One danger with asking questions that are too specific is that the answer sought will be telegraphed which will bias the response. In general, participants are very enthusiastic about giving their opinions and do not take much probing. Sample questions:

- What does this convey to you?
- Is there anything you like or dislike?
- Who is this for?
- What is this telling you to do?

Find out likes and dislikes

Getting a sense of whether the content is understood is important but pretesters also need to find out whether it is appreciated and liked. For example, the content may try to invoke an emotional reaction that may or may not work. It is also important that the behaviour change recommended is understood and that members of the target population see that it concerns them and that the message is for them.

17.8 How many sessions are needed?

Some better than none

Two sessions with four people is better than one, and three is better than two. One approach is to continue until the same comments are heard over and over again. The more pretesting sessions that are held, the clearer the pretesting insights will be. On the other hand, it is a waste of resources and energy to do too much. As a rule, if you get the same reactions after several pretest sessions, there is no need to do more. Time and budget restraints may reduce the number of sessions and participants. Ten participants and three sessions might be an ideal minimum.

17.9 What do the results mean?

Expect changes

It is rare that no recommendations for changes are made in a pretest. Almost always the changes suggested make sense and greatly improve the product. Integrating major changes should be considered a natural part of the process and not a criticism of the quality of the work done.

Analysis can be tricky

Analysing the results takes special skills since not all representatives of the target population can be expected to see the results exactly the same way. Some of the pretest recommendations can be ignored in some cases. For example, in one region soldiers recommended replacing the images of soldiers with civilians because they did not want the public to associate HIV with them. This recommendation was ignored since the materials would not be seen by the general public.

Ignore minor opinions

If three-quarters of those participating in the pretest have the same reaction, the quarter that has a different reaction can be ignored. After the results have been analysed and the suggested changes made, ideally another pretest should be done to see if it is now more acceptable. There is a chance that changes will be needed again.

17.10 How can the results be used?

Get decision-makers on board

Decision-makers may have strong ideas on what BCC strategies, messages and materials may work or not work. Since they are often from an older generation and better educated than the other ranks, they may be out of touch with the socio-cultural realities of their rank and file. Pretesting helps bridge that gap.

18. Implementation of behaviour change communication strategies

18.1 Why ensure links to services?

Coordinate partners

In the implementation phase, all the elements of the strategy go into operation. All partners including the producers, programmers and delivery channels of the BCC strategy must coordinate their work closely since each element is interdependent with the others.

Ensure services available

Behaviour change will not occur if support services are not available. There will certainly be links among critical programme elements, such as between supply and demand for products or services. If personnel discover that the condoms are not available where they were promised, the programme will suffer for it.

18.2 Why respond rapidly to criticism?

Criticism can derail progress

Misinformation such as false rumours about condom reliability need to be dealt with or they will evolve from rumour to perceived fact. Criticisms from vocal minority voices such as those who believe condom use increases promiscuity also need to be dealt with discreetly. Research and pretest results that prove the acceptance of messages and materials by a target population can help diffuse some negative reactions.

18.3 What is the importance of coverage?

Need to reach majority of personnel

Many uniformed services concentrate HIV/AIDS programming efforts on reaching personnel located in the national capital. This can be attributed to inadequate resources for transportation, limited staff capacity or resistance from regional commanders who have not been sensitized. Personnel in the capital may be the easiest to reach and a good starting point but effective programming needs national coverage.

19. Monitoring and evaluation

19.1 What is monitoring and evaluation?

Guides programming

Monitoring and evaluation are essential components of HIV/AIDS programming, especially in resource-limited settings. Monitoring allows the programme planner to ascertain how effective the strategies and approaches have been and to adjust them where necessary.

BCC needs effective monitoring and evaluation

During the implementation phase, it is necessary to look back at the preceding steps in the BCC process to be sure the programme is addressing the identified problem, the target populations and the formative assessment findings. This effort can also help identify whether behaviour change and communication objectives are being achieved and whether channels are being used most wisely.

19.2 What is monitoring?

Tracks progress

Monitoring is the regular assessment of the inputs and outputs of a project. This feedback provides the eyes and ears for planners and allows them to find and correct problems. To monitor the course of a BCC strategy effectively, an information gathering system should be established. The information that must be gathered for BCC is linked to the programme's overall monitoring system. This means checking to see if the communication is being disseminated as planned.

- If you have produced TV or radio advertisements, it is important to monitor when they are being aired.
- If you have produced print materials, it is important to monitor the distribution and the use of these materials.
- If the communication promotes services, it is important to know if there is an increase in the use of those services.
- If you have a peer education element, it is important to monitor what is actually said in peer education sessions.

Periodic focus group discussions and in-depth interviews can help the BCC organizers keep track of the perceptions of the target population.

19.3 When do you monitor?

Regular checks

At each stage planners should take a look and see if things are going as planned and do some fine-tuning if they are not. Resources should be committed at planning stage to ensure that monitoring is a continuous process.

19.4 How do you analyse results?

Use common sense

A good monitoring system can identify problems before they are widespread. For example, a uniformed service found that its peer educators were giving lectures on HIV

and not stimulating discussions as was planned. The acceleration of the development of support materials to encourage interactivity and refresher training in participatory processes were planned to correct this.

Not possible to fix everything

Not all problems will be identified through monitoring and it will not necessarily be possible to fix all the problems. It is important to make the changes that are possible and apply all the lessons learned for future planning.

19.5 Summative evaluation

See if objectives met

Summative evaluation looks at implementation and its success in meeting pre-determined project goals and objectives. Interventions should be evaluated against their stated objectives and in reference to a baseline that may be qualitative or quantitative. It is not easy to measure effectively what specifically influences changes in behaviour since there are many potential inputs.

Qualitative or quantitative

For large-scale programmes, baseline quantitative research may be repeated to show changes in knowledge, attitudes and reported behaviours. Change can also be assessed through qualitative research on the target group response to the intervention. Qualitative evaluation (or assessment of communication effects) examines anecdotal evidence for change in behaviour.

19.6 Why is it important?

Proof of success

Without evaluation, insights into what worked and what did not are lost, as is the opportunity to guide future planning. Evaluation is also valuable in proving the cost-effectiveness of interventions.

19.7 Feedback and redesign

Apply results to reprogramming

As projects evolve, target populations acquire new knowledge and behaviour, and communication needs to change. The needs of target populations must be reassessed periodically to capture where they are along the behaviour change continuum. As epidemics develop, the types of information and communication needed will evolve from basic AIDS information to discussions related to stigma, care and support, and sustaining safe practices. Monitoring and evaluation studies should lead directly to modifications of the overall programme and the BCC strategies, messages and approaches.