UNIT 11 SOCIETAL INFLUENCES ON HIV AND AIDS TRANSMISSION AND PREVENTION

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11.1 INTRODUCTION

You already know the modes of transmission of HIV. In this unit we will examine the societal influences on what are, apparently, individual behaviours. It will then go on to examine the role of HIV and AIDS education in AIDS prevention, recognizing the crucial complementary role of other measures if the education is to lead to prevention. AIDS education is an important component and one that teachers can contribute too most directly. This unit will therefore, focus on HIV and AIDS education.

People contract HIV through specific risk behaviours, either their own or of others. The behaviours of infected include those that are stigmatized by society, i.e., extra marital sexual intercourse, intravenous drug abuse etc. Injections given by medical personnel without adequate sterilization can transmit HIV due to their negligent behaviour. The monogamous sexual partner of an HIV infected person and the child of an HIV positive mother acquire the infection without any transmitting behaviours.

HIV selectively affects young adults. Eighty to ninety percent of those affected are in the age group of 15-49 years and in the prime of their productive and reproductive lives. Certain kinds of socio-political environments marginalize weaker groups. The social marginalization increases their vulnerability to HIV infection. These include women in general, commercial sex workers in particular and migrant labour, street children, homosexuals, intravenous drug users etc. Therefore, special attention needs to be given for their protection.
HIV/AIDS has a long asymptomatic phase. AIDS usually appears many years after the infection has occurred. However, the danger is that during this period most people are unaware that they are infected and may spread the disease. Due to its serious outcome and the commonest mode of spread through multiple sex partners, HIV/AIDS arouses responses of fear, blame and stigma. It threatens basic human rights and invades the right to privacy and human dignity. Due to the stigma associated with HIV/AIDS and the long asymptomatic period, people tend to be diagnosed late and therefore, may infect many others thus, making prevention difficult.

11.2 OBJECTIVES

This unit deals with the societal factors that influence HIV transmission and those that are relevant for preventive efforts through education and behaviour modification in the context of HIV and AIDS. By the end of this unit you should be able to:

- understand the societal context underlying HIV-transmitting behaviours;
- explain the strategies for implementation of an AIDS control programme;
- list the goals of HIV and AIDS Education;
- describe the principles of HIV and AIDS education: do’s and don’ts; and
- discuss the steps for effective HIV and AIDS education.

11.3 SOCIETAL INFLUENCES ON TRANSMISSION OF HIV

In order to understand the societal influences, we begin with a brief sociological understanding of heterosexual activity and its social patterning.

The Sociology of Sexuality

Sexuality can be variously perceived as a necessity for procreation, as an expression of caring, sharing and bonding between two individuals, as a means of deriving emotional and/or physical pleasure from transient relationships, as a means of sublimation and spiritual transcendence, as means of displaying power, punishing adversaries and so on. All strands, i.e., those giving primacy to one or the other view, exist in all societies at all times but the relative proportion of persons subscribing to different views change with changes in societal values and social conditions. Social control, self-restraint, and the degree to which society values these, determine the dominant pattern of sexual behaviour in a society. India has had Kamasutra and Khajuraho, socially accepted forms of prostitution (such as devadasis and courtesans), polygamy and polyandry. On the other hand, the majority of people of all classes placed a high value on faithful, stable relationships within marriage. Of course, there has always been a greater space and tolerance for expression of male sexual desires outside a monogamous relationship than for women. However, in many societies, as a norm extra-marital and pre-marital relationships have been socially disapproved of.

With India's shift from predominantly agricultural, low subsistence and low consumption economy and a community based social structure, to an industrially developing nation with urbanization, migration and the breakdown of rural economies and communities, there have been shifts in social values and world views. The degree and nature of this impact has been varied across different sections. The weakening of earlier forms of social and community controls have
allowed greater individual freedom, releasing the stifling controls on men and women. While most males by and large experience this autonomy, for women it is primarily the upper and middle classes who can claim it to some extent. However, indications from different sources of data are that conditions of women of many sections may have relatively worsened. High consumption life-styles have spread to larger proportion, raised aspirations of others and increased the consumption gap between the top and bottom sections. Along with the increasing value placed on material consumption, there has also been an increase in perception of sexuality as a commodity to be consumed for pleasure.

The gap between material aspirations and socio-economic status has led to distortions such as the spread of corruption, the rise of mafias, dowry deaths etc. Similarly, here has been a rise in desires for sexual pleasures and consumption. But, given the nature of gender relationships, the pattern of family relationships and the level of living conditions including housing, it is not possible for the majority of the population to fulfill these desires through socially legitimate relationships. This, together with the loosening of community ties with no concomitant replacement by other forms of social control coupled with a decline in values of self-restraint and in norms for respecting other’s rights, has led to a rise in sexual assaults on women and even the girl child. These gross perversions of sexuality of men are indicative of the less visible shifts in social behaviour in our society. Increasing prostitution reveals the increasing demand for commercial sex. Pre-and extra marital relationships are thus, likely to be on the rise and some surveys do indicate high levels in different sections. All these changes are most conducive to the spread of HIV and AIDS in women.

However, when we compare the Indian scene with information available on sexual norms and behaviour in other societies, we still seem to be ‘conservative’ and a higher order of sexual restraint is maintained. Whether it be the industrialized West, the African situation or closer home Thailand, the social sanction against transient multi-partner relationships is much more. The impact of this is evident in the levels of HIV infection in these respective areas. Refer to the table 11.1 for details regarding behaviour pattern of married persons.

**Table 11.1**

<table>
<thead>
<tr>
<th>S.1. No.</th>
<th>Country</th>
<th>Norms and definition of marriage</th>
<th>Extra-marital sexual experience (ems)</th>
<th>% Going to CSWs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>India</td>
<td>Marriage almost universal and as life long stable relationship with disapproval of other partners. Greater freedom for males.</td>
<td>M 15-30% (Ever engaged in ems in lifetime) P 5-10%</td>
<td>M 3-20%</td>
</tr>
<tr>
<td>2.</td>
<td>Thailand</td>
<td>Marriage almost universal and as life long relationship but with high extra-marital sexual activity.</td>
<td>M 77% (Ever engaged in ems in lifetime)</td>
<td>M 50%</td>
</tr>
<tr>
<td>3.</td>
<td>Sub-Saharan Africa</td>
<td>Multiple patterns: Life long stable monogamy + polygamy + short-term stable relationship. (WHO-GPA definition of Marriage-relationship)</td>
<td>M 8-47% (Multiple partners in previous one year)</td>
<td></td>
</tr>
</tbody>
</table>

Thus, among Indians the sexual norms are still to abide by the life-long rule of monogamy, while in the U.S., parts of Europe, Africa and some parts of Asia, the norm has become change of partners. In India, those indulging in sex outside marriage, the number of partners and the network within the group appears to be less than in the other countries.

This is not to say that AIDS is not a public health problem in India but that it may need a different kind of intervention as followed in U.S. Sub-Saharan Africa and parts of Asia to minimize the spread of AIDS. Twenty percent of young males engaging in activities that can transmit HIV is epidemiologically significant. Also important is the high level of resort to CSWs in some pockets e.g., among migrant workers in Chennai and college students in Mumbai (ICRW, 1997); the level of prevalence of extramarital sex (10-30% by different studies), and the high level of STDs (about 1-3 percent of VDRL positivity for syphilis) and a prevalence of 0.5 percent of HIV infection in the population. In addition, current changes in social structures, economy and culture with increasing globalization are likely to be giving a thrust towards behaviour change from safe to risky behaviour.

Check Your Progress

Notes:  
a) Use the space provided for your answer.

b) Check your answer with those provided at the end of this unit.

1. What are some of the societal influences on spread of HIV?


11.4 IMPLICATIONS FOR STRATEGIES OF HIV AND AIDS PREVENTION AND EFFORTS

A General Population Perspective

The differences outlined above are epidemiologically extremely significant. Even statistical epidemiological models for generating projections of the future of the epidemic have used the following factors as those which influence extent of sexual spread of HIV (Isham 1988, May & Anderson 1987, Schalfe 1990):

- The average number of partners per unit time;
- The average rate of acquiring new partners;
- The distribution of partner change in the population.

The epidemiological significance of this difference in sexual behaviour norms is corroborated by the data on prevalence of AIDS in the different countries (UNAIDS & WHO, 1997). Though the real difference will be less than this data depicts because of the incomplete reporting of HIV/AIDS cases, the margin of difference between the Indian and other rates is too much to be explained by differences in reporting system alone.

With such significant differences in sexual behaviour norms, and differences in prevalence of AIDS can we have a common approach to controlling the epidemic across the globe, whether in the U.S., in Africa, in Thailand or in India? In the
U.S. (and European countries) where sexual activity outside marriage and changing partners is the norm or is socially accepted, it is logical to make promotion of condom use the primary measure for prevention. In countries like India where it is not the norm in most social groups and is engaged in by a minority, but changes are occurring in society such that risky behaviour is likely to be adopted more often, the primary prevention strategy must certainly be designed differently. It must have a doubled-pronged approach, simultaneously, giving consideration to both the 75% and 25%.

Fig. 11.1: Sexual behaviour pattern of people
(a) India
(b) U.S.A.

The strategic approach should be one which considers all the three parts of sexual behaviour patterns influencing the epidemiology of HIV/AIDS in India, the prevailing levels of monogamous relationships, the extent and nature of sexual activity outside marriage, and the nature of changes currently occurring in sexual behaviours. To develop a comprehensive view to the problem one would need to examine:

- The conversion of members from one group to the other i.e., from ‘monogamous to multi-partner’ and vice-versa.
- The interaction among the two groups.
- The impact of measures targeted at one group on the other e.g. of condom promotion on the monogamous.
- The factors allowing the monogamous to continue in that group and the factors making them shift to other group.
- Devising measures to strengthen the positive factors, e.g., community and family ties which maintain monogamy.
- Devising measures to counter the negative factors. Thus would include provision of better housing living and working conditions to migrant labour
so that whole families can migrate instead of just the earning male, as well as by countering the commodification of sex by generating a social perspective about gender relationships.

- Devising targeted interventions for the high-risk behaviour pockets, using the understanding of prevailing relationship between the monogamous and high-risk group perceptions to elicit a positive response e.g. giving importance to the romance and emotional dimension of a monogamous relationship. At the same time, it has to be ensured that these interventions do not act negatively on the majority group e.g., as by the IEC messages discussed later.

More Specific Considerations

With the overall consideration being to identify and strengthen the positive tendencies in the social context, some specific issues must necessarily be addressed. These include the following:

Different Practices and their Meaning for Diverse Social Groups

While a generalized analysis has been for ‘sexual behaviour patterns in India’, it needs to be clearly recognized that there is great diversity in social norms within Indian society for example, between rural and urban populations, between different tribal groups and between tribal and non-tribal groups. These differences are important to identify so as to examine the existing factors that can be harnessed to promote and plan HIV and AIDS control activities for the diverse groups appropriately.

Responsible sexuality, not merely ‘Safe Sex’

In such a cultural context, ‘safe sex’ is that which is socially legitimate. The use of terms like ‘safe sex’ and ‘safer sex’ shifts the image of the relationship from one with social responsibility implicit in it to merely a biological ‘safety’ through use of a condom. Such messages strengthen the negative changes. HIV and AIDS education or sex-education messages must consciously emphasize the social and emotional dimensions of sexual relationships in addition to the physical.

Check Your Progress

Notes: a) Use the space provided for your answer.

b) Check your answer with those provided at the end of this unit.

2. What should be some of the important considerations in the strategic approach for HIV prevention at population level?

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11.5 PREVENTION THROUGH HIV AND AIDS EDUCATION

Clearly, information of mode of spread of HIV is the first step in any effort at AIDS prevention. In this section we discuss the role, approaches and issues for consideration in AIDS education. We will also discuss the goals of HIV and AIDS
education. You will look at the attitudes reflected through them, the communication methods, the impact of how these messages are conveyed and the situation of the recipients of that education which makes them ignore it or act upon it.

11.5.1 Goals of HIV and AIDS Education

The general goals of HIV and AIDS education are:

- Providing correct information to the lay public about the new disease syndrome called HIV and AIDS, so that HIV positive persons are dealt with by society in humane and caring manner.

- Motivating people not engaging in high-risk behaviour to continue to maintain that behaviour.

- Motivating behaviour change among those engaging in high-risk behaviour such as sex outside marriage, intravenous drug abuse etc., which are likely to transmit HIV.

- Providing information on the fact that HIV can be transmitted by unsterile needles so that people can insist on the use of sterile needles and syringes for medical/surgical procedures.

- Providing planners, administrators and service providers with correct information, so that they can perform their duties effectively and in the best interests of HIV and AIDS control.

Experience shows that information alone will not have a significant impact on the spread of HIV infection. Social conditions, material inputs and services must allow for action in accordance with it. For instance, information about symptoms and modes of transmission may make individuals fear that they have an STD or HIV and AIDS, but social stigma and poor access to health services or unsympathetic attitudes of caregivers would hinder them from seeking treatment. Similarly, the psychological condition of the unemployed youth may make them easy prey to temptations offered by drug peddlers even if they are aware of the dangers involved. Social values and peer pressure can help to some extent by supporting refusal but the danger will remain as long as the drug mafia continues unchecked and the condition of unemployment creates a fertile ground for them. Again people may know the risks of infection with HIV if unsterile needles are used but they may not be in a position to ensure use of sterile equipment by medical personnel. The goals of AIDS education can therefore, be fulfilled only when:

- It is complemented by effective action in the other related spheres.

- It leads to capacity building for actions conducive to AIDS control.

Check Your Progress

Notes:  a) Use the space provided for your answer.

   b) Check your answer with those provided at the end of this unit.

3. What are the basic goals of HIV and AIDS education?

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Societal Influences on HIV and AIDS Transmission and Prevention
11.6 SOME DO’S AND DON’TS OF HIV AND AIDS EDUCATION

Lessons learnt from communication approaches earlier on HIV and AIDS epidemic across the world must be considered before any further HIV and AIDS communication is undertaken. These include the following:

Fear Campaigns are Counter-Productive

In many countries of the developed and developing world, fear campaigns were initiated with the reasoning that people would be shocked into behavioural change. However, studies showed contrary results. Since individuals at low risk became irrationally panic-stricken and those at high risk turned away from the messages, this approach did not fulfill the goals. It was found that such messages may provide short term improvements in some situations but the behavioural change was generally not sustained for long and reversion to earlier (risky) behaviour often occurred. Fear generated by the projected number of HIV infected and AIDS cases by the international agencies to draw the national policy-makers attention to the problem of HIV/AIDS also proved counter-productive. This led to a panic-stricken response leading to stigmatization of people with HIV/AIDS or in high risk professions and not a rational, well thought out control programme suited to local context. So later, much of the counter-productive efforts of the AIDS control activities are having to be undone. The fear generated also conveyed itself to the medical professionals who too responded irrationally and unethically by refusing to treat positive persons.

Significance of Images of Women, Gender Relationships and Sexuality

Images of the submissive passive female and the aggressive macho-male pervade attitudes towards sexuality. These attitudes reflect the difference in status between men and women. The controls have always been more stringent on women than on men. Female sexual desires have been represented as evil and, therefore, to be controlled even through coercion. Women’s virginity before marriage has been considered all-important and any extra-marital relationship is considered sinful. Male sexuality too has been condemned but society has been much more indulgent about fulfillment of male sexual urges. They have been liberal in cases of violation of social norms by men, even allowing for their institutionalization. Prostitution is one such institution; it has been viewed as necessary for fulfilling the male sexual needs and protecting the majority of the women as well as allowing their marriages to go on undisturbed. This view of women’s complete virginity on one side and commercial sexual exploitation on the other has undermined the emotional and mutually supportive dimensions of man-woman relationship. It allows for many forms of exploitation of women both within the home and outside it. The woman’s weaker position in the power equation of the relationship does not permit the societal situation to be checked by individuals within their specific relationships.

Propagating ideas of individual sexual freedom and sexual rights of both men and women without empowerment of women in other spheres of life only strengthen the existing exploitation. It commodifies sex more blatantly and creates a space for greater sexual irresponsibility by men, thereby increasing chances of spread of HIV. Therefore, there is a need for public questioning of the stereotyped-images about sexuality, particularly, in the context of various dimensions of gender relations. However, the debate must be within the framework of responsibility and mutuality, so that the new attitudes developed towards sexuality minimize exploitation of women and the spread of HIV.
In an attempt to produce HIV and AIDS education messages that are non-discriminatory and not based on the conventional sense of morality, we have witnessed IEC material (Information, Education, and Communication Material) that has furthered this trend. Promoting irresponsible sexual behaviour among women is not non-discriminatory in our socio-cultural context. It is a cultural onslaught and one that is not productive for HIV/AIDS control. On the other hand, promotion of the value of self-control by males is conducive to both. Not preaching about this, but creating an environment where the romance and pleasure of a stable, mutually supportive man-woman relationship is found attractive and sought after can take us long way in this direction.

Role of Mass Media

Films, advertisements and other such mass media have been promoting the commodification of sex in recent years. In this age of liberalization and globalization, both material consumerism and sex consumerism are being promoted as an onslaught on a culture that promotes exercise of self-restraint. AIDS education messages must be careful not to become part of such a market-driven approach.

A Non-Stigmatizing, Non-Discriminatory Attitude is Essential

The focus on certain socially marginalized groups as ‘high risk groups’ for HIV/AIDS (i.e. Truck Drivers, homosexual men, commercial sex workers and IV-drug users) has stigmatized HIV/AIDS positive persons when in fact the HIV can be found in many other pockets of society (e.g., in clients who infect sex workers) and in the population in general (e.g., when transmitted by medical interventions). This has led to discrimination against HIV positive persons to the extent that they have been turned out of jobs, been forced to leave their places of residence and suffer isolation. This creates suffering even while they are not suffering from ill health. Such social discrimination and the suffering of individuals also places the population at a greater risk as it makes the HIV positive persons hide their serological status. It makes others deny any risk to themselves, and thus, adds to spread of HIV. Therefore, a non-stigmatizing, non-discriminatory attitude must be developed for protection of the individual, the social group and the population as a whole.

Moralizing Messages have Little Effectiveness

AIDS education messages, which preach behaviour change to those engaging in activities likely to transmit HIV (such as preaching monogamy to those undertaking multiple partner sex or preaching about the negative consequences of drug abuse to those engaging in intravenous drug use) are seldom effective in inducing the desired behaviour changes. Making other optional behaviour attractive, ensuring the required material base, access to the necessary services and a psychological environment with social and peer group support for the required behaviour change, are all essential contributors. For instance, besides telling youth using intra-venous drugs about the risk of getting infected with HIV and AIDS, they must be helped to overcome the need for the addiction by giving them a meaning in life. Once they decide to give it up, they need constant support to actually enable them to do so.

Social Values Supporting Responsible Behaviour must be Strengthened

It has been effectively shown that social value frames and cultural norms support specific kinds of behaviour patterns. For instance, among certain tribes sexual experimentation is permitted between young, unmarried boys and girls, but if girl becomes pregnant the boy must marry her. Studies show that religious persons...
become sexually active at a later age and tend to be monogamous more often than the less religious, irrespective of which religion they practice, also demonstrates the role of social values in determining behaviour patterns. When individualism colors the predominant worldview (as it does in modern industrialized societies) and consumerism is a way of life, social relationships become low priority and socially responsible behaviour both at individual and societal levels is found to decrease. In such an environment, sexual relationships too tend to lack the mutual responsibility that is essential for people to adopt safe sex practices. Thus, large-scale impact can be made on sexual behaviour patterns through HIV/AIDS education only if it is supportive of, and supported by, societal structures (both economic and cultural) conducive to non-transmitting behaviour.

Keeping all these issues in mind, guidelines which can assist in avoiding some of the mistakes of the past, indicate that messages should:

- be consistent and accurate;
- be positive and aim to help people protect themselves and help those already infected to live productive and socially beneficial lives. They should contribute to creating a conducive environment in the long-term;
- be linked to service delivery. For example, information and counselling centres must be available to help people gain knowledge about the spread of infection and methods of prevention, and to counsel those in need. If condoms are being promoted, affordable, good quality condoms must be available in the area. STD treatment services should also be made easily accessible.
- offer options. For example, when dealing with difficult-to-change behaviour patterns such as drug use, it is helpful and more effective to provide the individual with options for action, for example your chances of getting HIV and AIDS are high if you inject drugs, so don’t inject; if you can’t avoid injecting, don’t share needles; if you can’t avoid sharing, at least clean the needles before sharing. Such behaviour options also apply to sexual transmission. For example your chances of contracting HIV and other STDs increase if you have multiple sexual partners; so abstain from sex or stick to one uninfected partner; or practice safer sex with condom use for every sexual encounter outside marriage; what is now known as the ‘ABC strategy’ - Abstain/Be faithful/Condom use.

**Check Your Progress**

**Notes:**

a) Use the space provided for your answer.

b) Check your answer with those provided at the end of this unit.

4. What are the major guidelines, which can assist in avoiding some of the mistakes of the past in an HIV/AIDS education campaign?
11.7 BASIC STEPS FOR EFFECTIVE HIV AND AIDS EDUCATION

Societal Influences on HIV
and AIDS Transmission
and Prevention

The steps which need to be taken for an effective HIV/AIDS education programme are planning, preparatory activities like materials development, undertaking the planned HIV/AIDS education activities, monitoring and evaluation.

Planning

The first step has to be a review of the current situation regarding the specific group for whom the education is meant to reach including a thorough assessment of the Programme's Information, Education and Communication (IEC) needs and existing IEC activities. Based on this, the second step would be identification of activities to be carried out, as well as potential partners for implementation.

Situation Analysis

The organizational structure and manpower available for HIV and AIDS prevention should be analyzed, while communication and outreach networks, both within the government, as well as among NGOs should be assessed for use in HIV/AIDS educational activities.

The situational analysis would require examination of existing epidemiological, cultural and behavioural data and exploration of the existing situation from a number of points of view, including:

- past/present preventive action and its effectiveness;
- the extent of spread of HIV in different groups and areas;
- assessment of vulnerable populations; and
- any information relating to the particular group and the population of the region, in terms of demographic data, social structure, the status of women and literacy levels, sexual culture, available health services in general, and for those infected with HIV.

Every effort must be made to fully utilize existing data from studies in various fields, including those in sociology, social anthropology, and psychology and fields related to health education. However, when looking for information related to sexual practices, it may be necessary to conduct new studies using qualitative approaches including ‘focus group discussions’ or individual in-depth interviews. Studies can be carried out to fill gaps in information on the following subjects:

- Who is at risk?
- What is the existing transmitting behaviour and what are the desirable changes?
- What are the factors, which might facilitate or inhibit desirable behaviour?
- Who are influencers of different groups?
- What is the access to media, and media habits (viewing/listening/reading) of those at risk?
- What is the access to and use of health services for those at risk?

Establishing Objectives for a Specific HIV and AIDS Education Programme

Based upon the transmitting behaviour patterns in the population, the overall HIV and AIDS control activities and the goals of HIV/AIDS education; the programme
would have to set its own objectives. These could be in terms of the different needs among different sections of the population and the desired outcome for each.

Developing AIDS Education Strategies

Strategies would have to be evolved in order to meet the objectives most effectively. This must be done keeping in view the existing context as delineated by the situational analysis. Different strategies would be needed for the varied social groups and the objectives of HIV and AIDS education for each. Also, the relationship between the different groups and the influence of HIV and AIDS education for one or the other must be considered. For instance, while emphasizing on the use of sterilized needles among groups of HIV drug users, the impact of this message on others vulnerable to drug abuse but not yet engaging in such activity must be assessed. While targeting HIV and AIDS education at a specific group, care should be taken that it does not become counter-productive for other sections of the population.

Implementation

Preparation of HIV and AIDS education messages, materials and manpower mobilization is the first step; their utilization in interaction with the population is the next. Data and inputs from target groups can be used to determine the message, and the medium and channels conveying them (such as, radio, television, posters, interpersonal approaches, and traditional media) to each segment of audience. This is the culmination of the conceptualization, analysis and planning exercise. Targeted IEC research including analysis of existing data, and knowledge of the target group, plays an important role in selecting and defining the message, format, presentation, medium etc., for each identified target group. At the design stage, the exact types of media, the channels for communication and the style should be determined. A balance between passive (e.g., posters, print or video) and interactive media must be created. In many cases, folk media such as puppetry, drama and story telling can be used quite effectively to support interpersonal communication and should be actively considered as part of the overall IEC plan.

Development of draft materials is based on decisions about messages, media and channels to be used for delivery to each target group. Materials may consist of radio/TV spots, booklets, posters, handouts or hoardings etc. IEC also involves tools for use in interpersonal communication. It must be kept in mind that materials are support tool for activities that lead to the achievement of goals and objectives. IEC materials alone will not produce behavioural changes.

Pre-testing of materials is one of the most important steps in materials development. Pre-testing allows the evaluation of message and materials with regard to acceptability and potential impact before large amounts of resources are used in production and distribution. Although it adds to the cost and time of producing materials, it prevents wastage of resources by ensuring that materials are effective.

Once draft materials are developed, they are carefully reviewed with groups selected from the specific target audience. For example, a television spot providing general information on HIV/AIDS should be tested with samples from the general public using a rough storyboard or outline of the pictures and text, before even beginning to film the spot. This process should continue once the rough film has been shot. In this way, planners can be assured that as much as possible the spot will convey the information desired as effectively as possible. Pre-testing should take place with every material from television spots to more specific outreach material being developed for non-literate audiences. Pre-testing is cost effective in the long run.

A summary of the steps to be followed in materials development is shown below:
Determining affordability and cost-effectiveness is important, as resources are always scarce. In this context, it would be well to judiciously and selectively use expensive media such as film and TV. The glamour of this media often results in an overemphasis on its use, even though the cost of production and dissemination is extremely high. On the other hand, traditional media (including puppetry, traditional theatre, and songs), interpersonal communication (through conversations and with help of tools such as flip-charts and flash cards) are often neglected, though they are generally very cost-effective. Special efforts must, therefore, be made to use traditional media wherever they are more suitable.

Planning effective ways to make sure that materials reach target audiences is as important as producing effective materials. It is often the case that good quality materials never reach those who need them or who could most effectively use them. Planning a distribution strategy and setting up a distribution network at the beginning is important. Using materials to support IEC activities, through mass media or for interpersonal communication requires knowing how to use them effectively. Instructions and suggestions for use must be supplied along with the materials.

Providing information to several persons within the community through an interactive process can lead to developing locally suited strategies for HIV and AIDS control and education. This requires a conscious effort to keep the HIV and AIDS education process a two-way affair and not merely a passing down of information. Peer educators (e.g. youth of the area trained to provide HIV/AIDS education and support behaviour change, ex-addicts as educators for IV-drug users and CSWs for other CSWs in their area) have been found to be the backbone of several effective HIV/AIDS education programmes. The effectiveness of these programmes is greater when they allow the peer educators to inform the content and strategy of the AIDS control effort.

**Monitoring and Evaluation**

Monitoring and evaluation provide inputs:

- for guiding and improving programme implementation;
HIV and AIDS Prevention
and Care

- for appropriate redefinition or fine-tuning of messages and materials; and
- for reworking objectives/goals and for the overall IEC approach.

Monitoring can be defined as the ongoing process of collecting and analyzing information about implementation of the programme. It allows managers to follow the progress of planned activities identify problems, give feedback to staff and solve problems before they cause delays. Monitoring can answer such questions:

- Have relevant health care workers and others received training?
- Are the appropriate services in place?
- Have the,IEC materials been distributed to those they are intended for?
- Are the IEC materials being utilized?
- Are the IEC materials appropriate?

Aspects such as the target groups interest in the material, comprehension of it, reaction to the format, language and characters used (if any), and visual appeal (where relevant) are crucial to the whole exercise.

Evaluation is the process of collecting and analyzing information at regular intervals about the effectiveness and impact of either particular parts of the programme or the programme as a whole. A variety of different evaluation methods are possible depending on programme needs. Regardless of method, planning for evaluation, including development of programme indicators and planning for information collection, should take place at the beginning of the programmes to ensure that essential data will be available when needed. Collection of appropriate baseline data is essential if an evaluation of impact is to take place.

Impact is measured against the programme objectives. Baseline data will be needed, and methods for collecting the information need to be spelled out so that the amount of change can be assessed. Evaluation should include (i) impact assessment and (ii) process evaluation. At a given point in time, evaluation can answer such quantifiable, impact-related questions as:

- What proportion of the general population who are sexually active report that they are practicing monogamy?
- Has the incidence of STDs declined?
- Is access to condoms and information on their correct use increasing?
- What proportion of health care workers are providing health education?
- What proportions of CSWs report the correct and consistent use of condoms by clients?
- What proportion of the general population can cite at least two acceptable ways to protect themselves from HIV infection?
- What proportion of women who have been advised on the risks of HIV infection and pregnancy at antenatal clinics can cite two factors for HIV infection?

Evaluation can also be designed to help in understanding programmes? Did certain types of activities have bigger impacts than others? What type of problems occurred? How can such problems be solved or prevented in the future? Periodic programme reviews provide more qualitative or descriptive information on the status of the programme.
5. What do you understand by monitoring and evaluation?

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11.8 EDUCATION RESPONSES FOR NON-DISCRIMINATORY COMMUNITY

Another role of the teacher would be educating the general community, the parents and school staff as well as children so as to create a non-stigmatizing environment for the children of HIV positive parents and those who are infected themselves.

11.9 CONCERNS OF THE COMMUNITY

A general understanding of AIDS as an infection leading to death and caused by high risk behaviour easily ends up with society condemning those already infected. There could be rejection of the individual and family from lack of awareness about infectivity or of methods of transmission of the disease on the part of the community.

By marginalizing and isolating those infected or at risk of infection it would practically drive the disease underground, thus making effective health education and prevention all the more difficult.

The main concern of a community in the context of HIV/AIDS would be:

- Spread of the disease from one individual to the rest of the community.
- Ostracisation of the community itself from the rest of the world.
- Impact of such ostracisation on the social and economic lives of the people in the community.
- If a large number in their community were HIV positive, how it would affect them as a community.

11.10 HOW CAN AIDS EDUCATION HELP?

Education

AIDS education helps in making the community become aware and understand the disease. They realize that this is not a disease which spreads through casual contact and therefore, they are unlikely to get it through that route.

Counselling

Counselling is essential in helping people to:
understand the consequences for themselves and for others of their risk behaviour;

- define their potential for changing risk behaviour to protect both their own health and the well being of others;

- find and use the personal and social resources necessary for starting and maintaining behavioural change or managing illness; and

- access facilities for voluntary testing with pre and post test counselling.

**Group Intervention**

Any intervention, which facilitates interactions with and among people with HIV/AIDS, will help to decrease rejection and stigma while providing education, social support and role models, for coping with illness. Peer groups can be focused or targeted to a specific audience.

**Check Your Progress**

**Notes:**

- Use the space provided for your answer.
- Check your answer with those provided at the end of this unit.

6. What are the concerns of the community in the context of HIV/AIDS?

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7. Do you feel that HIV/AIDS education is important for preventing discriminatory attitudes against HIV positive children? Describe how.

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**11.11 LET US SUM UP**

In this unit on societal influences on HIV and AIDS Transmission and Prevention, we have discussed certain specific aspects regarding the sociology of sexuality, and HIV/AIDS education in the context of experiences gained from across the globe. In the process, we have learned the goals of HIV/AIDS education, some of the Dos and Don'ts of HIV/AIDS education, education for preventing heterosexual transmission and the implications for a strategy of an HIV/AIDS control programme. The illustration of the advertisement demonstrates several important considerations for preparation of AIDS education materials and messages. Also discussed is the role of the teacher in preventing discriminatory attitudes towards HIV positive children or those of HIV positive parents.
11.12 UNIT-END EXERCISES

1. As a teacher, what you will do to develop right attitudes and behaviour among your students towards people infected with HIV and AIDS?

2. In your view, how education can help in developing non-discriminatory attitude towards HIV and AIDS in the members of the community.

11.13 SUGGESTED READINGS


11.14 ANSWERS TO CHECK YOUR PROGRESS

1. The dominant pattern of sexual behaviour in a society determines the extent of spread of HIV since it is the major mode of HIV transmission. This is evident from the comparison of data across countries such as India, Thailand, U.S.A. and Sub-Saharan Africa. The nature of economy, social structures and culture that promote self restraint as a social value will limit the spread of HIV. Breakdown of rural economies, the persistent gender inequality and loosening of community ties has led to its decline. Prostitution is increasing, revealing an increasing demand for commercial sex. Thus, current changes in social structures, economy and culture with increasing globalization are likely to increase risky behaviour.

2. The strategic approach for AIDS prevention in a population should be one which considers all the three parts of sexual behaviour patterns influencing the epidemiology of HIV/AIDS in it; the,prevailing levels of monogamous relationships; the extent and nature of sexual activity outside marriage; and the nature of changes currently occurring in sexual behaviours. To develop a comprehensive view to the problem one would need to consider- the impact of measures targeted at one group on the other e.g., of condom promotion on the monogamous, the factors allowing the monogamous to continue in that group and the factors making them shift to the other group; devising measures to strengthen the positive factors (e.g., community and family ties which maintain monogamy), devising measures to counter the negative factors, devising targeted interventions for the high-risk behaviour pockets. Differences in different social groups in a society are important to identify so as to examine
the existing factors that can be harnessed to promote and plan HIV/AIDS control activities for the diverse groups appropriately. Also, HIV/AIDS education or sex-education messages must consciously emphasize the social and emotional dimensions of sexual relationships in addition to the physical.

3. The goals of HIV/AIDS education include:

- Providing correct information to the lay public about the new disease syndrome called HIV/AIDS, so that HIV positive persons are dealt with by society in humane and caring manner.
- Motivating people not engaging in high-risk behaviour to continue to maintain that behaviour.
- Motivating behaviour change among those engaging in high-risk behaviour such as sex outside marriage, HIV drug abuse etc., which are likely to transmit HIV. Providing information on the fact that HIV can be transmitted by unsterile needles, so that people can insist on use of sterile needles and syringes during medical/surgical procedures.
- Providing planners, administrators and service providers with correct information, so that they can perform their duties effectively and in the best interests of HIV/AIDS control.

4. Some guidelines which can assist in avoiding some of the mistakes of the past are given below:

- Be consistent and accurate.
- Be positive and aim to help people protect themselves and help those already infected to live productive and socially beneficial lives. They should contribute to creating a conducive environment in the long-term.
- Be linked to service delivery. For example, information and counselling centres must be available to help people gain knowledge about the spread of infection and methods of prevention, and to counsel those in need. If condoms are being promoted, affordable, good quality condoms must be available in the area. STD treatment services should also be made easily accessible.
- Offer options. For example, when dealing with difficult-to-change behaviour patterns such as drug use, it is helpful and more effective to provide the individual with options for action, for example your chances of getting HIV/AIDS are high if you inject drugs, so don't inject; if you can't avoid injecting, don't share needles; if you can't avoid sharing, at least clean the needles before sharing. Such behaviour options also apply to sexual transmission. For example your chances of contracting HIV/STD's increase if you have multiple sexual partners; so abstain from sex or stick to one uninfected partner.
- Point out that to be effective it needs to be complemented by action in other spheres.

5. Monitoring can be defined as the ongoing process of collecting and analyzing information about implementation of the programme. It allows managers to follow the progress of planned activities; identify problems, give feedback to staff and solve problems before they cause delays. Monitoring can answer questions such as:

- Have relevant health care workers and others received training?
- Are the appropriate services in place?
- Have the IEC materials been distributed to those they are intended for?
- Are the IEC materials being utilized?
- Are the IEC materials appropriate?

Aspects such as the target group's interest in the material, comprehension of it, reaction to the format, language and characters used (if any), and visual appeal (where relevant) are crucial to the whole exercise.

Evaluation is the process of collecting and analyzing information at regular intervals, about the effectiveness and impact of either particular parts of the programme or the programme as a whole. A variety of different evaluation methods are possible depending on programme needs. Regardless of method, planning for evaluation, including development of programme indicators and planning for information collection, should take place at the beginning of the programmes to ensure that essential data will be available when needed. Collection of appropriate baseline data is essential, if an evaluation of impact is to take place.

6. The main concern of a community in the context of HIV/AIDS would be:
   - Spread of the disease from one individual to the rest of the community.
   - Ostracisation of the community itself from the rest of the world.
   - Impact of such ostracisation on the social and economic lives of the people in the community.
   - If a large number in their community were HIV positive, how it would affect them as a community.

7. Educating the general community, the parents and school staff as well as children could contribute to creation of a non-stigmatizing environment for the children of HIV positive parents and those who are infected themselves. AIDS education helps in making the community become aware and understand the disease. They realize that this is not a disease which spreads through casual contact and therefore, they are unlikely to get it through that route. Counselling helps people to understand the consequences for themselves and for others of their risk behaviour, define their potential for changing risk behaviour to protect both their own health and the well being of others, find and use the personal and social resources necessary for starting and maintaining behavioral change or managing illness, and access facilities for voluntary testing with pre and post test counselling. Finally, group interventions that facilitate interactions with and among people with HIV/AIDS will help to decrease rejection and stigma while providing education, social support and role models, for coping with illness. Peer groups can be focused or targeted to a specific audience.