Guidelines for Health Education and Risk Reduction Activities

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ACKNOWLEDGEMENTS

Centers for Disease Control and Prevention

John Katz, BA
Iowa Department of Public Health

Andrew Lentz, MPA
Baltimore City Health Department

Rita LePicier
KCET-TV Educational Enterprises

Steve Lew
GAPA Community HIV Project

Lynn Lisella, MS
Centers for Disease Control and Prevention

Carol Marquez-Baines
American Indian Health Care Association

Doug McBride, BA
Texas Department of Health

Ann McLendon, MEd, CHES
Connecticut Department of Public Health

Henry Montes, MPH
Centers for Disease Control and Prevention

Henry Murdaugh
South Carolina Department of Health and
Environmental Control

Judy Norton
Arizona Department of Health Services

Tim Offutt, MPA, BS
San Francisco Department of Public Health

Lorenzo Olivas, BS, CHE
New Mexico Health Department

Concha Orozco, MA
National Coalition of Hispanic
Health and Human Services Organizations

Maurico Palacio, MSH Ed
Colorado Department of Health

Les Pappas, MPA
San Francisco AIDS Foundation

Thomas A. Peterman, MD, MSc
Centers for Disease Control and Prevention

Randall Pope, BS

Michigan Department of Public Health

Jeanne Pruyn, MS, CHE
Florida Department of
Health and Rehabilitative Services

Linda Robb, MSW
City of Philadelphia Department of Public
Health

Hart Roussel, MDiv
Whitman-Walker Clinic, Inc.

Ronald M. Rowell, MPH
The National Native American AIDS
Prevention Center

Idalia Sanchez, MPH
Connecticut Department of
Public Health and Addiction Services

Tonia Schaeffer, MPH
Chicago Department of Health

Carol Schechter, MA, MPH
Academy for Educational Development

John F. Schunhoff, PhD
Los Angeles Department of Health Services

Richard Scott, PhD
Philadelphia Department of Health

Michael J. Siska, MS, BS
Leo Burnett Company, Chicago, Illinois

Bonnie B. Sitko, MPH
State of Florida Department of Health and
Rehabilitative Services

Walter Smith
Austin, TX

Nancy Kay Sullivan, MPH, CHES
Mississippi State Health Department of Health

S. F. Tomajczyk
New Hampshire Division of Public Health
Services

Ronald O. Valdiserri, MD, MPH
Centers for Disease Control and Prevention

Robert R. Waller, DDS, MPH
Centers for Disease Control and Prevention

Claudia Webster
Oregon State Health Division

Reginald Williams

National Task Force on AIDS Prevention

Toni Young
National Women and HIV/AIDS Project

GENERAL CONSIDERATIONS REGARDING HEALTH EDUCATION AND RISK REDUCTION ACTIVITIES

Introduction

Preventing the spread of human immunodeficiency virus (HIV) and sexually transmitted disease (STD) requires a comprehensive strategy composed of service delivery systems coupled with effective, sustained health education and health promotion interventions. These individual components of a prevention program must not operate in isolation, but must work together toward the well-being of the person at risk and the community as a whole. All education activities related to HIV/STD prevention should contribute to and complement the overall goal of reducing high-risk behaviors.

The guidelines presented in this document are written to encourage HIV/STD prevention programs to focus on developing programs and services that are based on health education and health promotion strategies. In *Health Behavior and Health Education*: Theory, Research, and Practice, the authors describe the ultimate aims of health education as being "positive changes in behavior" (Glanz et al., 1990, p.9). Green and Kreuter further define health promotions as ". . . the combination of educational and environmental supports for actions and conditions of living conducive to health" (Green and Kreuter, 1991).
Health education is a powerful tool in an epidemic in which the behavior of using a latex condom can make the difference in whether or not a person becomes infected with HIV.

It is critically important that members of the populations to be served are involved in identifying and prioritizing needs and in planning HIV/STD education interventions. Their involvement ensures that decisions are made, purposes are defined, intervention messages are designed and developed, and funds are allocated in an informed and realistic manner. Limited educational resources can be proactively directed to specific populations, rather than reactively directed or directed on the basis of guesswork or stereotyping.

Moreover, to be effective, an education intervention must be culturally competent. Participation of client populations throughout the process of designing and implementing programs helps assure that the program will be acceptable to the persons for whom it is intended. For the purposes of this document, cultural competence is defined as the capacity and skill to function effectively in environments that are culturally diverse and that are composed of distinct elements and qualities. Cultural competence begins with the HIV/STD professional understanding and respecting cultural differences and understanding that the clients' cultures affect their beliefs, perceptions, attitudes, and behaviors.

Health departments across the country have implemented an HIV prevention community planning process whereby the identification of a community's high priority prevention needs is shared between the health departments administering HIV prevention funds and representatives of the communities for whom the services are intended. The HIV prevention community planning process begins with an accurate epidemiologic profile of the present and future extent of HIV and acquired immunodeficiency syndrome (AIDS) in the jurisdiction. Special attention is paid to distinguishing the behavioral, demographic, and racial/ethnic characteristics of the epidemic. This is followed by an assessment of HIV prevention needs that is based on a variety of sources and is collected using different

assessment strategies. Next, priorities are established among needed HIV prevention strategies and interventions for specific populations. From these priorities, a comprehensive HIV prevention plan is developed.

Of the eight essential components of a comprehensive HIV prevention program that are described in the community planning guidance document issued by CDC, four relate specifically to the interventions described in these Guidelines. These are as follows:

- *Individual* level interventions which provide ongoing health communications, health education, and risk reduction counseling to assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices which prevent transmission of HIV, and they help clients make plans to obtain these services.

- Health communications, health education, and risk reduction interventions for *groups*, which provide peer education and support, as well as promote and reinforce safer behaviors and provide interpersonal skills training in negotiating and sustaining appropriate behavior change.

- *Community level* interventions for populations at risk for HIV infection, which seek to reduce risk behaviors by changing attitudes, norms, and practices through health communications, prevention marketing,[1] community mobilization/organization, and community-wide events.

- *Public information* programs for the general public, which seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention in the community.

More information on the HIV prevention community planning process is contained in the *Handbook for HIV Prevention Community Planning* (Academy for Educational Development, 1994) or from the HIV/AIDS Program in your local health department. All HIV health education and risk reduction activities should complement and support the priorities established in the HIV prevention comprehensive plan developed by the local HIV prevention community planning group.

For the purpose of this document, communities are defined as social units that are at least one of the following: functional spatial units meeting basic needs for sustenance, units of patterned social interaction, or symbolic units of collective identity (Hunter, 1975).

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[1] Prevention marketing is CDC's adaptation of social marketing in which science-based marketing techniques and consumer-oriented health communication technologies are combined with local community involvement to plan and implement HIV/AIDS prevention programs. Essentially, Prevention marketing = social marketing + community involvement.

Communities are selected for interventions based on their specific and identified needs and on surveillance and seroprevalence data.

The recommendations in this document recognize that while communities may have different approaches to HIV/STD prevention programs, certain basic programmatic, management, and staff requirements are common to effective health education and risk reduction activities. These **Guidelines** describe the core elements that are essential for success in a number of types of health education and risk reduction activities -- Individual and Group Interventions and Community-level Interventions -- and in public information activities.

These **guidelines** are provided to assist program planners in enhancing their health education and risk reduction activities. In some cases, specific programs of state and local health departments have advanced beyond the basic steps outlined here. In other instances, programs may benefit greatly from these suggestions. The priority activities described in this document can be used in a variety of settings and can also be applied to other health issues.

Core Elements of Health Education and Risk Reduction Activities

A number of core elements should be considered in health education and risk reduction program and evaluation activities.

Effective Health Education and Risk Reduction program activities:

- State realistic, specific, measurable, and attainable program goals and objectives.
- Identify methods and activities to achieve specific goals and objectives.
- Define staff roles, duties, and responsibilities.
- Define the populations to be served by geographic locale, risk behavior(s), gender, sexual orientation, and race/ethnicity.
- Assure that educational materials and messages are relevant, culturally competent, and language- and age-appropriate.
- Include professional development for all program staff.
- Include a written policy and personnel procedures that address stress and burnout.
- Include written procedures for the referral and tracking of clients to appropriate services outside of the agency.
- Provide for collaboration with other local service providers to assure access to services for clients.
- Assure confidentiality of persons served.

Effective Health Education and Risk Reduction evaluation activities:

- Include process evaluation. (See Appendices.)
- Require consistent and accurate data collection procedures, including number of persons served, quantity and type of literature or materials distributed, and

demographics of persons served. A description of the tools to be used and definitions of various measurements (e.g., "unit of service" and "contact") should be outlined.

- Include staff supervision, observation, evaluation, and feedback on a regular basis. (See Appendices B-D.)
- Include feedback from persons served.
- Designate staff who are responsible for evaluation and quality assurance activities, for compiling and analyzing data, and for documenting and reviewing findings.
- Define methods for assessing progress toward stated process goals/outcome objectives.
- Include mechanisms for measuring the use of referral services.
- Provide findings for program modifications.

Core Training for Health Education and Risk Reduction Activities

Staff training is an important element in the development of a sound program. The suggested areas in which health education and risk reduction staff should receive training are listed below. Not all staff members should receive training in all the listed areas. The outlined training areas provide various program and management staff with the specific technical support necessary to implement their component of the health education and risk reduction program.

Effective training plans for Health Education and Risk Reduction staff:

- Provide basic HIV, STD, and tuberculosis (TB) health education information.
- Provide bleach use instruction.
- Increase knowledge of substance use/abuse.
- Provide orientation to human sexuality, including diverse lifestyles and sex practices.
- Enhance sensitivity to issues for persons living with HIV/AIDS and STDs.
- Recognize cultural diversity and enhance cultural competence.
- Provide an orientation to the agency, community, and available community resources.
- Include ongoing professional development for staff.
- Provide opportunities for role play, observation, and feedback, including the use of video replay where possible.
- Provide training in the dynamics of community and agency collaboration.
- Enhance basic health education concepts.
- Provide orientation to community resources.
- Identify additional sources for updated information.
- Build communication skills (e.g., active and reflective listening, clear speaking).
- Provide for regular updates on analyses and programmatic interpretations of data.
- Provide training on program planning, operations, and supervision.
- Provide orientation to safer sex guidelines.
- Provide training on developing HIV/AIDS publications and resources.
- Enhance basic knowledge of family planning and contraception.
- Increase knowledge of treatment and therapy for people living with HIV and AIDS.

- Provide training on crisis intervention.
- Provide training on street and community outreach.
- Provide ongoing discussion on grief and bereavement.
- Provide training on confidentiality and privacy.

Community Needs Assessment

The HIV prevention community planning process requires an assessment of HIV prevention needs based on a variety of sources and different assessment strategies. This assessment serves as the basis for the development of a comprehensive HIV prevention plan. In addition, more targeted needs assessment may be needed for effective health education program planning for health departments and non-governmental organizations (NGOs). Tailored needs assessments enable the program planner to make informed decisions about the adequacy, availability, and effectiveness of specific services that are available to the target audience.

For the purposes of developing specific health education and risk reduction activities, a targeted needs assessment assists in the following:

- Establishing appropriate goals, objectives, and activities.
- Defining purpose and scope.
- Identifying social/behavioral attitudes, behaviors, and perceptions of the target community.
- Providing the basis for evaluation as part of formative and summative studies of interventions.
- Establishing community-based support for the proposed activities.

The needs assessment may be informal or formal. An informal needs assessment may occur through frequent conversations and personal interactions with colleagues and clients. Staff and clientele interact with each other when services are being delivered; therefore, clients may inform them about services they find useful or unsatisfactory. Also, staff meetings are a vehicle for sharing and transferring information among colleagues. Through both of these processes, staff can usually determine whether there are gaps in services.

A formal needs assessment involves a systematic collection and analysis of data about the client population. This process may uncover needs that may not be identified through an informal process.
A formal needs assessment requires the program planner to do the following:

- Identify questions that need to be answered.
- Determine how the information will be collected and from whom.
- Identify existing sources of data, e.g., needs assessment data from the HIV prevention community planning group.
- Collect the data.
- Conduct a comprehensive analysis of the data.

The program staff should review data from the HIV prevention community planning needs assessment to determine what additional information is needed. A variety of information would be useful in developing program activities, including the following:

- Socioeconomic and demographic status of the overall community and the specific populations being targeted.
- Current statistics and trends involving HIV/STD disease.
- Existing gaps in HIV/STD programs and services.
- Social indicator data to examine significant and relevant factors that influence prevalence of HIV/STD disease, e.g., substance abuse, teenage pregnancy.
- Identification of other programs and resources that focus on the same target audience.

Before conducting a needs assessment, program staff should consult with community leaders from the client or target populations. This is important in order to determine the leaders' perceptions of their communities' needs, to discuss the agency's plan for conducting the assessment, and to begin to cultivate a working relationship with the leaders in order to attain community support for the proposed activities.

How to Conduct a Needs Assessment

- Identify sources of information and data.
- Review existing literature on the specific problem.
- Survey other agencies/organizations in the community to avoid unnecessary overlap in program activities and to identify emerging issues and new resources.
- Interview key informants and community members who have knowledge of or experience with the problem.
- Consult with national/state agencies where specific data, literature, or experience are deficient.

How Needs Assessments Affect Program Evaluation

A needs assessment is a component of program evaluation. Each element of a needs assessment plays a significant role in the planning, implementation, and management of effective education programs. If a program is to be evaluated, the degree to which the program addresses the needs of the target audiences must be examined.

Both qualitative and quantitative methods of data collection and evaluation are useful. Qualitative methods afford the target audiences an opportunity to express their thoughts, feelings, ideals, and beliefs. Examples of qualitative methods include informal interviews, focus groups, and public forums. These methods are designed to assist the program staff in identifying problems or gaps that the agency may not have recognized, e.g., barriers to service delivery and client dissatisfaction.

Quantitative methods render statistical information. Examples include questionnaires and surveys, results of studies of the client populations' attitudes and beliefs about HIV/STD

disease, and information derived from program activities, e.g., number of condoms distributed and documented requests for services.

Note: For further reading on needs assessment, see "Chapter 5: Assessing and Setting Priorities for Community Needs," *Handbook for HIV Prevention Community Planning, Academy for Education Development*, April 1994.

Collaborations and Partnerships

The HIV prevention community planning process calls for health departments and affected communities to collaboratively identify the HIV prevention priorities in their jurisdictions. However, some members of these affected communities distrust health departments. They may feel that government officials have not traditionally reached out to them until certain health issues have also threatened the greater public health, i.e., the majority community. Sexually transmitted diseases, other communicable diseases, and substance abuse have long been problems in disadvantaged and disenfranchised communities. Injecting drug users (IDUs) were dying of endocarditis, hepatitis B, and drug overdose long before AIDS. For years, the tuberculosis epidemic persisted in poor African American and Hispanic neighborhoods, while prevention and treatment resources dwindled. Consequently, developing collaborative working relationships with affected communities for the purpose of HIV prevention may pose special challenges to many state and local health departments.

In the United States, public health officials frequently underestimate the strengths and resourcefulness of affected communities. As a result, state and local health departments and communities have seldom come together in partnership. In many instances, state and local health departments have not sought the support of, or consulted with, community members before designing and implementing community intervention efforts. At times, public health officials may have inadvertently stigmatized communities in their attempts to intervene and promote public health.

Affected communities are acutely aware of the peculiarities of public health as it relates to them. Some have asked, "Is this a war on drugs or on us" Despite government support for community-base and HIV prevention community planning, many communities remain wary of public health programs as they have been implemented by officials in their communities.
As if this lack of confidence were not challenging enough to state and local health departments, many communities genuinely suspect conspiracy when health officials implement programs for them. Many disadvantaged, disenfranchised persons not only distrust the government, but they may also fear it. For African Americans, the Tuskegee Study continues to cast its own specter of doubt as to whether or not public health officials are truly committed to ensuring the public's health. Hispanic farm workers continue to struggle with government pesticide regulators who seem indifferent to the dangers that farm workers face in the workplace. For Native Americans living on reservations, the quality of health is chronically poor, and life expectancy is diminished. Within many communities, there is a pervasive belief that the government "does not care," or worse, that it "will experiment on them."

Although the AIDS epidemic has illustrated the real value of developing partnerships among local and state health departments and communities, achieving communication, collaboration, and cooperation with these communities and maintaining the relationships in a climate of distrust, apathy, and even fear is daunting. Such a task will surely require cultural sensitivity, competency, respect, and the most critical of all elements, time.

In particular, for an effective HIV prevention community planning process, state and local health departments must develop strong linkages and collaborations with affected communities. A working definition of collaboration is *the process by which groups come together, establishing a formal commitment to work together to achieve common goals and objectives*. Collaborative relationships are also referred to as coalitions or partnerships. Regardless of the term, the concept is a crucial one.

To facilitate the formation of effective community planning groups and other partnerships, health departments need to understand not only the knowledge and behaviors of their client populations, but also their attitudes toward and beliefs about their own communities, the government, and public health. Health departments will want to assess these same issues among their own employees. In addition to this understanding, to fully achieve cultural competence, to have the capacity and skills to effectively function in environments that are culturally diverse and composed of distinct elements and qualities, health department professionals must also develop a respect for cultural differences. They must appreciate how culture and history affect their clients' perceptions, beliefs, attitudes, and behaviors, as well as their own.

For many health departments and community organizations, responding to the AIDS epidemic means long-term institutional change. Simply channeling HIV resources to affected communities through community-based and national non-go formation of real working relationships among partners who perceive each other as equal. The community planning process addresses these issues by emphasizing the importance of assuring representation, inclusion, and parity in the planning process.

An important program objective for health departments may be to gain acceptance and credibility in the communities they seek to serve. To assume that these will come automatically or even easily may demonstrate cultural insensitivity and incompetence. Respect and regard for the perceptions of those being served will help eliminate barriers to HIV prevention and will build the bridges to better health.

How Can Collaborations Help?

Collaborations can:

- Facilitate strategic planning.
- Help prevent duplication of cost and effort.
- Maximize scarce resources.
- Integrate diverse perspectives to create a better appreciation and understanding of the community.
- Provide comprehensive services based on the client's needs.

- Increase client accessibility to health services.
- Improve communication between the health department and its constituents.
- Provide liaison for clients unwilling to seek services from government organizations.

At the same time, public health agencies must be aware of some of the difficulties inherent in collaborative relationships:

- Organizations and individuals may have hidden agendas.
- Intra-agency trust may be difficult to develop.
- Decision-making processes may become complicated.
- Organizations have to collectively take the responsibility for program objectives, methods, and outcomes.
- The group may lack a clear sense of leadership and direction.
- The group may lack a clear sense of its tasks and responsibilities.

What Influences the Success of a Collaborative Effort?

Many factors influence the success of a collaborative effort; however, the following factors are vital:

- The group must develop a sense of mutual respect, trust, purpose, and understanding.
- There must be an appropriate representation of groups from all segments of the community for whom the activities will have an impact.
- All members must "buy into" and develop ownership in the development and outcome of the process.
- Effective communication among members must be constant and ongoing.
- The group must position itself as a leader in the community, eager to work with persons from all communities in developing effective prevention strategies.
- The group must be willing to try non-traditional strategies.

The development and maintenance of collaborative relationships are challenging and rewarding tasks. Collaborations can make positive, significant changes in communities, if they are developed in a way that is culturally competent and respectful of the people for whom interventions will be developed. Health departments must also consider whether efforts are cost-efficient, appropriate, duplicative, and accessible; they must determine where community-based organizations fit into the overall realm of prevention activities. Collaborations should be structured with long-term results in mind. They should serve as a bridge to better relations between state and local health departments and the community, ultimately effecting better health in the community.

Contracting With Community-Based Organizations

Request for Proposals

In many cases, a health department may determine that the best approach for reaching affected populations is by contracting with community-based organizations that have experience serving specific populations. In these situations, the health department may issue a Request for Proposals (RFP) from community-based organizations. The RFP

should be clear and directive to assure that proposals will address the areas that have been identified as priorities. The RFP might require the following:

- Specific, time-phased, and measurable program objectives and program plans that target populations whose behaviors place them at high risk for HIV, STD, and tuberculosis (TB).
- Interventions that are:
    - culturally competent (function effectively in environments that are culturally diverse and composed of distinct elements and qualities);
    - sensitive to issues of sexuality and sexual identity;
    - developmentally appropriate (provided at a level of comprehension that is consistent with the learning skills of persons to be served);
    - linguistically specific (presented in dialect and terminology consistent with the target population's native language and style of communication); and
    - educationally appropriate.
- Coordination and collaboration with other organizations and agencies involved in HIV/STD prevention programs, particularly those targeting the same populations.
- An evaluation plan.

The RFP also should be clear in outlining the eligibility requirements. A CBO may be defined as:

- A tax-exempt organization.
- An organization with a significant number of the affected populations in key program positions.
- An organization with an established record of service to affected communities.

The following additional points should be considered in the RFP process:

- RFPs should be disseminated widely.
- The initial award should be competitive; multi-year assistance is allowable only after an initial competitive award.
- A procedure should be in place to assure that funds are awarded to CBOs in a timely manner, no longer than 90 days.
- The RFP should provide details on the application procedures and how eligible applicants can obtain technical
- assistance in the application process, including a contact person and phone number.

Review Process

A review panel should judge applications strictly against the criteria outlined in the RFP. Members of the review panel should include qualified persons representing the target communities who do not have a conflict of interest in reviewing proposals. Other criteria for membership to the review panel should include the following:

- Members who reflect the characteristics of the epidemic in the population.

- Members who have expertise in understanding and addressing the specific HIV prevention needs of the populations they represent.

Technical Assistance

A person or organization (on staff or through contract) should be designated as the health department resource for technical assistance (TA) to CBOs.

Types of technical assistance should include the following:

- Assessing current and projected needs for HIV/STD prevention and early medical intervention.
- Developing strategies for meeting identified needs.
- Developing strategies for overcoming barriers to prevention.
- Planning, implementing, and evaluating prevention programs.
- Providing program management.
- Establishing a protocol for active monitoring and quality assurance (QA) of CBO activities.

As previously stated, linkages and coordination among organizations providing HIV/STD prevention activities are essential. This is particularly important among funded CBOs and health departments to avoid gaps in services and duplication of services. The HIV prevention community planning process plays a major role in assessing needs and identifying overlapping services.

In addition to contracting with CBOs, many health departments have full-time staff whose primary responsibility is to provide health education and risk reduction services to affected populations. The criteria outlined in these Guidelines apply consistently to services provided directly by health department staff as well as those provided through a contract with a community-based organization.

Note: For further reading on collaborations and partnerships see Chapters 1-3, *"Handbook for HIV Prevention Community Planning,"* Academy for Educational Development, April 1994. For further reading on contracting with CBOs, see *Cooperative Agreements for Human Immunodeficiency Virus (HIV) Prevention Projects Program Announcement and Notice of Availability of Funds for Fiscal Year 1993.*

HEALTH EDUCATION AND RISK REDUCTION ACTIVITIES

Individual and Group Interventions

Health education and risk reduction activities are targeted to reach persons at increased risk of becoming infected with HIV or, if already infected, of transmitting the virus to others. The goal of health education and risk reduction programs is to reduce the risk of these events occurring. Activities should be directed to persons whose behaviors or personal circumstances place them at risk. Street and community outreach, risk reduction counseling, prevention case management, and community-level intervention have been identified as successful health education and risk reduction activities.

Street and Community Outreach

Street and community outreach can be described as an activity conducted outside a more traditional, institutional health care setting for the purposes of providing direct health education and risk reduction services or referrals. However, before conducting any outreach activity in a community, an agency must define the specific population to be served and determine their general needs. Based on this definition and determination, an agency can then decide appropriately *where* to conduct intervention efforts. Street and community outreach may be conducted anywhere from a street corner to a pool hall, from a parish hall to a school room. To determine the setting, an agency need only decide that the setting is easily, readily, and regularly accessed by the designated client population.

Outreach demonstrates an agency's willingness *to go* to the community rather than *wait* for the community *to come* to it. Often, agencies enlist and train peer educators to conduct the outreach activities. It is recommended that the content of the outreach activity be contingent upon the setting. The nature of activity varies in scope and intensity; the activity is best determined before an outreach team or individual educator goes out. Yet, flexibility is also very important. Remember, *everything is not appropriate everywhere, all of the time*. A street corner may be an appropriate place to conduct a brief HIV risk assessment, but it is not an appropriate place to conduct HIV counseling and testing.

While street and community outreach can be complementary service components of a single agency, some agencies, based on needs assessment findings and staff capacity, may choose to provide one service and not the other. Street outreach and community outreach can also be "stand alone" pieces.

Street Outreach

Street outreach commonly involves outreach specialists moving throughout a particular neighborhood or community to deliver risk reduction information and materials. The outreach specialist may set up an HIV/AIDS information table on a street corner. They may supply bleach to injecting drug users at shooting galleries and condoms to commercial sex workers and their customers at the hotels or locations that they frequent. The fundamental principle of street outreach is that the outreach specialist establishes face-to-face contact with the client to provide HIV/AIDS risk reduction information and services.

Effective street outreach staff:

- Know the target group's language.
- Have basic training and experience in health education.
- Are sensitive to community norms, values, cultural beliefs, and traditions.
- Have a shared identity with the population served, stemming from shared common personal experiences with the group.
- Are trusted by the group they serve.
- Act as role models to the clients they serve.
- Advocate for the population served.
- Act as liaisons between the community and the agency.
- Are informed about community resources and use them.

Street outreach is not simply moving standard agency operations out onto the sidewalk. A number of specific issues are unique to the delivery of services through this type of outreach and must be considered before instituting a program of street outreach. These matters are usually addressed in an agency's street outreach program plan and include the following:

- Regular contact among educators, outreach specialists, and supervisors.
- Observation of potential outreach areas to determine the locations, times of day, and the day of the week that are most
- productive for reaching the population to be served.
- A written and comprehensive field safety protocol that is regularly updated. (See Figure 1 Table Fig1.)
- Establishment of and adherence to regular and consistent schedules of activities, including times and locations. (See
- Figure 2 Table Fig2.
- A mechanism for measuring the use of referral services.
- Creation and maintenance of a positive relationship between the agency and the local law enforcement authorities.
- Identification and development of collaborative relationships with gatekeepers (key informants) in the community.
- Activities for building and earning the trust and respect of the community.
- Descriptions of skills-building exercises relevant to stated program objectives.
- Establishment of mechanisms for maintaining client confidentiality.

Figure 1
Field Safety Protocol

Field safety protocols are based on program activities and are intended to provide the staff and peer educators with guidance regarding their professional behavior.

- Carry picture identification (I.D.) at all times that includes name of the organization, name of the project, your name, and the purpose for your presence.

- Work in pairs and **always know where your partner is**.

- Establish a mechanism to keep your supervisor aware of your location and activities (e.g., carry a beeper, call telephone mailbox at a specified time).

- Establish contact with local police precincts in the area. Leave copy of I.D. with the commander. If appropriate for your program, maintain relations with the police; introduce the program and staff.

- Have contingency plans for worst case scenarios and share them with your partner.

- Make sure you have made contact with and have permission from a key person in the community before entering the setting in which you will conduct the intervention (e.g., shooting galleries, crack houses, or local high schools).

- Leave the area if tension or violence is observed or perceived.

- Avoid controversy and debate with clients and program participants.

- When you start your job as a peer educator in the field, get a TB skin test; you should be re-tested periodically thereafter.

- Be aware of weather conditions and be prepared for natural occurrences.

- Design and adhere to a schedule for outreach or peer education.

- Avoid drinking alcoholic beverages and buying, receiving, or sampling drugs while conducting outreach or peer education.

Figure 2
EXAMPLE OF WEEKLY OUTREACH SCHEDULE

	8 a.m.- 12 noon	1-5 p.m.	6-8 p.m.
MONDAY	no activity	no activity	no activity
TUESDAY	office staff meeting	homeless shelter IDU outreach	methadone clinic client presentation
WEDNESDAY	STD clinic waiting room	city park IDU outreach	no activity
THURSDAY	office paperwork and data analysis	street work 10th and Vine IDU outreach	no activity
FRIDAY	office materials development	motel alley sex worker/IDU outreach	shooting gallery outreach
SATURDAY	no activity IDU outreach	city park 10th and Vine IDU outreach	street work
SUNDAY	no activity	no activity	no activity

Community Outreach: Workshops and Presentations

Workshops and presentations are typical activities of community outreach. Because they usually follow lecture formats, they can be highly structured health education and risk reduction intervention efforts. While they supply important opportunities to disseminate HIV/AIDS prevention information, their impact on behavior change is limited because they are usually single-encounter experiences. Although they provide crucial technical information that raises awareness and increases knowledge and may be a critical first step in the change process, the information alone is usually inadequate to sustain behavior change.

To maximize their benefit, workshops and presentations should be planned carefully with knowledge goals and objectives specified before the individual sessions. To the extent possible, presenters should be informed about the setting where the workshop or presentation will take place, as well as the composition and knowledge level of the anticipated audience. The following are examples of issues the presenter might consider before conducting a presentation or workshop:

- Where will the workshop or presentation be held?
- What is the age range of the participants/audience?
- What is the language(s) of the participants/audience?
- What audiovisual equipment is available?

A well-planned, detailed outline, which allows flexibility, can prove useful and beneficial to the presenter and the participants/audience. Such an outline helps keep the presentation on track and focused. If a pretest evaluation is to be used, an outline can ensure that all relevant material will be covered in the lecture.

In a workshop or presentation, audience participation is to be strongly encouraged. Time must be allotted, usually at the end of the presentation, for a question and answer session. However, some questions may be so pressing, or some participants so persistent, that the presenter will have to address some questions and concerns during the presentation. The presenter should answer the questions succinctly and return to the original order of the presentation.

To increase the number of workshops and presentations they are able to provide, some agencies will elect to develop speaker's bureaus to augment their paid staff. Recruitment, training, and retention of volunteers present complex programmatic questions and are not to be undertaken lightly. Several references related to volunteers are provided at the end of this document and should be reviewed carefully.

A more detailed list of important points to consider for workshops and presentations is contained in Appendix C. The points below are relevant to agencies providing workshops and presentations either by paid staff or by volunteers in a speaker's bureaus. Effective presenters:

- Possess organizational and public speaking skills.
- Are well informed and comfortable talking about the subject.

- Ensure that the presentation is linguistically appropriate for the audience.
- Elicit and encourage audience participation.
- Are adaptable to logistics and audience needs.
- Are non-judgmental.
- Assess the nature of questions to make appropriate responses, i.e., whether better answered in private.
- Seek accurate answers to difficult questions and provide information in a timely manner.

A few items specifically needed in a Community Outreach Program Plan are listed below.

- A comprehensive workshop/presentation curriculum. (See Appendix C.)
- Assurance that curricula provide for discussion of related issues.
- Detailed workshop/presentation outlines.
- Logistical guidance for workshops/presentations (e.g., time and location, room arrangement, number of participants,
- number of facilitators).
- Methods to assure that the audience is informed about workshop/ presentation goals and objectives and that discussion
- of subject matter is facilitated.
- Descriptions of skills-building exercises relevant to stated program objectives.
- Training in the operation of audiovisual equipment and the use of diverse forms of audiovisual equipment.
- Recruitment of staff with organizational and public speaking skills.

Peer Educators

Agencies that provide street and community outreach will frequently engage peer educators to conduct intervention activities. Peer education implies a role-model method of education in which trained, self-identified members of the client population provide HIV/AIDS education to their behavioral peers. This method provides an opportunity for individuals to perceive themselves as empowered by helping persons in their communities and social networks, thus supporting their own health enhancing practices. At the same time, the use of peer educators sustains intervention efforts in the community long after the professional service providers are gone.

Effective peer educators:

- Have a shared identity with the targeted community or group.
- Are within the same age range as the targeted community or group.
- Speak the same "language" as the community or group.
- Are familiar with the group's cultural nuances and are able to convey these norms and values to the agency.
- Act as an advocate, serving as a liaison between the agency and the targeted community or group.

Peer education can be very powerful, if it is applied appropriately. The peer educator not only teaches a desired risk reduction practice but s/he also models it. Peer educators demonstrate behaviors that can influence the community norms in order to promote HIV/AIDS risk reduction within their networks. They are better able to inspire and encourage their peers to adopt health seeking behaviors because they are able to share common weaknesses, strengths, and experiences.

Agencies often recruit and train peer educators from among their client populations. However, not everyone is an educator. The model client does not necessarily make the model teacher, no matter how consistently s/he practices HIV/AIDS risk reduction or is liked by agency staff. Peer educators should be instinctive communicators. They should be empathetic and non-judgmental. They should also be committed to client confidentiality.

Peer educators will not replace an agency's professional health educators, but they can complement the intervention team and enhance intervention efforts. Peer educators may act as support group leaders or street outreach volunteers who distribute materials to friends. They may be members of an agency's speaker's bureau and give workshop presentations.

They may run shooting galleries, keeping bleach and clean water readily available to other (IDUs). They may be at-risk adolescents who model responsible sexual behaviors. The role of the peer educator is determined by the intervention need of the client population and the skill of the peer educator.

Although some agencies will hire peer educators as paid staff, others will not. As in the case of speaker's bureaus, engaging volunteer peer educators also involves issues of volunteer recruitment, training, and retention. Several references in the list of publications included at the end of this document provide more information on this issue. In addition to the core elements identified for health education and risk reduction activities, an effective peer education program plan contains the following:

- A written and comprehensive field safety protocol. (See Figure 1 Table Fig1.)
- Establishment of and adherence to regular and consistent schedules of activities, including times and locations. (See
- Figure 2 Table Fig1.
- A description of skills-building exercises relevant to the stated program objectives.

Risk Reduction Counseling

The purpose of risk reduction counseling is to provide counseling and health education interventions to persons who are at high risk for HIV infection. The interventions promote and reinforce safe behavior. The participants may range from a single individual to couples, families, groups, or entire communities.

Risk reduction counseling is interactive. Such counseling assists clients in building the skills and abilities to implement behavior change. These programs offer training in the interpersonal skills needed to negotiate and sustain appropriate behavior changes. For example, sessions could concentrate on delaying the initiation of sexual activity, on methods for avoiding unsafe sex and negotiating safer sex, and on techniques to avoid sharing injecting drug paraphernalia. Risk reduction may be implemented in a variety of formats. The interventions may take the form of role plays, safer sex games, small group discussion, individual counseling, or group counseling.

Effective risk reduction counseling sessions:

- Emphasize confidentiality.
- Begin with an assessment of the specific HIV/STD prevention needs of the client(s).
- Identify, with the group or individual, the appropriate goals/ objectives (e.g., condom use negotiation skills for female sex
- partners of IDUs).
- Use skills-building exercises designed to meet the specific needs of the client(s).
- Include negotiations with the client(s) on suggestions and recommendations for changing and sustaining behavior change
- as appropriate to their situation.
- Enable/motivate participants to initiate/maintain behavior change independently.
- Enhance abilities of the participant(s) to access appropriate services (e.g., referrals to drug treatment).

Risk Reduction Program Plans

An effective risk reduction program plan includes the following:

- Protocols and procedures specific to each activity and logistical check lists for implementation.
- Development of innovative behavior modification strategies.
- Provision for regular updates in techniques for skills building.
- Provisions for updates on client-focused approaches to risk reduction activities.
- Provision for updates in techniques for increasing facilitators' skills in managing group or one-on-one dynamics.

Conducting Groups

Groups can provide significant informational and therapeutic HIV risk reduction interventions to individuals who are ready to initiate and/or maintain specific health promoting behaviors. Groups are usually formed around common issues or problems. Some groups, originally established to provide information and skills training, may evolve into support groups, which encourage maintenance of newly acquired behaviors. Utilizing groups suggests a systems approach to intervention. Groups provide access to

social networks that enable and reinforce health enhancing behavior change through peer modeling and peer support.

Although open-ended groups (e.g., support groups) may have less structure than the more close-ended kinds of groups (e.g., educational or skills-building), both types should have clearly defined goals/objectives and specifically defined processes. The structure of a group should be determined based upon the needs of the members.

At times, the open-ended group with its open enrollment and extended life is more suited to members' needs. By being open-ended, potential members are able to drop in when they need to and thus avoid the wait for new groups to form. This type of group is likely to appeal to the individual whose commitment to the group's process is initially limited. In the open-ended group, members determine their own topic of discussion at each meeting. For this reason, an open-ended model, that encourages drop-ins, is perhaps less amenable to instructional sessions which usually need to build on information presented at earlier meetings. The open model, because of its unpredictable structure and enrollment, may be more amenable to process evaluation (i.e., percentage of agency's clients attending a determined number of sessions).

The close-ended model will have a defined lifespan and is also likely to set membership limits. The closed group allows for important continuity and facilitating the development of trust among members, as they get to know each other over time. Members can expect the same individuals to be present each week, which can aid in building significant, supportive relationships. The closed group model is more suitable to the establishment of client-specific outcome objectives that can be monitored over time (i.e., self-reported reduction in number of sex partners at the end of 8 weeks of group attendance).

There are significant advantages to both open and closed models, and determination of which model to employ is based on the needs of an agency's clients and on an agency's capacity to implement the model. Whatever the model selected, the size of the group is an important consideration. Group facilitation is not crowd control. Smaller groups can be more manageable and result in enhanced group dynamics.

Group facilitators or instructors may be peers or professionals; in some instances, they may be both. They should be skilled at promoting effective group dynamics, encouraging reticent members to speak up and guiding the dominant ones. Skilled facilitators and instructors are astute observers. They not only listen to what is being said, but they also note nonverbal cues. Good observation skills are especially critical for support or therapeutic group facilitators. Skilled facilitators and instructors are able to see changes in body language, hear sighs, and catch subtle changes in facial expressions.

Groups are a naturally occurring phenomenon. People come together for a variety of reasons and left to themselves, they will develop informal but powerful supportive networks. Proactive HIV risk reduction programs can tap into this resource and enhance program effectiveness.

HIV Prevention Case Management

HIV Prevention Case Management (PCM) is a one-on-one client service designed to assist both uninfected persons and those living with HIV. PCM provides intensive, individualized support and prevention counseling to assist persons to remain seronegative or to reduce the risk for HIV transmission to others by those who are seropositive. PCM is intended for persons who are having or who are likely to have difficulty initiating and sustaining safer behavior. The client's participation is always voluntary, and services are provided with the client's informed consent.

Prevention Case Management involves the assessment of HIV risk behavior and the assessment of other psychosocial and health service needs in order to provide risk reduction counseling and to assure psychosocial and medical referrals, such as housing, drug treatment, and other health and social services. PCM provides an ongoing, sustained relationship with the client in order to assure multiple-session HIV risk reduction counseling and access to service referrals. PCM should not duplicate Ryan White CARE Act case management services for persons living with HIV.

Case managers work with clients to assess their HIV risk and psychosocial and medical needs, develop a plan for meeting those needs, facilitate the implementation of the PCM plan through referral and follow-up, provide ongoing HIV risk-reduction counseling, and advocate on behalf of the client to obtain services. HIV Prevention Case Management creates bridges to assist clients in obtaining services with which they are unfamiliar or that pose special barriers to access. Clients are active participants in developing their PCM plan for risk reduction. Prevention Case Management may be carried out in a variety of settings, including the client's home, a community-based organization's office or storefront, clinics, or institutional settings.

Referral services may include HIV counseling and testing services (CT), psychosocial assessment and care, other HIV health education and risk reduction programs, medical evaluation and treatment, legal assistance, substance abuse treatment, crisis intervention, and housing and food assistance. Additionally, HIV PCM services should assist the client in obtaining STD prevention and treatment services, women's health services, TB testing and treatment, and other primary health care services. A strong relationship with STD clinics, TB testing sites, HIV counseling and testing clinics, and other health service agencies may be extremely beneficial to successfully recruiting persons at high risk who are appropriate for this type of intervention. PCM services are not intended as substitutes for medical case management, extended social services, or long-term psychological care.

The case manager needs a thorough knowledge of available community social and medical services as well as HIV prevention, treatment, and related services. This includes specific knowledge of the scope of services available, the protocol for accessing these services, and contact persons working with local agencies. Case managers are usually skilled in providing individual or couples' HIV risk-reduction counseling on an ongoing basis. Case managers usually have an academic background or special training in psychosocial assessment and counseling (e.g., social work, drug and alcohol treatment counseling, nursing, health education). Prevention Case Management supervisors need the academic training and/or experience to adequately develop PCM protocols, case documentation, and policies. The following provides further information on counseling

and testing issue*s: HIV Counseling, Testing, and Referral: Standards and Guidelin*es,
U.S. Department of Health and Human Services, Public
Health Service, Centers for Disease Control and Prevention, May 1994.

Staff Characteristics of the Prevention Case Manager

Effective case managers are:

- Non-judgmental in addressing the needs of the client.
- Empathetic and critical listeners.
- Skilled in dispute mediation.
- Skilled in individual and relationship counseling.
- Skilled in conducting a thorough behavioral risk assessment and psychosocial assessment at client intake and skilled in
- developing an individualized case plan.
- Comfortable working in the home environments of their clients as well as in street settings, if necessary.
- Continually concerned about the protection of the client's rights, including confidentiality, and always respectful of
- guidelines in the agency protocol document.
- Sensitive to the client's ability to read literature and comprehend oral presentations.
- Responsive to the financial resources of clients in regard to case planning and referrals.

Additionally, case managers:

- Maintain communication with case managers from other agencies working with the client to assure a coordinated
- treatment plan.
- Identify resources and services for the client and assist them in accessing service needs.
- Take into account and provide for cognitive impairments that may be related to the health status of the client.
- Reinforce behavioral change accomplished by the client at all opportunities.
- Troubleshoot episodes of client's unsafe behavior and relapse to identify barriers to practicing safer behavior and
- provide support and skills-building counseling.
- Establish a rapport with clients and maintain open communication with them and their partner(s).
- Act as an advocate in gaining access to services for clients.

Characteristics of the Prevention Case Management Program Plan:

- Includes specific, measurable, realistic, and time-phased program objectives.
- Assures that all services in the plan conform to agency policies and local, state, and Federal laws (for example,

- confidentiality of information).
- Assures the development of a written, formal PCM protocol for service delivery.
- Provides for the development of specific, measurable, realistic, and time-phased objectives in each client's case plan.
- Provides for regular meetings with each client to assess changing needs, monitor progress, and revise the service plan
- accordingly.
- Assures that each case manager negotiates a risk reduction plan with the client, referring to the plan at each session in
- order to assess progress.
- Assures the development and use of a comprehensive HIV risk assessment instrument to assess the behavioral variables
- influencing the client's risk taking.
- Assures the development and use of a comprehensive psychosocial assessment instrument to assess psychosocial and
- medical service needs of the client as well as financial resources, language preferences, barriers to accessing these
- services, etc.
- Assures that prevention case managers and their supervisors meet frequently for case presentations and supervision.
- Defines collaboration with other local service providers through memoranda of agreement and regular meetings between
- agencies to facilitate access to other social and health services as well as to discuss and coordinate treatment plans for
- individual clients.
- Assures that the memoranda of understanding among agencies are periodically updated, accurately reflecting
- collaborative activities.
- Assures that the assessment of progress in meeting the case plan is communicated to the client for review and comment.
- Assures that case records include documentation that acknowledges voluntary client participation and mutually
- satisfactory case plans.
- Assures that an updated written or computerized database of service referrals and a system for documenting successful
- referrals are maintained.
- Assures that regularly scheduled staff meetings are held to discuss challenges, successes, and barriers encountered by
- case managers; adequate time must be allocated for staff to share concerns, frustrations, grief, and other emotions
- experienced through the close work with persons at risk or with persons living with HIV.

PCM staff training plans usually include the following:

- Staff training in established PCM protocols, agency policies, and referral mechanisms.

- Periodic training addressing the local services available for client referral.
- Skills training to improve the HIV risk reduction counseling provided to clients.
- Training that addresses how to effectively intervene with clients who are in extreme states, such as persons who are
- combative, in emotional crisis, mentally ill, or under the influence of drugs and/or alcohol.

Community Level Intervention

Community Level Intervention combines community organization and social marketing -- a strategy that takes a systems approach. Its foundation is an assumption that individuals make up large and small social networks or systems. Within these social networks or systems, individuals acquire information, form attitudes, and develop beliefs. Also, within these networks, individuals acquire skills and practice behaviors.

The fundamental program goal of Community Level Intervention is to influence specific behaviors by using social networks to consistently deliver HIV risk reduction interventions. Although the intervention strategy is *community-based*, Community Level Interventions target specific populations -- not simply the *community in general*. The client populations have identified shared risk behaviors for HIV infection and also may be defined by race, ethnicity, gender, or sexual orientation.

In order to influence norms that support HIV risk reduction behavior, Community Level Interventions are directed at the population, rather than at the individual. The primary goal of these interventions is to improve health status by promoting healthy behaviors and changing those factors that negatively affect the health of a community's residents. A specific intervention may take the form of persuasive behavior change messages, or it may be a skills-building effort. Whatever its form, an intervention achieves reduced HIV risk by changing group norms to improve or enhance the quality of health for members of the client, population. These norms may relate to condom use, contraceptive use, or needle-sharing. They may also focus on diagnosis and treatment of sexually transmitted diseases or HIV-anti

It takes time to change social norms. Social norms cannot be changed quickly or at the same rate that knowledge acquisition or skills development can occur. Change occurs as a result of sustained, consistent intervention efforts over time. The intervention must be implemented thoroughly throughout the social networks. A firm grounding in behavioral theory is essential to the development and implementation of Community Level Interventions.

Community-based needs assessment is critical to the development and implementation of Community Level Interventions. This phase is important for identifying and describing structural, environmental, behavioral, and psychological facilitators and barriers to HIV risk reduction. To successfully conduct this intervention, a program must identify the sources for and patterns of communication within a social network. Peer networks must be defined and described.

Note: Community Level Intervention is referred to as Community Intervention Programs in Program Announcement #300.

The following questions should be considered in designing community level interventions:

- Who are the gatekeepers to the client population?
- What are the important points of access?
- What are the appropriate and relevant risk-reduction messages, methods, and materials?
- What are the linguistic and literacy needs of the client population? A needs assessment should yield this vital information.

For further reading on the developmental steps of Community Level Intervention, see *Cooperative Agreement for Human Immunodeficiency Virus (HIV) Prevention Projects Program Announcement and Notice of Availability of Funds for Fiscal Year 1993.*

A variety of methods exists for collecting the answers to these questions. It is recommended that programs select the method that is most appropriate for their professional orientation (e.g., social work, health education). Whatever method is chosen, it is critical that the formative activity be *community-based* and as *collaborative* as possible with the client population.

The information gathered during the formative phase provides the foundation on which an effective program can be built. Completing this activity should result in culturally competent, developmentally appropriate, linguistically specific, and sexual-identity-sensitive interventions that promote HIV risk reduction.

Members of existing and relevant social networks can be enlisted to deliver the interventions. Other peer networks may also be created and mobilized to provide intervention services. This, of course, means volunteer recruitment and management. Community Level Intervention strategies offer opportunities for peers to acquire skills in HIV risk reduction and, in turn, reinforce these abilities when the peers become the teachers of these same skills to others.

In this manner, Community Level Interventions become *community-owned* and *operated*; thus, they are more likely to be sustained by the community when the program activity is completed. Social norms changed in this way are likely to have a long-lasting and effective impact upon HIV risk reduction.

PUBLIC INFORMATION

The Role of Public Information in HIV/AIDS Prevention

Public information activities alone do not represent a sufficient HIV prevention strategy. However, planning and implementing effective and efficient public information programs are essential to successful HIV/AIDS prevention efforts.

As defined here, the purposes of public information programs are to:

- Build general support for safe behavior.
- Support personal risk reduction.
- Inform persons at risk about infection and how to obtain specific services.
- Encourage volunteerism.
- Decrease prejudice against persons with HIV disease.

Public information programs craft and deliver data-driven and consumer-based messages and strategies to target audiences.

The public information program standards and guidelines set forth here are based on CDC's standards for health communication.

Definitions

CDC defines *health communication* as a "multidisciplinary, theory-based practice designed to influence the knowledge, attitudes, beliefs, and behaviors of individuals and communities" (Roper, 1993). Sound health communication practice is based on a combination of behavioral and communication sciences, health education, and social marketing. Current practice extends beyond information dissemination to include a variety of proactive strategies addressing both individual and societal change.

A *communication (public information) program* is the delivery of *planned messages* through one or more *channels* to *target audiences* through the use of *materials*.

Successful public information programs share a number of basic characteristics, which include:

- A person in charge who manages the program well.
- Activities planned to fit what the community and target audience need and want.
- A variety of activities, including mass media, that can be directed over a period of time to the target audience.
- A measurable program objective or purpose.
- A commitment to evaluation -- tracking and measuring progress toward objectives.
- A time schedule.
- Efficient use of people and other resources.

Well-planned and well-executed health communication in public information programs can accomplish the following:

- Raise awareness.
- Increase knowledge.
- Refute myths and misconceptions.
- Influence attitudes and social norms.
- Reinforce knowledge, attitudes, and behaviors.
- Suggest and enable action.
- Show the benefits of a behavior.
- Increase support and/or demand for services.
- Help coalesce organizational relationships.

Public information programs should use multiple approaches to motivate and involve people and communities. Using health communication methodologies, however, is not sufficient to guarantee change. Plans for creating sustained behavior change should include information/communications in combination with other prevention strategies. In this way, effective communications can significantly enable and contribute to change. For example, public information programs funded by CDC carry out parts of CDC's overall HIV prevention strategy. Consumer-influenced messages and strategies are best achieved by a systematic approach involving research, planning, implementation, evaluation, and feedback. The purpose of this section is to offer guidelines for conducting public information programs that have been developed as integral parts of an overall HIV-prevention strategy.

In addition to planning, pretesting, and evaluating public information strategies, specific components of public information programs -- producing educational materials, working with the print and broadcast media, hotlines, and special events -- are addressed here.

Planning for Public Information

To be effective, public information programs must be consistent with and supportive of broader programmatic objectives (e.g., to inform target audiences about and motivate them to use existing HIV counseling and testing services). Therefore, public information plans should be developed as one component of the comprehensive HIV prevention plan.

During the planning process, a number of key questions should be asked. The answers, which should be derived from targeted needs assessment data, will help to assure that public information efforts will support the HIV/AIDS prevention program objectives. These questions cover the following issues:

- What are the media preferences and habits of the target audience? What information sources (such as social networks,
- churches/religious institutions, coaches) do they consider credible?
- What are the media and other organizations that provide information in the targeted area? Which activities are related to public information? What are the specific audiences?
- What prevention program goals and objectives can public information support (e.g., increased knowledge, change in
- attitudes, motivation to act, increased skills, other behaviors)?

- What services/program activities should be promoted?
- What measurable objectives can be established? How can progress be tracked?
- What are the broad message concepts for the target audience? What should they be told? What do they want to know?
- Who will they believe and trust?
- What communication channels are most appropriate for reaching target audiences (e.g., radio, TV, print media,
- worksite, face-to-face, voluntary organizations, or the health care sector)?
- What materials formats will best suit these channels and messages? Are there any existing materials that can be used or
- adapted?
- How can the resources be used most effectively and for what combination of activities?

In addition to answering these key questions, an important part of the planning process is determining the short- and long-term objectives of the public information program. Objectives could include the following:

- Increase the number of persons (target audience) calling a hotline or requesting information/expressing an interest in
- other ways.
- Increase the number of program participants, volunteers, requests for activities within a community.
- Increase beliefs among community leaders that support for HIV/AIDS issues is important.
- Increase the numbers of partner, family, or other discussions about HIV/AIDS.

A comprehensive program could include all of these objectives. Most communities may find that they can take on one or two objectives at a time, then add to or alter their program focus as the program develops or community needs change.

Staff Training in Planning for Public Information

Staff working in public information programs should review, discuss, and receive training based upon the CDC health communication framework or a similar planning model such as that found in *Making Health Communication Programs Work*: A Planner's Guide. (See Resources and References p. 74).

Staff should also be familiar with methods for tracking and evaluating public information activities.

Standards For Effective Public Information Programs

Public information activities must support other components of health education and risk reduction activities.

Target audiences for public information activities must be selected, based on needs identified through the community needs assessment.

Objectives for public information must be based on a realistic assessment of what communications can be expected to contribute to prevention.

Messages must be based on the target audience's values, needs, and interests.

Messages and materials must be pretested with the target audience to assure understanding and relevance to their needs and interests.

Community representatives must be involved in planning and developing public information activities to ensure community "buy in."

Guidelines For Effective Public Information Programs

Commit adequate time, effort, and resources to communication planning and pretesting.

Review existing market research on the target audience to understand what will motivate them. (Conduct new research only when necessary.)

Make sure that messages and materials appear where the target audience will pay attention to them.

Produce/tag existing public service announcements (PSAs) that are of high production quality, community-specific, marketed to stations, and targeted to audiences likely to see them when public service air time is available (such as "fringe" viewing times).

Combine PSAs with news and other uses of the mass media to increase exposure to prevention issues.

Use a combination of the mass media and community channels that will reach the target audience.

Work collaboratively with other organizations and/or community sectors that have complementary strengths. Begin to coordinate as early as possible in program planning.

Use a two-pronged communication strategy to focus both on what an individual should do and on factors that help enable individual change such as peer approval and community support.

Track progress and identify when and what kind of changes are needed in public information activities.

Set reasonable, short-term public information objectives to reach the long-term goal. Then, commit to public information as one program component over the long term. (Remember that "one-shot" public information campaigns are unlikely to leave a lasting effect, and that progress toward prevention goals is incremental.)

Channel Selection

Communication channels are the routes or methods chosen to reach the target audiences. Types of channels include mass media, interpersonal transactions, and community-based interactions. Understanding the advantages and disadvantages of communication channels can help assure the best use of each, including the coordination of mass media activities with other strategies where beneficial. Each channel has its own characteristics and advantages and disadvantages, as listed here:

MASS MEDIA (radio, television, newspapers, magazines)

Advantages:

> can reach many people quickly
>
> can provide information
>
> can help change and reinforce attitudes
>
> can prompt an immediate action (e.g., calling toll-free number)
>
> can demonstrate the desired action

Disadvantages:

> are less personal and intimate
>
> are less trusted by some people
>
> do not permit interaction
>
> offer limited time and space
>
> offer limited opportunities to communicate complex or controversial information alone, usually cannot change behavior
>
> can be costly

COMMUNITY CHANNELS (schools, employers, community meetings and organizations, churches/religious institutions, special events)

Advantages:

> may be familiar, trusted, and influential
>
> may be more likely than media alone to motivate/support behavior change

can reach groups of people at once

can sometimes be inexpensive

can offer shared experiences

Disadvantages:

can sometimes be costly

can be time consuming

may not provide personalized attention

INTERPERSONAL CHANNELS (e.g., hotline counselors, parents, health care providers, clergy, educators)

Advantages:

can be credible

can permit two-way discussion

can be motivational, influential, supportive

Disadvantages:

can be expensive

can be time consuming

can have limited target audience reach

Selecting the Appropriate Channel

The appropriate channel or channels for a specific project can be selected by assessing whether the channel is:

- Likely to reach a significant portion of the target audience. (Local media outlets can provide a demographic profile of
- their viewers/ readers/listeners.)
- Likely to reach them often enough to provide adequate exposure for the message/program.
- Credible for the target audience.
- Appropriate and accessible for the selected HIV/AIDS message.

- Appropriate for the program purpose (e.g., provide new information versus motivate action).
- Feasible, given available resources.

Choosing multiple channels can help combine the best traits of each and reinforce the message through repetition. For example, a major daily newspaper may reach the most people. Adding stories in a local African American newspaper may provide credibility within that community, and publicizing the hotline in these stories can help the reader get more information tailored to his or her needs.

Educational Materials

Educational materials are learning or teaching aids. They can be used to reach masses of people, to reinforce or illustrate
information given in a one-on-one setting, or serve as references to remind people of information they received earlier. Materials also teach skills by providing hands-on experience or by illustrating a step-by-step approach. Effective materials can also influence attitudes and perceptions.

Development or selection of educational materials is directed by several considerations:

- What is the public information objective? Is it to inform, demonstrate, persuade, or remind? These considerations
- determine how educational materials are designed and used.
- Who is the target audience? Where (which channels) can they be reached? Are there any target audience preferences
- for types of materials (e.g., non-print for low-literacy audiences, fotonovelas for Latinas)?
- What is the specific message? Is it a skill, an attitude to be considered, medical information, a negotiation approach, or a
- synopsis of previous instruction?
- What materials are already available? Will they fit the audience, channel, and objective? Can they be purchased?
- Reproduced? Modified?
- What financial, staff, and other resources are available for materials development? Should development be handled
- in-house or by contract?

Choose Formats for Education/Information Materials

In selecting formats for educational and informational materials, choice should be guided by the amount and type of information to be presented, the channels to be used, and target audience preferences. For most messages, using as many different formats as appropriate will provide more options for message promotion. Commonly used formats include:

Channel: Television
        Formats: Public service announcements, paid advertisements, editorials, news
            releases, background or question and answer (Q and A) for public affairs
            programs

Channel: Radio
        Formats: Live announcer copy (PSAs), taped PSAs, topic ideas for call-in shows

Channel: Newspaper
        Formats: News releases, editorials, letters to the editor

Channel: Outdoor
        Formats: Transit ads, various sizes
            Billboards, various sizes
            Ads/posters for bus stop enclosures, airports

Channel: Community
        Formats: Posters for beauty and barber shops, pharmacies, grocery stores,
            worksites
            Bill inserts: shopping bag inserts or imprints, paycheck inserts
            Special event giveaways: calendars, fact cards, pencils, balloons, key chains
            Table top or other displays for health fairs, waiting rooms, libraries, schools
            Newsletter articles for community, employer, business newsletters Fotonovelas,
            flyers, pamphlets, coloring books for distribution through community settings

Channel: Interpersonal
        Formats: Posters for physicians' offices and clinic waiting and examination rooms
            Talking points, note pads for patient counseling, presentations at schools,
            organizations, religious institutions
            Videos for classroom use

Review Available Materials

Before developing new materials, make sure that new production is necessary. If
materials are available that will meet identified program needs, expense and effort can be
saved. Contact the CDC National AIDS Clearinghouse (1-800-458-5231) to find out what
is available.

Use the Materials Review Checklist to assess appropriateness of existing materials. (See
Appendix E.)

Determine whether appropriate materials can be used or modified:

*   Is the organization willing to share its materials? (Note: Virtually all materials
    produced by the Federal government are in
*   the public domain. This means that they are not copyrighted and can be freely
    reproduced.)

- Can your program identity be substituted or added to the materials? (Make changes to fit planned public information
- activities.)
- Is the material available in the quantities needed? Is it affordable?
- Were the materials tested? With what results?
- How are the materials currently being used? By whom? With what effects?
- Are the materials suitable for the identified target audience and your community? (Testing may be needed to find out.)
- Are the messages consistent with specified public information and prevention program objectives?

Pretest Messages and Materials

Pretesting is defined as the testing of planned public information strategies, messages, or materials before completion and release to help assure effectiveness.

Pretesting is used to help make sure that messages and materials will work. It is important to test messages and draft materials with target audiences. Also, testing with media or other "gatekeepers" is a good idea, e.g., PSA directors or others who can influence whether messages and materials are used.

Pretesting can help determine whether messages and materials are:

- Understandable.
- Relevant.
- Attention-getting.
- Memorable.
- Appealing.
- Credible.
- Acceptable to the target audience.

These factors can make a difference in whether messages or materials contribute to meeting public information objectives.

The most frequently used pretest methods include:

- Focus groups.
- Self-administered questionnaires.
- Central location intercept interviews.
- Individual interviews.
- Theater-style testing.
- Readability testing.
- Gatekeeper review.

Specific pretest methods will vary, depending upon:

- Materials format(s).

- Complexity of the materials or messages (e.g., for complex messages, more time may be needed to explore audience
- reactions).
- Degree of sensitivity or controversy (e.g., a combination of methods helps make sure that responses are honest).
- Previous experience with or knowledge of the target group (i.e., less testing, or less in-depth exploration may be called
- for if a great deal is already known about audience views).
- Resources.
- The pretest questions to be explored.

Note: Additional information about pretesting can be found in *Making Health Communication Programs Work: A Planner's Guide*. (See Resources and References.)

Staff Characteristics for Materials Development and Pretesting

Staff who are involved in the development of educational materials should know the attributes and limitations of the educational
materials formats to be used. In addition, they should:

- Speak, read, and write the language or dialect of the designated audience or have access to someone who does.
- Have the ability to identify accurately and incorporate appropriate literacy levels in design of materials.
- Communicate effectively in print and audiovisual media, or have access to competent materials producers.
- Be familiar with characteristics and life styles of designated audience.
- Be non-judgmental.
- Know the message and materials objective.
- Be able to personalize the material's message to be relevant to the target audience.
- Be able to design and conduct message and materials pretests or have access to trained and experienced help.
- Be able to design and implement distribution and promotion plans to assure appropriate use of materials to support public information activities.

Training for staff materials development and pretesting should:

- Emphasize how to design objectives, messages, and educational material.
- Instruct how to design and implement dissemination, promotion, and evaluation plans to assure appropriate use of
- materials.
- Inform about sources of additional information and related services.
- Teach how to determine appropriate motivator of behavior change.
- Instruct how to design and conduct pretests, including how to conduct focus groups.

- Provide practice sessions and opportunities for observation before conducting target audience pretests.
- Provide other training as needed (e.g., cultural sensitivity, low literacy materials development, sexuality attitudes,
- interviewing skills).

Using the Mass Media Effectively

The mass media is a vast and powerful sector of our society that includes television, radio, newspapers, magazines, other mass circulation print vehicles, and outdoor advertising. For HIV/AIDS prevention public information outreach, this category also can include shoppers' weeklies, newsletters published by businesses, periodicals distributed by organizations, newsletters from major employers, school/college newspapers, closed circuit television, and broadcast radio stations.

Opportunities for Messages in the Mass Media

The media offer more than news and public service announcements:

Beyond "hard" *news*, consider "soft" news that you help create:

- an upcoming activity;
- an event;
- findings from a public opinion poll or survey;
- a local angle to a national story;
- news appropriate for health or community features; and
- community advocacy of an issue that creates news.

For *entertainment*, consider:

- features in print or on television;
- talk and call-in shows;
- health and advice columns;
- consumers' own stories; and
- interviews with local personalities.

In addition to *news* or *public service announcements* for television and radio, ask for the following:

- businesses to sponsor paid advertisements or add an HIV prevention message to their ads;
- stations to include reminders as parts of station breaks;
- broadcast associations to help negotiate better rates for paid ads;
- the media to help in producing PSAs or video segments;
- consideration before a newspaper editorial board;
- placement of your spokesperson on news, public affairs, talk shows, call-ins, or editorial segments;

- paid advertisements; and
- co-sponsorship of events within the community.

- *Editorial* time and space includes:

  - letters to the editor; and
  - print or broadcast editorials (e.g., on local policies, access to services).

The Character of the Media

In general,

Television--

- reaches the most and broadest range of people
- is not as targeted as other media channels
- covers issues in very short segments
- conveys human interest and personal stories well
- might have calendars of events

Radio--

- stations have more narrowly defined listeners (e.g., older teens, young adults, and drivers) and
- can target more discretely
- can be cheaper to work with than television (e.g., can use announcer copy public service announcements)
- call-in shows offer opportunities for two-way exchange
- may have more frequent news coverage than other media
- covers issues in very short segments (e.g., 10-second sound bytes)
- may produce public service announcements if they perceive that there is a local interest

Newspapers/Magazines--

- offer space to explain in more detail
- can be re-read, encouraging discussion
- are less emotional media than radio/television
- are more likely to have calendars of events
- may have a narrow target audience (e.g., a local Spanish-language newspaper)

Outdoor Media--

- include billboards, transit advertising (in subways and bus stops, on buses and taxis)
- are generally used for advertising
- are good for "at-a-glance" reminders
- in some cases (inside buses) might "capture" the viewer long enough to absorb a longer message
- can use locations to target your audience, based on where they live or work
- may offer public service space

From "Working with the Media" in *Nutrition Intervention in Chronic Disease: A Guide to Effective Programs*.

What Makes News

Remember that you are competing with all the other news happening on a given day. Be sure that your story has something extra to offer, such as:

- Widespread interest or interesting angle.
- A local angle.
- Timeliness.
- Human interest.
- Controversy.
- Celebrity involvement.
- Impact on the community.

Note: CDC's two guides, *HIV/AIDS Media Relations* and *HIV/AIDS Managing Issues*, provide additional information form working with the mass media. Also, the National Public Health Information Coalition (NPHIC) has prepared a "hands-on" guide for handling media interviews. (See References p. 74.)

Working with the Mass Media

Involve media professionals in planning. Like many other people, they prefer to be involved from the beginning and to feel their
opinions are valued, not just their *access* to media time and space.

Develop a media contact list. The public information office of the state health department probably can get you started. Also,
guidance is provided in CDC's *Media Relations* guide. (See References.)

Establish relationships with the media; concentrate on those media outlets your target population is most likely to see, hear, or read. Articulate a role for media that will contribute to objectives and capture the attention of the target population; build capacity to interact effectively with the news media.

Media relations can be labor intensive. To make sure that the efforts pay off, consider the following:

- Start with a media plan that includes a variety of strategies; coordinate that plan with other program strategies.
- Quickly and competently respond to media queries and deadlines.
- Plan media activities over time, rather than one event at a time.
- Track media results, report successes, and plan for improvement.
- Look for opportunities to turn existing events and stories into new angles to support the media strategy.
- Recognize the contributions of media, e.g., send letters.
- Periodically review what has been accomplished, what needs improvement, and what to do next.

To identify media strategies, consider:

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- What has not been covered and could be covered.
- Which media outlets might be interested in doing more.
- Which journalists, columnists, or media personalities might be interested.

Media strategies should:

- Contribute to program objectives.
- Be within your means to accomplish.
- Consider benefits and limitations of business and other partners.

Prioritize media strategies by weighing expected benefits, resources required, and how each could be "sold" to the media. Then, work first on those with the greatest potential. Use information about the public's interest in HIV/AIDS to convince the media to participate.

Assess exposure in the media:

- Quantity -- how much coverage (seconds, column inches) was received.
- Placement -- where the coverage appeared in relation to the target audience's media habits.
- Content -- whether it was likely to attract attention (e.g., with a provocative headline or lead in), favorable, accurate,
- incomplete, misleading, or negative information.
- Feedback -- whether the target population and/or decision makers in the community responded in a tangible way.

Ways to track media efforts:

- Keep a log of media calls -- track what was said, identify who to call back, identify when coverage will occur; use the
- log to update media contact lists.
- Clip and review print coverage; tape to review television and radio coverage (purchase videos of coverage from stations
- or commercial sources when high-quality videos are needed, e.g., for presentations).
- Request from stations a monthly printout that lists when PSAs were shown and the time donated (dollar value).
- Include an audience prompt in messages, and monitor who responds.

Provide media spokesperson training for staff who work with the media. Staff training should also:

- Follow the recommendations in CDC's Media Relations and Managing Issues guides.
- Explore options for working with the media beyond PSAs, including establishing media relationships and message
- placement.

Media Idea List

- Introduce a new activity with a media breakfast.
- Promote participation in an activity or event.
- Take pictures at events, recognition ceremonies, presentations--use them to help place stories in local newspapers or organizational newsletters.
- Announce personnel changes, celebrity involvement.
- Recruit volunteers or program participants.
- Announce grant awards or major contributions.
- Invite the media to any celebrations or recognition ceremonies.
- Tie events or information to the calendar--holidays, annual HIV/health-related days, weeks, or months.
- Make statements on HIV-related public policies.
- Highlight local aspects of national stories.
- Weave media coverage (a video, audio excerpt, a slide of print coverage) into community presentations.
- Report results from an intervention or activity.
- Communicate a message that will reinforce community intervention topics.
- Promote CDC PSAs to local stations, with local tags.
- Produce a series of articles or broadcast news or feature segments on the topic in partnership with the media.
- Send a four-color postcard with live announcer copy for a PSA to radio stations.
- Produce a Q and A column or quiz for community newspapers.
- Seek coverage for events.
- Conduct a yearly campaign lasting for 3 to 4 weeks featuring activities such as posters or displays in the community.
- Seek in-kind help, such as art work, video dubbing, and PSA and slide production to entice a media outlet into becoming a program sponsor.
- Produce articles for constituent, trade, or employee newsletters.
- Write letters to the editor, op eds (a page of special features usually opposite the editorial page), articles, or guest editorials to promote your topic through another angle.
- Promote activities through media calendars of events.
- Produce a PSA or feature production (such as a call-in) on cable television, public broadcasting (PBS) channels, university radio/television departments (perhaps as a class project).
- Develop a newspaper supplement on HIV/AIDS. The newspaper advertising department can help you develop it and locate businesses to advertise.
- Identify, duplicate, and tag with your program identification any PSA developed elsewhere (with permission).
- Meet with a newspaper editorial board. Tell them about your issue, related community needs, and your position; urge them to take a stand and give you coverage.

Hotlines

Because many people are uncomfortable discussing subjects that involve sexual issues and behaviors, accessing a hotline for HIV/AIDS/STD information is a viable, anonymous option. However, hotlines may not be appropriate for satisfying every program need. Information generated through a needs assessment can be used to determine whether a hotline is appropriate; provide indicators for needed hours of operation, number of staff, specialty services (e.g., for Spanish-speaking, the deaf); ascertain appropriate venues for publicizing the hotline number; identify which population(s) should be targeted; and indicate specific information needs.

If the establishment of a local hotline is not a viable option, the CDC National AIDS Hotline and the CDC National STD Hotline can be publicized.

Why Establish A Hotline?

A Hotline can do the following:

- Provide easy and immediate access for persons/populations who may not be reached by other methods, e.g., women at
- risk for HIV infection in rural communities.
- Provide an opportunity for a person to frame a question and have anonymous human contact.
- Provide information in a confidential manner, maintaining the privacy of the caller.
- Provide information in appropriate language level and style and permit discussion of issues caller does not understand.
- Afford the caller up-to-date, accurate information.
- Provide referrals for counseling and testing, treatment services, and various support systems.
- Serve as a monitoring mechanism for impact of public information activities, e.g., PSAs that publicize the hotline number.
- Permit pre-screening of "worried well" to decrease unnecessary HIV testing.

Quality Assurance

A quality assurance plan should be developed as part of the process of establishing a hotline. This plan should address the following minimum requirements:

- Description of staff recruitment process and necessary qualifications for specialists.
- Information and timeliness for monitoring the specialists for accurate information dissemination, appropriateness of
- referrals, and proper call management skills.
- Performance appraisal based on whether persons are able to achieve standards; remedial activities for elevating
- performance; volunteers and paid staff judged according to the same expectations; and volunteers should understand

- that this is a "job" and conform to hours, vacation rules, confidentiality, etc.).
- Information on publicizing the hotline (in all languages the hotline offers) and methods for documenting calls.
- Explanation of data collection procedures and reporting forms, e.g., collection of information about callers -- who is
- being reached and what they are asking.
- Description of management techniques for referral information, e.g., a regular review of database or written materials.

Guidelines for Establishing A Hotline

- The hotline should not impose any financial difficulties/barriers on prospective callers (e.g., should be free for the caller).
- Days and hours of operation should meet the needs of the target audience (e.g., not just during business hours, when
- employed callers could not be assured of privacy for calls).
- The CDC National STD and the CDC National AIDS Hotline numbers should be provided on a taped message for
- calls received after normal operating hours in order to provide access to callers having immediate needs.
- Physical space should accommodate future staff expansion and additional phone lines.
- Telecommunications equipment should be up-to-date and of sufficient capacity.
- Venues should be available for publicizing the hotline and should be appropriate for targeted audiences.
- Consideration should be given to phone lines that may be needed for special audiences, e.g., non-English speaking
- people and people who are deaf or hard of hearing.

Also consider offering an auto-attendant system to operate during off-hours and weekends. Such a system can offer a menu of pre-recorded messages for callers who do not need to speak with a counselor, but who want quick and anonymous access to information.

Staff Characteristics for Hotlines

Hotlines are staffed by information specialists who may be paid personnel or volunteers, depending upon available financial resources. If volunteers are used, the organization should commit at least one paid staff person for management purposes. A paid staff member is needed to ensure consistency and continuity of services because of the high turn over of staff commonly experienced among volunteers, the need to ensure quality services, and the need to maintain consistency in the implementation of policies and procedures. The manager should maintain and regularly update a comprehensive list of HIV/AIDS/STD services and organizations. A hard copy and/or computer-based list should be used by information specialists during work hours.

Information specialists provide information over the telephone; therefore, they require unique skills and abilities. They should always be prepared for the unexpected and act accordingly.

The successful information specialist should possess the following attributes:

- Be knowledgeable about HIV/AIDS/STDs.
- Understand the importance of anonymity and confidentiality.
- Have the ability to speak at various levels that are consistent with the language needs of the callers, e.g., physicians, lay
- persons who are or are not AIDS-knowledgeable.
- Exhibit active listening skills and be courteous, patient, understanding, and compassionate.
- Display a sensitive and non-judgmental attitude when callers describe concerns, sexual activities, drug use, and/or
- symptoms.
- Refrain from giving advice during crisis-oriented calls, but appropriately refer to organizations adept in crisis intervention.
- Refer callers to appropriate resources in a timely, efficient manner by using proper call management skills.
- Demonstrate resourcefulness and ingenuity in providing referrals and finding answers to questions.

Once the information specialists have been recruited, they should be comprehensively trained to meet the challenges of their positions. Consider teaming new information specialists with more experienced staff until the new person is comfortable handling calls independently.

A training plan should address the following minimum requirements:

- Measurable goals and objectives for the training.
- Basic medical knowledge about HIV/AIDS/STD, including modes of transmission, disease-causing organisms, signs and
- symptoms, disease epidemiology, diagnostic methods, disease progression and complications, and treatment.
- Knowledge about common myths and misconceptions about HIV/AIDS/STD and correct information to dispel myths
- and misconceptions.
- Skills-building exercises in active listening and effective information dissemination (including crisis intervention).
- Interpersonal and multi-cultural communication skills-building.
- In-service training and updates on a continual basis to remain current on issues surrounding HIV/AIDS/STD.

For additional information, consult the training bulletins that the CDC National AIDS Hotline distributes to state health departments and others.

Special Events

Special events such as street fairs, job fairs, health fairs, World AIDS Day activities, and local celebrations in communities sometimes can deliver public information to large numbers of people and can gain media exposure.

Community Involvement and Support

Community groups and organizations can play an important role in implementing special events. Libraries, schools, churches, businesses, or social groups provide leadership in communities and are able to pool resources and inspire citizens to join their efforts.

The types of events that can be organized are unlimited and can be as original and varied as the ideas and resources of the people organizing them. Networking can heighten the visibility of events, resulting in greater public awareness when interested persons are identified and contacted. Efforts can begin with one or more of the following types of organizations:

- Schools, colleges, and other educational organizations, such as local PTA chapters and nursing schools.
- Civic associations, fraternal organizations, social sororities, and clubs.
- Community-based organizations including the National Association for the Advancement of Colored People (NAACP),
- the American Red Cross, the National Urban League, and the Young Men Christian Association/Young Women
- Christian Association (YMCA/YWCA).
- Neighborhood associations.
- Churches and other religious institutions.
- Businesses such as shopping malls, health and fitness clubs, drug stores, laundromats, bars, bookstores, and groceries
- where members of the target audience can be found.
    Media outlets such as newspapers, television, and radio stations.

Creativity is an important aspect of successful special events. A number of innovative ideas have been implemented across the country. For example, The Condom Resource Center whose goal is to reduce the incidence of sexually transmitted disease, including HIV/AIDS infection, sponsors a yearly event entitled "National Condom Week." (See References for contact information.) To distribute pamphlets and condoms, information tables are set up in public areas and in more secluded locations for self-conscious people or people who are shy about sexual matters. Additional public events are staged, such as the following:

- A contest for prizes in which people design posters with condom messages.
- A contest to guess the number of condoms in the jar with the person with the closest guess winning the contents of the
- jar.
- An annual "media conference" for high school and college newspaper staff to provide accurate information and to

- encourage coverage of National Condom Week.

Planning Special Events

- Identify persons and organizations in the community interested in planning an observance or event.
- Consider what types of activities will draw the target audience to an event (e.g., different people may be drawn to music,
- dance, art, sports, celebrity events).
- Agree to sponsor an activity or a group of activities making sure that each will contribute to public information objectives
- with the designated target audience.
- Discuss resources needed, such as a guest speaker, financial sponsors, and publicity materials.
- Get members of the target audience involved in planning.
- Create a planning schedule and set a date for the activity.
- Delegate responsibilities for work by assigning persons to be in charge of specific aspects of the planned activity; put
- people in charge of location, special attractions, hospitality, publicity, and media according to their skills and interests.
- Develop a publicity plan to assure attendance; publicity is crucial for the success of any event.
- Decide on the most effective way to publicize the events, e.g., announcements in the media and at meetings, flyers,
- public service announcements, posters, or mass mailings.
- Track planning progress: use the planning schedule and publicity plan as a guide to make sure that the event is a success.
- Evaluate the success of the event by comparing the number of attendees expected with actual attendance; identify how
- many of the target audience attended and what they thought of the event; review media coverage and other publicity that
- supported prevention objectives; identify increased awareness of the program as a result of publicity (e.g., through pre-
- and post-event surveys); compare effort involved in developing the event with the value of the outcome.

RESOURCES
AND
REFERENCES

The following is a list of resources and references to help guide program design and development. They are divided into subheadings of health education, materials development, public information, evaluation, and behavioral risk factors and groups at risk. These lists are starting points for literature reviews or program design on these subjects, but they are not exhaustive.

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American Social Health Association	919-361-8400
CDC National AIDS Clearinghouse	1-800-458-5231
National Association of People With AIDS 1413 K Street, N.W., 10th Floor Washington, DC 20005	202-898-0414
The Condom Resource Center	510-891-0455

Look for media resource guides in your public library, including:
       Broadcasting Yearbook
       Broadcasting Cable Sourcebook
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APPENDICES

Example of Completed Form

Street Outreach Activity Report

MSM's Client   Group **4/22/92** Date

Southside Location   **_A.M.X P.M.** Evening

35 **Total # of Contacts**   **AMR/JAV** Team

Demographics of Contacts

30 # Male   5 # Female

21 # African American   9 # Latino   1 # White   2 # Native American

2 # Asian/ Pacific Islander   0 Other

Materials Distributed To Individuals	**Referrals for Services**
105 # of Condoms Distributed	3 # STD Clinic
2 # of Bleach Kits Distributed	___ # HIV C/T Site
35 # of Safer Sex Kits Distributed	0 # TB Clinic
29 # of Brochures Distributed	3 # Drug Treatment
1 # of Other poster	0 # Family Planning

Materials Drop-off Sites

Type of Site:	**Materials Distributed**:
Al's Place (bar)	100 condoms, 200 brochures, 1 poster
Midtown Adult Book Store	200 condoms, 200 safer sex cards
St. Mary's Homeless Shelter	2 posters, 100 condoms, 50 bleach kits
Hair Unlimited (beauty shop)	100 condoms, 50 brochures, 2 posters

Appendix B
QUALITY ASSURANCE

PROGRAM ASSESSMENT FORM
STREET AND COMMUNITY OUTREACH

OUTREACH SPECIALIST: _____

REVIEWER: _____

DATE: _____

DIRECTIONS: Check the appropriate columns to indicate degree to which the facilitator met criteria:

>**EXCELLENT** indicates that performance met criteria beyond **fully successful**.

>**FULLY SUCCESSFUL** indicates performance met criteria **successfully**.

>**NEEDS ATTN** indicates performance needs supervisory guidance to meet criteria.

>**N/A** indicates this criteria **did not apply** to this situation.

Check only within and not between the boxes. If undecided, use "comments" section to clarify.

EXCELLENT   FULLY SUCCESSFUL   NEEDS ATTN   N/A

STAFF

1. Staff respects client's privacy and confidentiality at all times.

2. Staff is trained and experienced in health education.

1. 3. Staff is sensitive to community norms, values, cultural beliefs, and   traditions.

3. Staff advocates for the population served.

4. Staff acts as liaison between the community and agency.

5. Staff is representative of the population served.

6. Staff is informed about community resources and is able to use them.

    COMMENTS:

PROGRAM

1. Program proposes realistic, measurable, and attainable goals and objectives.

2. Program identifies specific methodologies and activities t achieve stated goals and objectives.

3. Program defines target population by geographic locale, risk behavior(s), gender, sexual orientation, and race and ethnicity.

4. Program ensures adequate supplies of appropriate and relevant risk- reduction materials before conducting outreach activities (e.g., pamphlets, condoms, bleach, sexual responsibility kits).

5. Program includes observation of potential outreach areas to determine the locations, times of day, and the day of the week that are most productive for reaching the population to be served.

6. Program has regular and consistent hours for outreach activities.

7. Program facilitates professional development of program staff.

8. Program has a comprehensive and written field safety protocol.

9. Program has a written policy and personnel procedures to address stress, burn-out, and relapse among staff.

10. Program has written procedures for the referral of clients to appropriate services outside the agency.

11. Program has long-range plans for the continuation of services.

12. Program establishes and maintains a relationship between the agency and other local authorities.

13. Program identifies and develops collaborative relationships with relevant gatekeepers (key informants) to the target population.

14. Program coordinates intervention services with identified gate-keepers.

   COMMENTS:

EVALUATION

1. Evaluation plan includes process evaluation measures.

2. Evaluation plan has consistent, accurate data collection procedures.

3. Evaluation plan includes staff supervision, observation, and feedback on a regularly scheduled basis.

4. Evaluation plan provides findings for program modifications, as appropriate.

   COMMENTS:

TRAINING

1. Training plan defines staff roles, duties, and responsibilities.

2. Training plan includes staff orientation to the agency (organization) and the community served.

1. Training plan includes ongoing staff professional development.

2. Training plan uses role play, observation, and feedback.

   COMMENTS:

Appendix C
QUALITY ASSURANCE

PROGRAM ASSESSMENT FORM - COMMUNITY EDUCATOR

TITLE: _____ **EDUCATOR**: _____

GROUP (TYPE & SIZE): _____ **REVIEWER**: _____

DATE: _____ **TIME**: _____ **PROGRAM LENGTH**: _____

DIRECTIONS: Check the appropriate columns to indicate degree to which the facilitator met criteria:

> **WELL** - would indicate met criteria **well**.
>
> **ADEQUATELY** - would indicate met criteria **adequately.**
>
> **NEEDS ATTN** - **needs attention** and supervisory guidance to meet criteria.
>
> **N/A** indicates this criteria **did not apply** to this situation.

Check only within and not between the boxes. If undecided, use "comments" section to clarify.

EXCELLENT   **FULLY SUCCESSFUL**   **NEEDS ATTN**   **N/A**

INTRODUCTIONS

1. Introduces self by name and title.

2. Introduces others as appropriate.

3. Clearly states purpose, goals, and objectives for session.

4. Starts program at or within 10 minutes after starting time.

5. Attends to participants' physical comfort.

    COMMENTS:

CONTENT

1. Selects program content relevant to agency goals and audience needs.

2. Imparts factual information.

3. Displays confidence in knowledge of material.

4. Provides background and supporting evidence to substantiate facts stated by participants and by self.

5. Organizes activities and information in clear manner.

    COMMENTS:

PROFESSIONAL PRESENCE

1. Dresses in a manner that doesn't detract from aims of presentation.

2. Remembers and uses names of people, as appropriate.

3. Is tactful when discussing controversial topics.

4. Imparts attitudes and information consistent with agency goals and policy.

5. Avoids careless use of slang words.

6. Uses grammatically correct English.

7. Handles unexpected or difficult questions with minimal display of embarrassment or confusion.

8. Makes positive and tactful corrective statements.

9. Acknowledges contrary viewpoints.

   COMMENTS:

STRUCTURE

1. Focuses attention on topic with films, pre-test, or other motivational techniques.

1. Selects teaching methods geared to audience and content (i.e., brainstorm, lectures, etc.).

2. Selects teaching materials that enhance lesson plan.

3. Allows sufficient time for activities.

4. Modifies teaching plan as indicated by audience response.

5. Keeps session on track, sticks to the point.

6. Creates opportunities for questions, comments, clarifications, and expression of opinions and feelings (elicits and pauses, etc.).

   COMMENTS:

PROCESS SKILLS

1. Uses descriptive and reinforcing gestures.

2. Maintains eye contact with entire audience.

3. Adapts vocabulary level to understanding of group.

4. Enunciates and projects voice clearly.

5. Sets stage for activities and materials.

6. Explains materials used.

7. Demonstrates knowledge and skill in operating a.v. Equipment.

8. Uses illustrative examples.

9. Encourages all participants to be involved in activities.

10. Avoids lags in flow of presentation.

11. Acknowledges and accepts statements of feelings and experiences of others.

12. Listens actively.

13. Affirms information accurately.

14. Restates/clarifies/ emphasizes participants' comments and questions.

   COMMENTS:

CONCLUSION

1. Summarizes major program points.

2. Reviews program objectives before concluding.

3. Helps group identify further human or material resources.

4. Remains available for individuals to approach them after the program.

5. Uses a tool to assess participants' satisfaction with program and program impact.

   COMMENTS:

COMMENTS ON CONCLUSION:

AUDIENCE RESPONSE TO SPEAKER:

OVERALL SUGGESTIONS AND REMARKS:

SPEAKER'S COMMENTS AND SIGNATURE:

Appendix D
QUALITY ASSURANCE
PROGRAM ASSESSMENT FORM - SUPPORT GROUP FACILITATOR

TITLE: _____ **FACILITATOR**: _____

REVIEWER: _____

DATE: _____

DIRECTIONS: Check the appropriate columns to indicate degree to which the facilitator met criteria:

> **EXCELLENT** indicates that performance met criteria beyond **fully successful**.

> **FULLY SUCCESSFUL** indicates performance met criteria successfully.

> **NEEDS ATTN** indicates performance needs supervisory guidance to meet criteria.

> **N/A** indicates this criteria **did not apply** to this situation.

Check only within and not between the boxes. If undecided, use "comments" section to clarify.

EXCELLENT   FULLY SUCCESSFUL   NEEDS ATTN   N/A

INTRODUCTIONS

1. Introduces self by name and title.

2. Facilitates introductions and stresses confidentiality among group members.

3. Clearly states purpose, goals, objectives, and ground rules for session.

4. Allows members to share their expectations from the group.

5. Starts group at or within 10 minutes after starting time.

6. Attends to group members' physical comfort.

7. Makes required administrative announcements.

   COMMENTS:

_____

GROUP FACILITATION

1. Assures maintenance of group structure and schedule by promoting adherence to rules and guidelines.

1. Guides members through group processes, e.g., group dynamics.

2. Asks open-ended questions.

3. Maintains focus of discussion.

4. Synthesizes and abstracts pertinent information.

5. Creates opportunities for questions, comments, clarifications, and expressions of opinions and feelings.

6. Makes appropriate referrals and interventions, as needed.

7. Provides members with educational materials and information to substantiate discussion.

   COMMENTS:

_____

PROFESSIONAL PRESENCE

1. Dresses in suitable attire.

2. Remembers and uses names of group members, as appropriate.

3. Is tactful when discussing controversial topics.

4. Imparts attitudes and information consistent with agency goals and policy.

5. Avoids careless or inappropriate use of slang words.

6. Handles unexpected or difficult disclosures with minimal display of value judgement, embarrassment, or confusion.

7. Makes positive and tactful corrective statements.

8. Acknowledges contrary viewpoints.

   COMMENTS:

PROCESS SKILLS

1. Uses descriptive and reinforcing gestures.

2. Maintains eye contact with group members.

3. Speaks in vernacular that is germane to group.

4. Clearly enunciates and projects voice.

5. Sets stage for group session.

6. Encourages all group members to be involved in activities.

7. Listens actively.

   COMMENTS:

CONCLUSION

1. Brings group to closure in a tactful manner.

2. Summarizes group session.

3. Reviews session objectives with group members.

4. Helps group identify further human or material resources.

5. Remains available for group members' questions and comments after the session.

6. Uses a tool to assess participants' satisfaction with session and group impact.

   COMMENTS:

COMMENTS ON CONCLUSION:

GROUP RESPONSE TO FACILITATOR:

OVERALL SUGGESTIONS AND REMARKS:

FACILITATOR'S COMMENTS AND SIGNATURE:

Appendix E
QUALITY ASSURANCE
MATERIAL REVIEW CHECKLIST

TITLE: _____ **AUTHOR**: _____

REVIEWER: _____

DATE: _____

DIRECTIONS: Check the appropriate columns to indicate degree to which the author met criteria:

> **EXCELLENT** indicates that performance met criteria beyond **fully successful**.

> **FULLY SUCCESSFUL** indicates performance met criteria **successfully.**

> **NEEDS ATTN** indicates performance needs supervisory guidance to meet criteria.

> **N/A** indicates this criteria **did not apply** to this situation.

Check only within and not between the boxes. If undecided, use "comments" section to clarify.

EXCELLENT   FULLY SUCCESSFUL   NEEDS ATTN   N/A

MATERIAL REVIEW CHECKLIST

1. Material is clearly introduced and states the purpose of the text to the reader.

2. Major points of text are summarized at the end.

3. Materials are brief, concise, and in the language or dialect of the target audience.

4. Materials are written at the educational and reading level of the target audience. avoids jargon and technical phrases.

5. Materials use language and terms with which the target audience is comfortable.

6. Use active verbs and short, simple sentences, with one concept per sentence in short paragraphs.

7. Materials avoid or define difficult words and concepts. Examples are used to clarify.

8. Use terms consistently (e.g., "HIV" and "AIDS virus" are not used interchangeably).

9. Materials are straightforward and clear.   (Do not use abbreviations, acronyms, euphemisms, symbolism, statistics, or anything else that could cause confusion.)

10. Text uses line drawings if illustrations are included.

11. Illustration of anatomy shows position of organs within the whole body (gives relative size and location reference).

12. Text uses lists, bullets, or illustrations instead of long discussions. Visuals (overheads, slides) are used to emphasize key points.

13. Text is underlined, boldfaced, or "boxed" for reinforcement.

   COMMENTS:
   _____

MATERIAL REVIEW CHECKLIST

14. The text dispels myths, uses acceptable channels, refers to value systems for reasons to change behavior or adopt a new perspective.

15. Materials provide a call for action.

16. The text illustrates manual skills from audience perspective.

17. The text provides reasons for changing behavior.

18. Materials provide current and accurate medical information.

19. Materials do not contain sexual preference or racial, gender, or ethnic bias.

20. Text offers alternative behaviors to the one(s) that put a person at risk.

21. Realistic and relevant examples are given.

22. The format of the text is not visually distracting:

    a) Small type (less than 10 point) is not used.
    b) Sentences are neither too short nor too long.
    c) Text does not contain larger blocks of print.
    d) Right margins are justified.
    e) Only photographs that are reproducible are included.*
    f) Only professional-quality drawings are included.
    g) Technical diagrams are avoided.

23. Graphics are immediately identifiable, relevant, and simple. They reinforce the text.

   COMMENTS:
   _____

* Note: A written release should be obtained from all persons pictured. The release should clearly state permission to use the photograph and the conditions for use.

HIV PREVENTION CASE MANAGEMENT (PCM) CHECKLIST

Develop a quality assurance plan that:

- Establishes a minimal level of service delivery and identifies methods to monitor service delivery.

- Identifies and assesses evidence of the quality and quantity of all services provided through the PCM program.

- Reviews PCM protocols periodically for adequacy and relevancy and is revised accordingly.

- Reviews intake and case management documents for accuracy and compliance with program protocol.

- Examines the documentation of case termination and transfer.

- Ensures regular, periodic audits of case files by the supervisor.

- Provides for a mechanism to respond to discrepancies in performance identified by the supervisor.

APPENDIX G
SAMPLE EDUCATIONAL MATERIALS

_____

EXAMPLE
"Cleaning Your Needles" Pamphlet

OBJECTIVE: Demonstrate and remind

- **WHO**:   The designated audience is out-of-treatment IDUs.

- **WHAT**:   The specific message is "clean your needles with bleach".

- **WHERE**:   In their "copping" area (e.g., 10th and Vine).

- **HOW**:   Outreach specialists initiate conversation with people in the area, identify IDUs, provide instruction on needle cleaning, supply IDUs with bleach kits and a brief pamphlet, "*Cleaning Your Needles*" (illustrating the needle cleaning process) as a reminder of the instruction.

EVALUATION: **Process**: Outreach specialists keep track of the number of hours spent at outreach locations, the number and demographics of people spoken to, and the number of people who took bleach kits and pamphlets. Outreach specialists observe whether people keep or discard pamphlets.

_____

EXAMPLE
"Teens and AIDS" Video

OBJECTIVE: Inform, demonstrate, and remind.

WHO: Sexually active teens.

WHAT: The message is condom use and negotiation skills.

WHEN: Early afternoon (after school).

WHERE: Neighborhood community center.

HOW: Outreach worker:

- shows video portraying situations where sex is being considered and the parties negotiate condom use;

- leads discussion to personalize negotiation;

- facilities role play by participants;

- demonstrates proper care and use of condoms and has participants practice on a model;

- supplies pamphlets outlining negotiation strategies and other pamphlets illustrating condom use as reminders or references.

EVALUATION:

Process: Outreach worker documents how many presentations are done, how many teens attend, group demographics, the number of pamphlets distributed.

GLOSSARY
GLOSSARY OF TERMS USED IN HIV/AIDS HEALTH EDUCATION AND RISK REDUCTION ACTIVITIES

1. **COMMUNICATION CHANNELS**
   Routes or methods selected to reach target audiences with HIV/AIDS information. Types of channels include mass media, interpersonal transactions, and community-based interactions.

2. **COMMUNITIES**
   Social units that are at least one of the following: functional spatial units meeting basic needs for sustenance, units of patterned social interaction, or symbolic units of collective identity.

3. **COMMUNITY THEATER**
   Local community theatrical presentations used to provide HIV/AIDS awareness and educational interventions that are developed, casted by, and targeted toward school-age youth.

4. **CULTURAL COMPETENCY**
   Having the capacity and skills to function effectively in environments that are culturally diverse and are composed of distinct elements and qualities. Cultural competence begins with the STD/HIV professional understanding and respecting cultural differences and realizing that the client's culture affects his/her beliefs, perceptions, attitudes, and behaviors.

5. **DEVELOPMENTALLY APPROPRIATE**
   Material developed at a level that is consistent with the learning skills of the person served so as to ensure comprehension.

6. **DISTRIBUTION OF BLEACH**
   The distribution of bleach is the handing out of free, small bottles of bleach for the purpose of cleaning injecting drug use needles and syringes. Bleach is usually distributed as part of outreach to injecting drug users. Needle cleaning instruction labels are usually put on the bleach bottles. Outreach staff are usually involved in filling and labeling bleach bottles. Other materials distributed to IDUs include bottle caps for cookers, cotton, alcohol wipes, and bottles of water for rinsing needles.

7. **CONDOM DISTRIBUTION**
   The distribution of condoms is the handing out of free condoms as part of an HIV/AIDS educational intervention. Condoms and literature with instructions on proper use may also be distributed as an item in safer sex kits.

8. **HOTLINE**
   Telephone service (local or toll-free) offering up-to-date information on HIV/AIDS and referral to related local services, e.g., counseling/testing and

support groups. Hotlines may receive crisis calls; however, the intent is usually to provide information and referral.

9. **LINGUISTICALLY SPECIFIC**
    Dialect and terminology consistent with the target population's native language and style of communication.

10. **MASS MEDIA**
    Means by which information is conveyed to large groups of people; generally includes television, radio and print. These mass media are often used to disseminate information about HIV/AIDS and its impact on the local community. The use of broadcast or print media for the dissemination of information about HIV/AIDS and its impact on the local community.

11. **PAID ADVERTISING (TV, RADIO, PRINT)**
    Paying for the placement of advertisements/announcements/information on radio, TV, newspapers, magazines, billboards, and bus cards/bus shelters.

12. **PEER EDUCATION**
    Peer education is HIV/AIDS education provided by trained, self-identified Peer educators usually serve as role models, demonstrating to their peers behaviors that promote risk-reduction.

13. **PEER SUPPORT COUNSELING**
    Individual or group support counseling sessions facilitated by a trained, self-identified member of the target group, population, or community, i.e., a peer outreach educator.

14. **PRETESTING**
    Testing of planned public information strategies, messages, or materials before completion and release to help assure effectiveness.

15. **PROFESSIONAL TRAINING**
    HIV/AIDS training (lectures in basic AIDS facts, counseling and testing training, and AIDS updates/seminars/forums/workshops) provided usually for health, education, and social service professionals in the community, e.g., nurses, doctors, counselors, social workers, teachers, and law enforcement officers.

16. **PUBLIC INFORMATION**
    HIV/AIDS prevention activities directed to target audiences that are designed to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk of infection how to obtain specific services.

17. **RISK-REDUCTION COUNSELING**
    Individual or group counseling sessions focusing on behavior change activities, such as safer sex practices, proper condom use and demonstration, and needle cleaning. Usually conducted by trained AIDS health educators/counselors. Trained peer outreach educators may also conduct risk-reduction counseling with their peers in or out of an office setting, e.g., as part of street outreach.

18. **SPEAKERS BUREAU**
A group of volunteers who have been trained to provide basic HIV/AIDS educational presentations usually targeted toward community social, cultural, and educational groups. In addition, presentations may be given in other settings where persons at high risk for infection can be reached, such as homeless shelters or juvenile detention centers. These presentations are intended to raise AIDS awareness in the community.

19. **SPECIAL EVENTS**
HIV/AIDS outreach/educational activities conducted at community events such as street fairs, job/health fairs, and local community celebrations, e.g., Black History Month, Cinco de Mayo, and Gay and Lesbian Pride Day.

20. **STREET OUTREACH**
HIV/AIDS educational interventions generally conducted by peer outreach educators on the street, face-to-face with high-risk individuals. The handing out of condoms, bleach, sexual responsibility kits, and educational materials, e.g., safer sex cards and pamphlets, is usually done as part of street outreach targeted at high-risk groups.

21. **WORKSHOP PRESENTATIONS**
HIV/AIDS educational sessions in which a speaker presents information to an audience. Depending on the audience, presentations may be given by HIV/AIDS health educators, peer outreach educators, or trained volunteers. Workshop presentations represent the most structured health education and risk reduction intervention efforts. However, their impact is limited because they are single-encounter experiences. These presentations provide technical information that could initiate the changing of norms or individual behavior.