Applying
Prevention Marketing

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The Prevention Marketing Initiative:

Applying Prevention Marketing

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National Association of Broadcasters

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National Council of La Raza

National Council of Negro Women

National Dental Association

National Conference of State Legislatures

National Education Association

National Episcopal AIDS Coalition

National Family Planning and Reproductive Health Association

National Gay and Lesbian Task Force

National Indian AIDS Media Consortium

National Latino/a Lesbian and Gay Organization

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Chicago Department of Health, Division of HIV/AIDS Public Policy and Programs, Youth in High Risk Situations Project, Coalition on Adolescent Risk Reduction

Greater Brownsville Youth Council

Houston AIDS Foundation

Intertribal Council of Arizona

Immigrant Center

Los Angeles County Department of Health Services, Adolescent HIV Coalition

Maricopa County Community AIDS Partnership

Midwest Hispanic AIDS Coalition

Navajo Health Education Program

Northern Virginia Citizens Against Censorship

The Northern Virginia HIV Consortium, Northern Virginia Planning District Commission

Northwest Portland Area Indian Health

United Way of Middle Tennessee

United Way Regional AIDS Planning and Coordination Committee/Sacramento Area

U.S.–Mexico Border Health Association

Local

ACT UP/Golden Gate

Adolescent AIDS Program at Montefiore

Adolescent HIV Prevention Project

AID Atlanta

AIDS Action Committee

AIDS Foundation of Chicago

AIDS Project Los Angeles

AIDS Services of Dallas

Bay Area Young Positives

Beacon Hill Multi–Cultural Psychological Association, Gender Identity Support Services for Transgenders (GISST)

California Prevention Education Program

Communication Technologies

Crittenton Services, Inc.

District of Columbia Commission on Public Health, Office of Maternal & Child Health

Family Place, Inc.

Gay Asian Pacific Alliance (GAPA) Community HIV Project

Gay Men's Health Crisis Network

Health Crisis Network

Health Watch Information & Promotion Service

HIV Law Project

Jackson State University Alumni AIDS Prevention Project

Lavendar Youth Recreation and Information Center (LYRIC)

Los Angeles Gay and Lesbian Community Services Center

Metro Teen AIDS

Mobilization Against AIDS

New York City Department of Health

New York Hall of Science

New York Peer AIDS Education Coalition

Northwest AIDS Foundation

Outreach, Inc.

Puerto Rican Organization for Economic Education Development (PROCEED)

Public ICE (Information, Communication, Education), Filipino Task Force on AIDS

Salud, Inc.

San Francisco AIDS Foundation

San Francisco Black Coalition on AIDS

Sexual Minority Youth Assistance League (SMYLE)

Stop AIDS Project – San Francisco

United Migrant Opportunity Services

Whitman–Walker Clinic

Women and AIDS Resource Network

List of Acronyms

AIDS	acquired immune deficiency syndrome
AIDSCOM	AIDS Public Health Communication Project
ASO	AIDS service organization
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CPG	community planning group
HIV	human immunodeficiency virus
IDU	injecting drug user
KABBs	knowledge/skills, attitudes, beliefs, and behaviors
KAPs	knowledge/skills, attitudes, and practices
MSM	men who have sex with men
NAC	National AIDS Clearinghouse
NMO	national minority organization
PMI	Prevention Marketing Initiative
PSA	public service announcement
RFP	request for proposal
RMO	regional minority organization
STD	sexually transmitted disease
TA	technical assistance
USAID	U.S. Agency for International Development

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Foreword

One of the Centers for Disease Control and Prevention's top priorities is preventing HIV transmission among people 25 and younger because this group now accounts for half of all new HIV infections. Nationwide, countless community-based organizations (CBOs), AIDS service organizations (ASOs), faith-based AIDS ministries, HIV Prevention Community Planning Groups, state and local health and education departments, other federal agencies, and national organizations share this goal. Some are already using various aspects of social marketing in HIV and sexually transmitted disease (STD) prevention programs, drug use prevention programs, and other public health efforts. Many HIV Prevention Community Planning Groups, in particular, have used key elements of social marketing in developing their plans. They have used epidemiologic and demographic data — combined with information about possible audiences gleaned through focus groups, individual interviews, and other means, to define priority groups and their needs and to guide decisions about interventions. What social marketing offers these groups and others is a new perspective and a systematic way to design, deliver, and evaluate prevention programs that are focused on behavioral goals.

This document is designed for a wide-ranging audience of those responsible for HIV prevention programs for young people. It was written to help organizations develop, deliver, and evaluate interventions by:

- increasing understanding of the principles and processes of social marketing to reinforce or change behaviors to prevent HIV infection;

- providing a framework for creating, carrying out, and evaluating effective social marketing-based HIV prevention programs in community settings; and
- describing CDC's Prevention Marketing Initiative (PMI) and other interventions based on social marketing.

This document is divided into two parts. The first section describes social marketing — its key elements, real-life applications, benefits — and illustrates its principles with sketches of successful programs.

The second section lays out community guidelines for implementing social marketing-based HIV prevention programs. The recommendations in this section were developed by CDC and the Prevention Collaborative, an alliance of local, state, regional, and national public- and private-sector organizations working to prevent HIV transmission. On March 3–4, 1994, the Prevention Collaborative met in Washington, DC, to begin the process of developing these guidelines. Young people, both staff and constituents of member organizations, are an integral part of the Collaborative and of the development of these guidelines. At the March 3-4 meeting, attendees were asked to develop recommendations in five key areas:

- research and evaluation;
- linkage and integration with existing health, education, and social services agencies;
- coalition building;
- health communications; and
- community implementation.

Working groups were created to focus on each of these five topics. Additionally, the young adults formed an ad hoc group to discuss these five issues as well as other priorities, needs, concerns, and questions for HIV prevention and education focusing on young people.

A complete list of current Prevention Collaborative members is in Appendix A. Also included is a list of the Guidelines Working Group, which was nominated by the whole Prevention Collaborative to help develop this document, and the Resource Working Group, a team of state and community representatives involved with HIV Prevention Community Planning, who assisted in assuring the applicability of these guidelines in that setting. (For more information on applying social marketing within the context of HIV Prevention Community Planning, see Appendix B.) These two groups met in Washington, DC, on August 29, 1994, to refine a draft of this document and to develop additional recommendations for community-based social marketing programs.

This primer is one of the first steps in CDC's efforts to provide information and guidance on social marketing to HIV prevention program planners. More detailed technical assistance will be available in 1995 and beyond. CDC is working with the Prevention Collaborative and HIV Prevention Community Planning participants to define and develop that technical assistance and will incorporate findings and insights from the PMI local demonstration sites, five community projects that are applying prevention marketing in real life at the local level. (For more information on PMI and the local demonstration projects, see Appendix C.)

What Is the Prevention Marketing Initiative?

CDC's Prevention Marketing Initiative is a multi-level program that includes national activities (such as public service announcements and other television programming) and local activities to help communities improve the effectiveness of their HIV prevention programs through social marketing. In its first phase, begun in 1994, PMI focuses on preventing the sexual transmission of HIV among young people 18–25.

PMI is based on social marketing. A program funded in 1987 by the U.S. Agency for International Development (USAID) called AIDSCOM (AIDS Public Health Communication Project) demonstrated how social marketing can be used in HIV prevention. AIDSCOM contributed to the field of social marketing by adding strong behavioral science to program planning. Behavioral science examines people's behaviors in depth — who's doing what, with whom, where, when, how, and how often. Most importantly, behavioral science tells us *why* people behave as they do — what their knowledge is, what their skills are, what their beliefs are, what their attitudes are, and what motivates them. Knowledge, skills, attitudes, and beliefs combine to result in behavior, all of which is illuminated by behavioral science. AIDSCOM integrated program planning, social marketing, and behavioral and social sciences. PMI has capitalized on that experience.

In addition to social marketing and behavioral science, prevention marketing relies on a third critical component: community participation and action. Social marketing has always relied on target audience input for program materials — through focus groups, surveys, and other means. The community participation and action component is more than that. Prevention marketing relies on broad community mobilization and action to design, develop, deliver, and evaluate programs. It has as its foundation this belief: *Communities are experts in what their needs are, and, when equipped with supportive resources, are the best people to address those needs. Working with specialists in the sciences of behavior and communications, communities can best develop their own HIV prevention programs.*

Prevention marketing is CDC's "brand" of social marketing. Prevention marketing adds important qualities to social marketing with its emphasis on behavioral science and community participation and action. A key part of community mobilization is *issues management*, which systematically ensures that the media carry needed messages and information to audiences, including gatekeepers and other influentials. Competing, conflicting, and misunderstood messages can cripple community participation. Prevention marketing depends on constituents understanding issues and acting on them.

Prevention marketing is not a short-term solution. It's a long-term commitment — because changing and sustaining people's behavior is not accomplished overnight but over time.

For more information on PMI, see Appendix C.

A Rationale for New Approaches

Information Is Not Enough

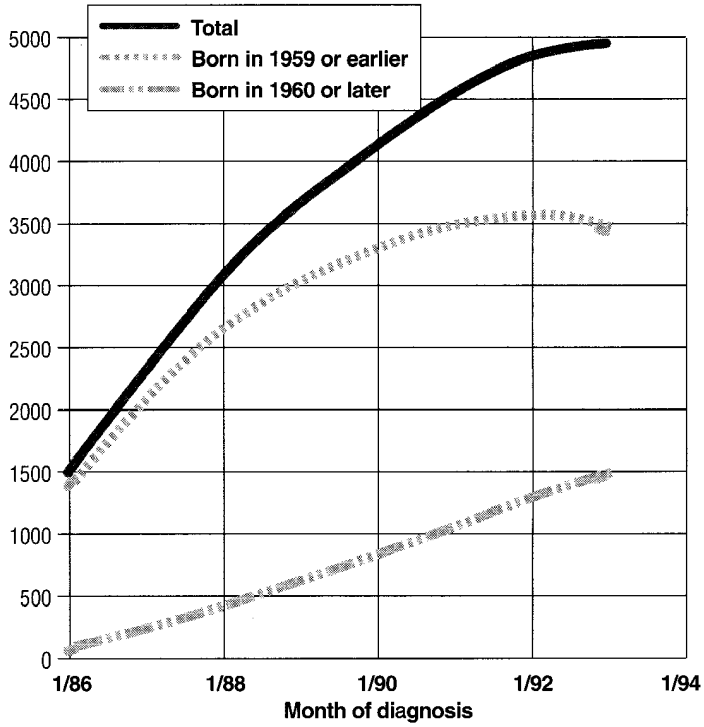
Accurate information about AIDS is critical to halting its spread. In the epidemic's early days, most prevention programs focused on giving people the facts about AIDS and HIV — what the disease is, how it's spread, what people can do to keep themselves safe.

But, as many people knew all along, information is not enough. Now, almost everyone knows the basic facts about HIV and its transmission. People need more than facts — they need support in changing behaviors that put them at risk.

Approximately 80,000 new HIV infections still occur every year among men, women, and children in the U.S. The CDC estimates that about a million Americans are infected with HIV, and many don't know they're infected. The median age of infection continues to decline,

AIDS cases in the U.S. population are still on the rise among young adults

AIDS cases are increasing much more rapidly among Americans born in 1960 or later.



Source: National Cancer Institute

as shown in the graph on the previous page. It is estimated that, by 1991, one of every four newly infected people was younger than 22 at the time he or she became infected. AIDS is now the leading cause of death among 25-42 year olds. Men who have sex with men account for approximately 43% of people with AIDS in America. New HIV infections and AIDS are increasingly reported among women and people who are racial/ethnic minorities. As the epidemic spreads to new populations, prevention programs must respond to new needs and perceptions with new ways of communicating, new messages, and new understanding.

Social Marketing Focuses on the Audience

Applying Proven Private-Sector Marketing Techniques to Health

Social marketing uses many of the tools of private-sector marketing — chiefly, intensive audience research — to guide program development and delivery. But instead of selling a product, like a car or detergent, a social marketing-based program "sells" behaviors that benefit both the individual and society. In the case of HIV prevention, behaviors could include...

choosing not to engage in sexual activity,

abstaining from penetrative sex,

not using unclean needles, or

using condoms.

Over the past 40 years, social marketing interventions to discourage smoking, promote seatbelt use, and prevent heart disease have shown that tailored messages delivered through credible channels and bolstered by appropriate support services can change people's health behaviors.

Social marketing's successes are the result of much more than just mass media, public service announcements, or advertising campaigns. Social marketing has three key features:

- *thoroughly understanding how and why "consumer segments" (target audiences) behave as they do;*

Social Marketing in Action

- *In the U.S., the National Cancer Institute used a social marketing campaign focusing on African-American women to increase early detection of breast cancer. The number of Black women who got mammograms rose from 28% in 1987 to 62% in 1992.*

- *The National Heart, Lung, and Blood Institute has used social marketing to guide a 22-year-long multi-dimensional campaign to decrease untreated high blood pressure. As a result, more than 95% of Americans have their blood pressure checked at least yearly, an increase of more than 40% since the campaign began.*

- *A social marketing program in the Eastern Caribbean targeted sexually active youth and their parents with messages centered on sexual responsibility and family communication. The comprehensive campaign reached more than 90% of the target audience. It resulted in a significant increase in the number of people who thought parents and teens must talk about sexual responsibility. The campaign also triggered a sharp increase in the number of people who said they believed their partners wanted to use condoms and who believed that their friends used condoms.*

Social Marketing in Action

- *In Ghana, a comprehensive AIDS prevention program was developed using social marketing processes. The intervention used television and radio spots, comic books, key rings, T-shirts, a school outreach program including movies, discussions in popular TV and radio series, and articles in news media. A key message was HIV's incubation period; another was about safer sex. The campaign had these results: More than half of the hard-to-reach rural male population was reached; the number of people who understood HIV's incubation period increased by almost 20%; sexual activity decreased significantly among youth; and sexually active men reduced their number of sexual partners.*

- *In the U.S., complete social marketing programs have not been extensively applied to HIV prevention efforts. CDC's Prevention Marketing Initiative is based on social marketing, and is posting some promising results in its first year. (For more information on PMI, see page 4.) Community-based programs that choose to use social marketing in their prevention efforts will be at the cutting edge of applying this tool to prevent HIV infection.*

- *According to the World Health Organization, vigorous AIDS awareness and condom promotion campaigns have been conducted in Vanuatu, a republic comprising 82 Pacific islands between Fiji and New Caledonia. Field workers hired by the Department of Health ensured that pharmacies, stores, markets, nightclubs, bars, hotels, and other sites had a ready supply of condoms. The national AIDS program developed billboard messages in Bislama, a common language that is a form of Pidgin. The estimated 150,000 inhabitants of Vanuatu speak 115 distinct Melanesian languages.*

- *creating beneficial exchange relationships (exchanging an unhealthy behavior for a healthy one to get some perceived benefit) to influence those behaviors; and*
- *strategically managing prevention programs by continuously monitoring and altering interventions as needed to stay relevant to targeted audiences.*

The Audience, The Audience, The Audience

"What are the three most important things in selling a house?" goes an old saying in real estate. The answer: "Location, location, location."

What's the most important thing in a successful social marketing program? "The audience, the audience, the audience."

Social marketing and behavioral science study what influences and motivates certain behaviors among groups of people. Only then are strategies to affect those behaviors — either to change or sustain them over time — designed and implemented.

Virtually all program decisions are therefore based on audience research. Any behavior is viewed as a choice among many competing options. The program planner's task is to know why a certain option is more compelling to people than other options, and then to design prevention programs that use the concept of beneficial exchange to increase the appeal of the desired behavior or decrease the appeal of the undesirable behavior.

How Do We Get To Know An Audience?

Perhaps more than any health challenge of the last several decades, preventing infection with HIV and other STDs requires an understanding of some of the most complex and

intimate human behaviors. Social marketing places tremendous emphasis on knowing as much as possible about targeted audiences and their behaviors and what determines those behaviors. It uses a variety of measures to get that knowledge. This process is often called formative research, because it forms the basis of the program plan. (For more information on formative research, see page 42.)

People analyze various kinds of data as part of formative research, including information in the following areas.

Epidemiology

Epidemiology — the science of disease patterns — gives program planners information about the people affected by a given health problem. In HIV prevention, epidemiology gives us invaluable information about:

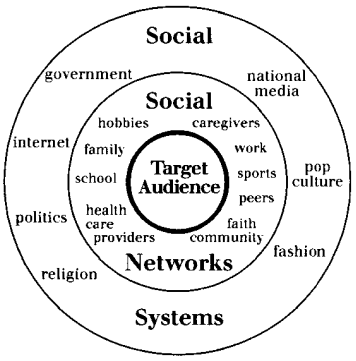
- **Seroprevalence:** Who is infected with HIV? How did they get infected? What does this tell us about prevention objectives?
- **Incidence of HIV Infection and AIDS:** What is the number of new infections or new diagnoses of AIDS in given groups? What does this tell us about where we might want to concentrate our prevention efforts?
- **Prevalence of AIDS:** How many people within a given group already have AIDS? What does this tell us about how the disease has progressed in the past? How it might progress in the future? What about the relative risk for people within the group to continue to spread infection?
- **Surrogate Indicators:** The incidence and prevalence of STDs, teen pregnancies, drug use, etc., can reveal key information about populations at risk for HIV infection.

Demographics

Demographic data give program planners information about target audiences' characteristics, including:

- race/ethnicity
- where they live
- how old they are
- education level
- sexual orientation
- religion
- marital status
- income.

Spheres of Influence



Psychographics

Psychographics adds to the picture by contributing information about:

- what the targeted audience's hopes and fears are
- what they do for work and recreation — where they spend their time, what's fun to them
- how they view themselves in the world
- who they associate with — their peers, people whose opinions they value
- whether they are innovators — willing to try new products, roles, activities, ideas, etc.
- what their social norms are — what they and their peers find valuable, believable, useful, worthwhile
- what their dreams are.

Psychographics gives program developers detailed information about the spheres of influence that affect the target audience and its behavior.

Media habits and other lifestyle factors

To begin narrowing the prospects for channels of communication, program planners gather information about the target audience's media habits and other lifestyle factors:

- what they watch

- what they listen to
- what they read
- how often they watch, listen, or read
- how much and how long
- where
- when
- other ways they get information
- what their behaviors as consumers are.

KABBs or KAPs

Knowledge/skills, attitudes, beliefs, and behavior surveys (or knowledge/skills, attitudes, and practice surveys) are at the heart of knowing the target audience.

- **Knowledge/Skills:** Program planners need to understand without a doubt what a target audience knows about program-specific topics. For example, what does the target audience know about using latex condoms versus natural membrane condoms to prevent transmission of HIV and other STDs? Do they know whether precum (pre-ejaculate) is risky? What about double-bagging (using two condoms at once)? And so on. Skills are also critical. Can those in the target audience negotiate safer sex with a new partner? With a long-time partner? Do they put condoms on correctly? Can they correctly withdraw from a partner after ejaculation?
- **Attitudes:** For example, how does the target audience feel about abstaining from or delaying sexual activity? Does "holding out" indicate they don't love their boyfriend or girlfriend? Does being a virgin mean you're cool, or does it mean you're a prude, or doesn't it matter one way or the other? If a girl has sex, is she "trashy"? If a boy has sex, is he "just being a boy"?

- **Beliefs:** For example, what does the target audience believe about condoms? That they have holes that let sperm and HIV through? That nothing's guaranteed 100%, so why bother? That condoms ruin the fun? That they reduce pleasure and spontaneity? What do they believe about sexual activity? That they are committing a sin if they have sex before they marry? That having a baby shows you're a grownup? That "having sex" means penetrative penile-vaginal intercourse, but doesn't include other sexual activities?

- **Behaviors:** What behaviors result from the target audience's knowledge, skills, attitudes, and beliefs? How many of them are already using condoms consistently and correctly? How many have tried condoms? How many have never used condoms? How many are abstaining from sexual activity? How many practice serial monogamy?

Epidemiologic and demographic information are generally available from the local or state health department — but you should be prepared to gather data at the community level. Much of the available information may not be broken down into small enough units — by block, or census track, or zip code, for example — to really give you a detailed picture of your target audience.

Information about a target audience's psychographic profile, media habits and other lifestyle factors, and their knowledge, attitudes, beliefs, and behaviors can be found in databases managed by Arbitron, The Roper Center/Institute for Social Inquiry, Mediamark Research, Inc. (MRI), Simmons Market Research Bureau (SMRB), and Yankelovich Partners, Inc., among others. These databases and other information are available in many public and university library research sections, through university marketing departments, and through most advertising agencies. In addition, often the major daily newspaper or radio and TV stations will have detailed data on demographic and psychographic character-

istics of the community, usually available through their advertising department and supplied to potential advertisers. Local and state governments and the U.S. Census Bureau and Government Printing Office are other potential sources of information. Program planners can enhance existing information through surveys, focus groups, research studies, or other means.

Four Models of Understanding Human Behavior – Highlights

Prevention marketing is about understanding the target audience's behavior — what motivates it, changes it, and sustains it, what the barriers and facilitators are to healthy behaviors, and so on — and developing programs that influence those behaviors. Since the beginning of the AIDS epidemic, four behavioral models have been most often used to discuss HIV-related behavior: the *health belief model, social learning theory,* the *theory of reasoned action,* and the *transtheoretical model.* These models have common elements, as you'll see in the brief descriptions below. PMI is based predominantly on social learning theory and the transtheoretical model.

The **Health Belief Model** assumes that people's health behaviors are caused by four key health beliefs:

perceived personal susceptibility or vulnerability;

perceived severity of the condition;

perceived efficacy of the behavior in dealing with the condition; and

perceived barriers to the behavior.

For example, a young woman, Kimba, might not perceive herself to be at risk for HIV infection because she doesn't have penetrative intercourse and she and her friends, includ-

ing her boyfriend, aren't "the type" to be HIV positive. Kimba feels AIDS is a terrible disease and would not want to have it. She feels her behavior — not having penetrative intercourse — is an effective strategy for preventing HIV infection. However, her boyfriend, Martin, is pressuring her to have penetrative intercourse and indicates he may find another girlfriend if she doesn't, and, besides, many of her friends have said they are sexually active and engage in penetrative intercourse.

These four beliefs, combined with other characteristics like Kimba's gender, age, culture, etc., together create a *readiness to act.* In this case, the action she might take — without a prevention program to intervene — might well be to have unprotected penetrative intercourse with Martin. In developing an intervention, program planners would need to know things such as which of the four factors has the most effect on her behavior and which is most likely to change. For example, programmers wouldn't want to spend a lot of time and energy seeking to convince Kimba that AIDS is a terrible disease. She already believes that. They wouldn't want to try to convince her that avoiding penetrative intercourse isn't effective in preventing infection, because it is. Instead, they might want to focus on addressing her perceptions of her ability to talk to Martin about their risks in having penetrative intercourse (perceived personal susceptibility or vulnerability).

Social Learning Theory asserts that two elements strongly affect health behavior: outcome expectations and self-efficacy. If a person believes that a behavior will lead to positive consequences, and those positive consequences outweigh any possible negative consequences, he or she is more likely to adopt and sustain the behavior. Self-efficacy is the individual's belief that he or she can actually perform the behavior.

Using Kimba as an example, if she believes that persisting in having only nonpenetrative sex will result in Martin leaving

her, she may be unwilling to maintain that behavior. Even if she is committed to it, she may not feel able to communicate that effectively to him. An intervention might focus on peers role-modeling communication about nonpenetrative intercourse, having Kimba role-play the communication, and/or attempting to reduce the perceived negative consequence of Martin leaving. PMI used social learning theory in working with Linda Ellerbee's Lucky Duck Productions on "SMART SEX." The young people in the show role-model successful HIV prevention behaviors (self-efficacy) and discuss the outcomes. For example, one young woman says, "What do I say to a guy who won't use a condom? Goodbye!"

The **Theory of Reasoned Action** says that changing behavior results from changing how people think about it. Because behavior results from beliefs, attitudes, and intentions — all thought processes — the task is to change those elements. For example, Kimba's behavior is a result of her intention ("that is what I intend to do to keep safe") her attitude ("I feel good about this — it keeps me safe from HIV, STDs, and pregnancy"), ("I am worried about this; it may mean that Martin will leave me for someone else") her fear, and a perceived social factor ("my friends are all doing it").

Underlying Kimba's attitude toward her current behavior is a set of beliefs about the outcomes of continuing and discontinuing the behavior and how she feels about those outcomes. (For example, "Martin will leave me if I insist on this. But I've seen other people stick by their decisions. Sometimes their boyfriend or girlfriend left, sometimes not. I could make it without Martin. And besides, he's going into the Army right after we graduate. I might never see him again anyway.")

Underlying the social factor is the set of perceptions Kimba has about particular individuals or groups and how they feel about the behavior (for example, "Martin wants to have 'real sex' and he's angry that I keep saying no. Mom and Dad

would be so disappointed if they knew I was having sex before I got married. My friends think I'm so old-fashioned. Everybody's doing it." And so on).

An intervention based on the theory of reasoned action could address Kimba's attitudes or her perceptions of the norm, depending on what was revealed about these elements during formative research. It might seek to help her feel more positive about her choice of nonpenetrative sex; it might seek to reduce her perceptions of the negative consequences of the behavior; it might seek to convince her that everybody isn't having penetrative sex; it might seek to increase her desire to comply with her parents' wishes.

The **Transtheoretical Model** draws from various other models of behavior, thus its name. It is commonly called the "Stages of Change Model," because it assumes that behavior change is a series of steps. People begin with no intention to change (precontemplation); begin thinking about change (contemplation); their intent to change strengthens (ready-for-action); they try the behavior, usually inconsistently at first, and assess the outcomes; and then move toward consistency if the outcome is favorable (action). Finally, they adopt the behavior as a routine part of their lives (maintenance or sustained change).

Various factors influence a person's movement through these stages, including knowledge, attitudes, and beliefs. For example, Kimba is contemplating changing her sexual behavior with Martin. Several things could move her forward or backward on the continuum. For example, Martin could continue to pressure her, and she could move to the ready-for-action stage. She might even try penetrative intercourse with him. If she found she did not like the consequences of that action (for example, she felt unsafe or she felt she let her parents down), she might return all the way to the precontemplation stage, and have no intention to change.

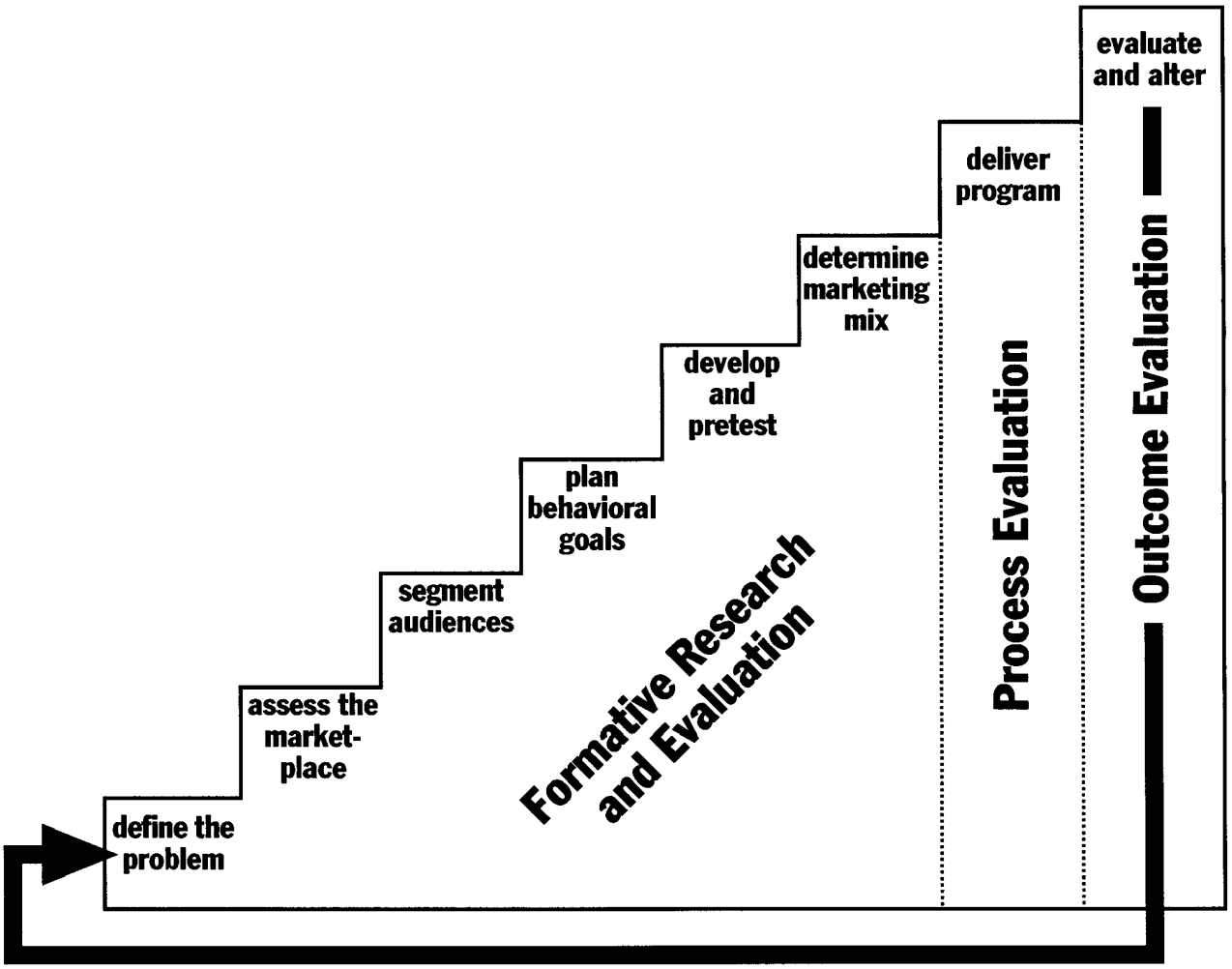
Interventions based on this model typically seek to move people from one stage to the next. For example, an intervention for people in the precontemplation stage might seek to increase their awareness of HIV/AIDS, their sense of personal vulnerability, and their knowledge about effective personal strategies for avoiding HIV infection. Unfortunately, this is where many, many prevention programs (not just about HIV) begin and end.

People in the contemplation stage might be moved to the next stage by increasing their skills in communicating with partners about sexual activities. Once in the ready-for-action stage, an intervention might address perceived consequences of asking a steady sexual partner to use a condom. An intervention in the action stage might address barriers to consistent condom use by ensuring that condoms are readily available to the target audience in the place(s) they might have sex. And an intervention in the maintenance stage might address the complex feelings of people who are HIV negative whose partners are HIV positive and the difficulties in continuing to practice safer sex. As you can see, the stages of change model is a framework that readily adapts to elements from all the other models.

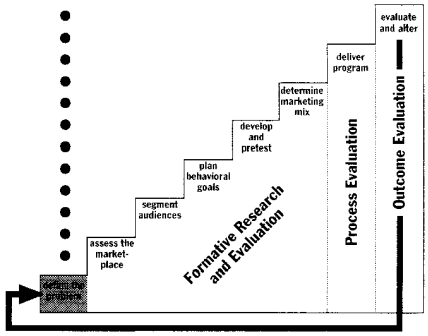
For more information about how prevention programs can use behavioral theory, see "Structuring HIV Prevention Service Delivery Systems on the Basis of Social Science Theory," by Valdiserri, West, Moore, Darrow, and Hinman in the *Journal of Community Health* vol. 17(1992):259-69.

Social Marketing Is A Series of Steps

Social marketing programs can be divided into a series of sequenced steps, each reinforcing and expanding the other. Information gathered during one step can influence a previous step. For example, data gathered as you segment audiences may cause you to revisit your definition of the problem, or you may change your marketplace assessment as you determine gaps.

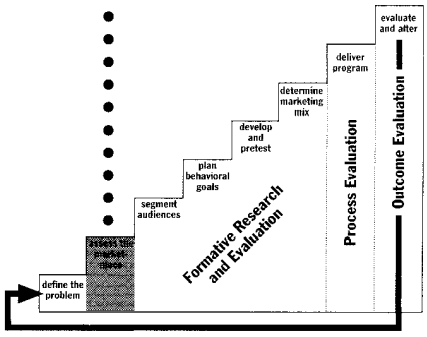


Define the Problem



At the heart of the HIV problem you will always find human behavior. Epidemiology helps pinpoint who's at risk and what they do that puts them at risk. But it isn't the whole story. Epidemiology doesn't give program planners the necessary insight into a target audience's perspectives on behaviors, especially the causes or "determinants" of behaviors: external factors like poverty and isolation from services, and internal factors like perceptions of self-efficacy (the individual's belief that he or she can do the desired behavior), social norms, barriers to performing lifesaving behaviors, and benefits of adopting lifesaving behaviors. This information is critical to understanding how an audience sees and reacts to a specific behavior you want to promote. To get it, you need behavioral science for insights into the target audience's current knowledge/skills, attitudes, beliefs, and behaviors, and marketing data about consumers' buying behaviors and the external and internal forces that prompt them.

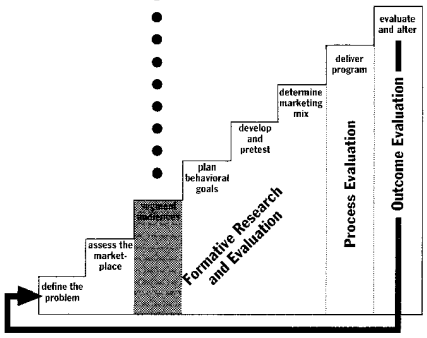
Assess the Marketplace



This stage is commonly called needs assessment. It includes "environmental scanning" to get a picture of the community in which you will be working: its politics, its consumers and their habits (what they buy, what they do for fun, etc.), what its media have reported on, and other characteristics. During this step, program planners should:

- identify and consult with relevant community groups;
- analyze what they know about the audience and what they need to know to design an audience-centered prevention program;
- assess local HIV prevention programs — Who do programs serve? What are their services? What are the gaps in service? What resources are available to address those gaps?

For more information on this step, see recommendations from the Prevention Collaborative, pages 37–47.

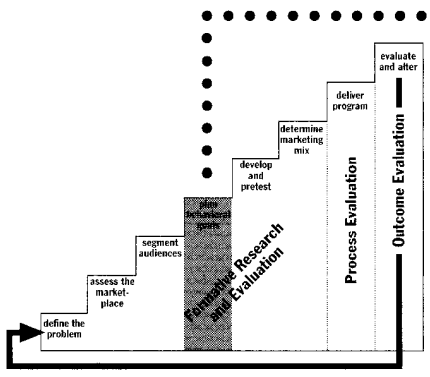


Segment Audiences

Demographics are an obvious way to define groups — for example, along racial/ethnic lines, by sexual activity, or by gender, or by age. But demographics don't provide the whole picture of a given audience. Within communities, within age groups, within sexes, within socioeconomic rungs, different people share different values, are affected by different pressures, and receive information through different channels. Social marketing defines groups according to these various lifestyle factors, and spotlights likenesses and dissimilarities within and across groups. For example, even across race, ethnicity, sexual orientation, and socioeconomic status, research shows that young adults 18-25 are more alike than they are dissimilar. It makes sense to create messages that capitalize on that similarity.

But even people who share lifestyle factors may be at different levels of readiness for new behaviors. In a single peer group, one teenager might be committed to abstaining from sex, another might be sexually active but willing to try condoms, another might reject the idea that he or she is at risk for sexually transmitted diseases, including HIV infection. Behavioral science helps program planners determine which perceptions, attitudes, and beliefs are important to specific audiences.

For strategies on this step from the Prevention Collaborative, see pages 37–47.



Plan a Program With Specific Behavioral Goals

Armed with extensive audience research, social marketers define audience segments and set measurable, realistic, and prioritized goals for each segment. Proposed interventions aim to influence specific beliefs, increase specific skills and knowledge, and to change or maintain specific behaviors.

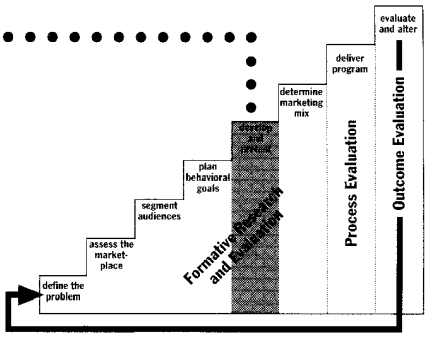
The program plan should outline specific strategies and methods for delivering messages and an evaluation plan that

includes both process and outcome measures to monitor the impact of your messages.

See pages 37–47 for more information.

Develop and Pretest Strategies and Materials

Design and test strategies and materials for effectiveness — delivery effectiveness, communication effectiveness, effectiveness in influencing audience behaviors. Adapt strategies and materials based on audience feedback. See pages 38–39 and 42 for more information.



Behavioral Model

Social marketing focuses on the audience's behavior and, just as important, the determinants of that behavior.

Behavioral Model

External Determinants of Behavior + *Internal Determinants of Behavior* ➢ *Behavior to be Influenced* ➢ *Health Outcomes*

External determinants of behavior are forces outside the individual that affect his or her behavior — for example, the availability of condoms or whether sexuality education programs are required for all students in high school. Internal determinants of behavior are the forces inside the individual that affect his or her perception of a behavior — for example, the perception that only "loose" girls carry condoms or the belief that condoms aren't "cool."

These two factors vary in importance from one audience and behavior to another. The focus of audience research is to identify the *targets of opportunity*: the determinants that are *both* important and possible to affect with available resources.

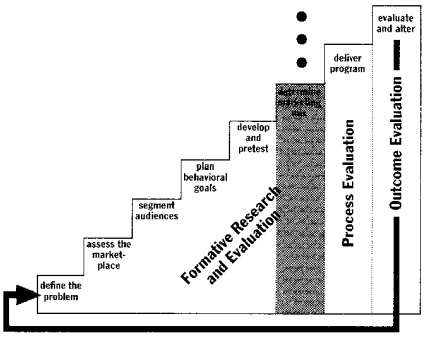
For example, community-based program planners may choose to concentrate on improving and extending available services rather than on a broad social issue that influences individual behavior, such as poverty; or on enhancing target audience members' self-efficacy (the individual's belief that he or she can do the desired behavior) rather than seeking to change broad social norms, such as American adults' notions about adolescent sexuality. At the community level, focused programs and messages to induce personal change — such as increasing people's skills in talking to partners about using condoms, thus enhancing their beliefs that they can perform such behaviors — are more likely to be effective than diffused programs to engineer social change, such as ending poverty.

External Determinants

- *Epidemiology*
- *Demographics*
- *Services*
- *Policy*
- *Culture*
- *Consequences*

Internal Determinants

- *Knowledge*
- *Perceived risk*
- *Attitude*
- *Perceived consequences*
- *Self-efficacy*
- *Perceived social norms*
- *Intentions*



Determine the Marketing Mix

A program's marketing mix — or the "4 Ps" of **product, price, promotion,** and **place** — is central to its success. These four elements balance the audience's perceptions and feelings about a given health behavior to create optimum appeal. This is where formative research with the target audience is invaluable, because that research reveals what the audience believes about your product, what they are willing to do (or not do) to get your product, how you can best position the product to appeal to them, where they can get the product and how, and so forth. For more information on formative research, see page 42.

Product

In commercial marketing, "product" usually means a thing to sell to consumers — an item, a service, sometimes an idea. In social marketing, the product is typically the desired attitude or behavior that will be exchanged for another attitude or behavior. To be successful, a product must offer a benefit people want. For example, tartar control cat food "offers" better pet breath. What does safer sex "offer" that people want — and want enough to exchange unsafe sex for?

Price

The old saying, "Everything has its price," couldn't be more true in social marketing. But the price usually isn't merely the actual monetary cost. In this context, the price is the monetary, physical, and/or emotional cost to the consumer to buy the product. The highest costs are often social, psychological, or emotional. For example, research with people at high risk for HIV infection often reveals they fear losing their partner if they insist on using condoms — a high, and seemingly unaffordable, cost to them.

Prevention program planners must understand and appreciate the costs their targeted audiences will pay in exchanging behaviors. At the very least, it is essential to know that changing behavior is seldom, if ever, easy. And

difficulties are increased monumentally when people's self-esteem, safety, comfort, and other central ego supports are involved. This is compounded when they don't get immediate benefits they care about after paying what to them may be very high costs.

Appreciating how consumers perceive costs helps you identify a desired behavior that has benefits that make the costs worth it. Only then can you position the desired behavior and its benefits and realistically ask people to change.

It's important to remember that messages may not center on lowering the cost, but on increasing the value of the product. For example, your audience might appreciate the benefits of latex condom use (protection from HIV and other STDs, peace of mind, greater staying power, etc.), making the costs of using condoms (loss of skin-to-skin contact, loss of sensation, or perceived lack of spontaneity, etc.) seem reasonable and affordable. Or they might value the benefits of complete abstinence (no need to worry about diseases or pregnancy, feeling good about being an individual and not going along with the crowd, knowing your partner cares for you and not just for sex), making the costs of abstaining (such as being perceived as a prude, not being like your peers, forgoing pleasure, losing love) seem less consequential.

Promotion

Promotion is about messages and the channels that deliver them. A comprehensive promotion plan takes into consideration the full range of communications tools — such as social advertising, public and media relations, media advocacy, entertainment media, personal selling, community-based programs, direct marketing, special events, and live entertainment. Messages should be clear, break through the clutter of other messages, be memorable, persuasive, accurate, and widely recognized. Promotion is

Promotion Evolves

As prevention programs have become more sophisticated in reaching target audiences and as target audiences' attitudes have changed, promotions have evolved.

- *The Stop AIDS program in San Francisco works to change or support **social norms** with pre-existing groups (PEGs) such as athletic leagues, service clubs, and choirs to promote safer sex discussions. This allows the PEGs project to reach a large number of people with a minimum of contacts and has the benefit of encouraging group members to support one another in safer sex behaviors. Program coordinators warn this approach can be time-consuming and that it requires gaining the buy-in of key group members. Results, however, are worth the extra effort. Stop AIDS is a Prevention Collaborative member. Telephone: 415/575-1545.*

- *CDC's Center for Prevention Services' AIDS Community Demonstration Projects targeted members of populations at high risk for HIV infection, including injecting drug users (IDUs) not in treatment, female sex partners of IDUs, women who trade sex for money or drugs, men who have sex with men (MSM), and youth at high risk. Demonstration site cities were Dallas, Denver, Long Beach, New York, and Seattle. Among the interventions used were **small media role-model stories** on baseball cards, flyers, and brochures. These featured an authentic story about a person in the targeted community, told in the person's own language, developed from interviews with community members. These small media interventions described the (cont.)*

designed to prompt a decision to practice the target behavior. That decision is then acted on in various places.

Again, the consumer's needs, lifestyle, and other factors must take precedence. Just because board members, program planners, or others may be personally influenced by editorial coverage in newspapers and magazines doesn't mean that consumers will be. The targeted audience may not regularly read newspapers or magazines. Or if they do, they may not find these sources of information to be credible.

person's stimulus and/or motivation for initiating or considering a behavior change, the type of behavior begun, how barriers to change were overcome, and the reinforcing consequences of the change. Message selection was guided by data and information from the targeted community and refined by focus group research and evaluation.

■ *Dismayed over Washington, DC, transit ads disparaging condoms, Whitman-Walker Clinic, AIDS National Interfaith Network, National Association of People With AIDS, National Minority AIDS Council, and Metro TeenAIDS used* ***media advocacy*** *to advance their position. They held a press conference and focused on the irrefutable scientific evidence that latex condoms are highly effective in preventing HIV infection. Press coverage included all three local network TV affiliates, the local independent television station, radio, and the* Washington Post, *as well as gay and ethnic print media coverage in Florida, San Francisco, and other towns across the country, all delivering the message: "Condoms work!"*

■ *AIDS educator Pedro Zamora used an* ***entertainment*** *show on MTV to promote safer sex. MTV also carried "SMART SEX," developed by producer Linda Ellerbee with assistance from CDC, which followed the lives of young people in communities across the U.S., offering a behind-the-scenes look at their sexual choices. "Reality Bites," a feature-length film about Generation X, carried one of the Prevention Marketing Initiative PSAs on its video rental version.*

Place

In commercial marketing, "place" refers to the location a product is offered. The optimal place is the most convenient outlet to consumers that is *also* the outlet that offers the most emotional benefits. For example, a product (perfume) with a high price ($65 an ounce) could be placed in a variety of retail locations ranging from discount stores to department stores. Discount stores would likely be the most convenient place for potential consumers. But would they offer consumers an emotional benefit? Consumer research would probably show that people would not expect to purchase expensive perfume in those locations and would not want to think of themselves as discount shoppers for this item. On the other hand, large department stores might be less convenient to get to, but shoppers would be more likely to expect to purchase a high-ticket item in them and consumers would feel good buying in such stores. In social marketing, when the product is usually a behavior, the analysis of convenience and emotional benefits is equally important, but the goals are different. Analyzing place is really analyzing the locational constraints on behavior. It takes into account that people may have made a previous decision — for example, to say no to sex or to always practice safer sex — and then examines how a particular place, such as a bar,

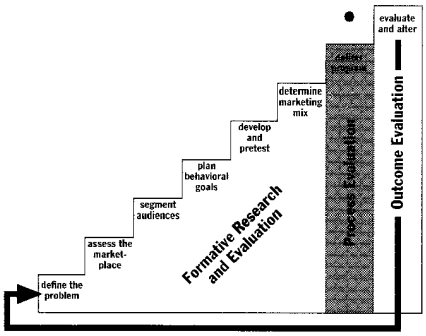
might affect that previously made decision. The analysis asks, "What can I do to make the place where people act on their decisions more likely to prompt the target behavior?"

A key question to ask in thinking about place is: What has the audience told us about this? Where do the consumers spend the majority of their time? Or, what various "lifepoints" — school, stores, restaurants, shelters, public restrooms, etc. — do they cross daily? Do you know how these locations affect their behavior? Sometimes, there is relatively little that can be done to make a place more likely to elicit the desired behavior. But other times your creative analysis of place will pinpoint some avenues for change.

Analyzing Place as a Catalyst for Behavior Change

The target behavior	→	negotiating safer sex
Where do people act on the decision to practice this behavior?	→	bars, home, streets, etc.
Can I change where people act on the decision?	→	no — not likely to change
What can I do to make one or more of those places more conducive to the target behavior?	→	make negotiating safer sex more **convenient** by having condoms free and available; increase **emotional benefit** by having safer sex posters displayed, giving safer sex promotional items (such as buttons, hats, etc.) to bartenders and other staff, and holding safer sex special events, so that patrons know the location as a safer sex place and think of themselves as safer sex practicers because they go there.

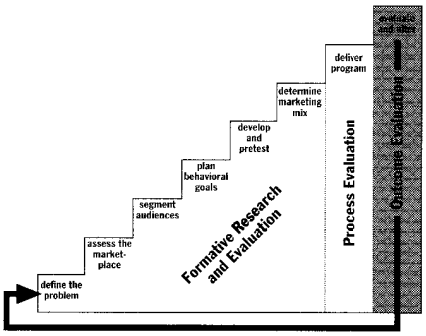
Deliver the Program



Put the program to work with the target audience. Distribute materials and messages, and generate support. Ensure all linked agencies — community-based organizations, AIDS service organizations, schools, etc. — work together to reinforce the program and its behavioral goals.

For strategies, see pages 49–54.

Evaluate and Alter As Needed



Monitor the program. Change strategies, messages, materials, and channels as necessary to meet evolving needs. Social marketing programs are not unchanging, static programs. They change as audiences change — constantly!

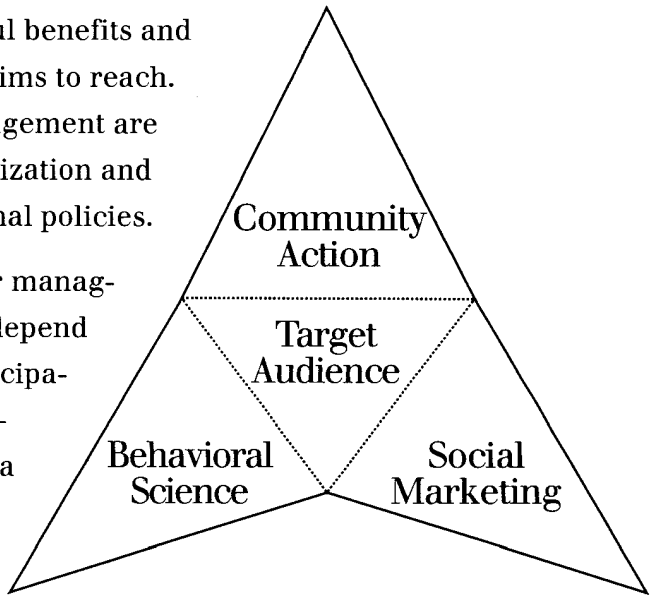
Evaluate the total program. Use both process criteria and outcome criteria. How many people did you reach? Who did you reach? When? Where? How often? Who responded? How? What changes occurred?

Based on what you learn, ask: "What do we need to change to move closer to our program goals?"

For evaluation guidelines from the Prevention Collaborative, see pages 37–47.

Community Action: An Integrated Framework

Social marketing is most effective when it draws upon various skills and resources — audience research, behavioral science, creative media and message development, innovative methods and places of delivery — to design and deliver HIV prevention programs that offer meaningful benefits and reduced barriers for the people the program aims to reach. These technical tools and their strategic management are best complemented by solid community mobilization and services, as well as supportive state and national policies.



Even if a single organization is responsible for managing a social marketing program, success will depend on the combined resources, support, and participation of many groups, including the target audience themselves. Support from the mass media can multiply the diffusion of messages many-fold. Policymakers can focus public attention on program issues. Credible community spokespeople, business and religious leaders, school staff, and board members can sanction public discussion.

The community has a vital stake in HIV prevention. And because HIV prevention is tied so directly to volatile emotional issues — among them sexuality; sexual identity; drug use; poverty; people's religious, moral, and ethical beliefs and behaviors — prevention program staff must take the prevailing attitudes in the community into consideration.

Clearly, HIV prevention programs must be driven by science — the sciences of epidemiology, human behavior, communications. But science alone will not guarantee success if large

segments of the community oppose or don't actively support a program or an intervention.

Prevention messages work best when the target audience gets them with the least amount of "noise" impeding their reception. Think of it like static on the radio. Lack of community consensus can lead to opposition or confusion as well as disintegrated and competing efforts — all of which will be sources of static cluttering the airwaves. Early in planning, prevention program developers must strive to integrate the various voices in their community to make the prevention message stronger and clearer and to reduce static that can break up the message. If you see opposition on the horizon, think strategically about what you can do to reduce it or at least to minimize the "noise" it may generate. Strategies are varied. For example, ask those who support you to put their support into action at community meetings, to write letters of support, to give positive interviews to local media, etc. Consider the opposition's vulnerabilities — do they lack knowledge about your target audience's risky behaviors and the determinants of those behaviors? Do they have experience with successful prevention programs? What are their concerns — could they be valid? This kind of analysis is often called "force field analysis," because it examines the forces that enhance or inhibit a course of action. Analyze the forces in your community to determine where you need to concentrate your pre-intervention efforts to position your program best.

Community action, coalition building, and collaboration are essential to successful prevention programs. This is why CDC's brand of social marketing — prevention marketing — includes community action as one of three equal elements. For guidelines from the Prevention Collaborative on this topic, see pages 55–62. For a list of questions to guide your thinking about applying prevention marketing to community-level interventions, see Appendix F.

Guidelines for Community-Based Prevention Marketing Programs

Overview of Resources

This section features recommendations from the Prevention Collaborative for prevention program staff. It also includes resources for more information and assistance. Included are guidelines in five key program areas:

- research and evaluation (see pages 37–47);
- linkage and integration with existing health, education, and social services agencies (see pages 49–54);
- coalition building (see pages 55–62);
- health communications (see pages 63–73); and
- community implementation (see pages 75–80).

Clearly, these topics are not totally distinct from one another. Linkages are part of successful coalition building; research and evaluation are cornerstones of effective health commu-

Program Examples

- *The Healthy Neighborhoods Coalition in Hampton, Virginia, focuses on building communities of care for children and families. The project works to gain a greater voice for youth in the community in three key ways: training youth and adults to work together, placing youth in advisory and decision-making roles in local organizations, and providing opportunities for youth input in community decisions.*

- *In San Francisco, the Mayor's Youth Forum brings young people — most of them with at-risk backgrounds — to participate in the city government process. The young people identify issues — such as violence prevention, education reform, and women's rights — and work in community organizing and advocacy projects. The program is supported by the U.S. Department of Health and Human Services.*

- *The HIV Center for Clinical and Behavioral Studies in New York City sponsors weekly meetings about topics in HIV prevention. One month's schedule included a meeting on gender differences among university students in preventing risky sexual practices and HIV-related risk behaviors; another examined homelessness, chronic mental illness, and HIV and women. Contact graduate departments of anthropology, psychology, public health, or social sciences in your area to find out about similar efforts or projects that might relate to your HIV prevention efforts.*

nications. Topics overlap because prevention marketing is an integrated approach to program design, delivery, and evaluation. The guidelines can be viewed as the backdrop for successfully implementing the prevention marketing steps outlined in the previous section.

Several overarching themes emerged as the Prevention Collaborative, the Guidelines Working Group, and the Resource Working Group worked to develop this document. These common elements are highlighted here to emphasize their importance to all prevention marketing efforts.

Involve the target audience in program conception, research, design, decision-making, implementation, and evaluation.

Involving the target audience helps shape each phase of any intervention and gives program planners a realistic perspective on the issues relevant to the program's consumers. This is especially important since formative research funding may be slim. A word of caution, however: Involving some members of the target audience should not replace formative research, because the information you get from that small group may be biased and cannot be generalized to the larger group. For more information, see the resources on page 42.

Design programs with cultural competence.

Cultural competence can be defined as cultural sensitivity combined with the ability to intervene successfully in a specific population. Cultural components to weigh include characteristics like race/ethnicity, gender, sexual orientation, age, education level, religion, activities, and so on. Don't stop at the obvious. For example, among injecting drug users, the culture of speed shooters is different from the culture of heroin users. Ask yourself: "What is it that distinguishes this particular group from others?" The answers you come up with are likely

to be key cultural components to consider. Involving the target audience is a sure-fire way to monitor the cultural competence of your intervention. Sometimes a target audience may have a standard of behavior that is at odds with the program's desired behavior. For example, if the norm within a group of young people is multiple sex partners, efforts to promote abstinence or decrease sexual partners will run counter to the prevailing norm and will likely be considered unacceptable, at least initially. A short-term culturally competent approach would seek to find an acceptable prevention alternative (such as condom use) that does not restrict the prevailing behavior, but does offer an acceptable degree of protection. Changing the group's norm may ultimately be accomplished *more quickly* with this kind of approach than if you had attempted to force a culturally unacceptable solution on the group.

Establish partnerships at the local, state, and/or national level.

Partnerships have the potential to enhance the efforts of all collaborating parties. Combining resources and expertise allows for greater reach, broader understanding of diverse constituencies, and more sustainable impact. Partnerships for HIV prevention should go beyond the typical boundaries to include alliances with varied organizations, among them private enterprise, religious groups, sports and arts organizations, and others.

Share information about HIV prevention programs and disseminate results of program evaluations.

A common concern among prevention program staff is that, as we move further into the second decade of the AIDS epidemic, there is still confusion and lack of knowledge about *what works*. Sharing information about program

evaluations and the results of research is vital to take advantage of lessons learned, to stop reinventing the wheel — and to make prevention more effective and efficient. Local networking is strongly encouraged, and should be part of each CBO's approach to community intervention. CBOs should make every effort to coordinate with their local HIV Prevention Community Planning groups. One vehicle for sharing information nationally is the Prevention Collaborative; for more information, call 404/639-0956 or leave a message toll-free, 24 hours a day by phoning 800/427-4784, then dialing 329-1659 to reach the Prevention Collaborative Liaison. Another vehicle is CDC's National AIDS Clearinghouse, a storehouse of information. NAC's toll-free number is 1-800-458-5231.

Resources for Working with Young Adults

Advocates for Youth has fact sheets and bibliographies on a wide range of adolescent sexuality issues, information and a curriculum on peer education (Teens for AIDS Prevention [TAP], and a national clearinghouse on school-based condom availability programs. For more information, contact Jennifer Hincks Reynolds at 202/347-5700 (phone) or 202/347-2263 (fax); 1025 Vermont Ave., NW, Suite 200, Washington, DC 20005. Advocates for Youth is a Prevention Collaborative member.

The Center for AIDS Education and Training, a Prevention Collaborative member, offers custom-designed HIV prevention programs, curricula, and training sessions for youth and adults as well as technical assistance in planning and developing HIV prevention and education efforts for youth. Contact Nancy Evans, 415/346-8316 (phone) and 415/928-1426 (fax); 1675 California St., San Francisco, CA 94109.

Center for Sexual Health, Planned Parenthood Federation of America, Inc., 810 Seventh Ave., New York 10019; 212/261-4628 (phone) and 212/247-6269 (fax). Offers information on HIV testing and counseling as well as sexual health for adolescents and adults. PPFA is a Prevention Collaborative member.

The Center for Youth Development and Policy Research. Working with the University of Michigan, the Center is conducting exploratory research in the fields of youth participation and neighborhood development. The project intends to identify ways in which young people can participate more actively in neighborhood development and to assess the forces that promote or limit youth involvement. Call 202/884-8267.

Community Partnerships with Youth, Inc. CPY is a national training and development center for youth and youth professionals. CPY designs training curricula, offers specialized training in trusteeship and governance, and provides technical assistance to youth-serving organizations and schools in the areas of youth empowerment, community service, service-learning, and adult-youth relationships. Call 219/422-6493.

ETR and Associates provides educational publications, training, and research services in HIV prevention, pregnancy prevention, and health education programs. They have a catalog of approximately 600 titles, including books, pamphlets, videos, and curricula, such as *The HIV Challenge: Prevention Education for Young People.* Contact Julie Taylor, 408/438-4060 or 800/321-4207 (phone) or 408/438-3618 (fax), P.O. Box 1830, Santa Cruz, CA 95061-1830.

Metro Teen AIDS has a how-to guide for youth and youth advocates who want to recommend, improve, and evaluate HIV counseling and testing services for adolescents. For more information, call 202/543-9355. Metro Teen AIDS is a Prevention Collaborative member.

The National Advocacy Coalition on Youth and Sexual Orientation provides information and expertise on local and national public policy issues affecting gay, lesbian, bisexual, and transgender youth. NACYSO is sponsored by New York's Hetrick-Martin Institute and is a Prevention Collaborative member. For more information contact 202/783-4165 ext. 49 (phone) or 202/347-2263 (fax) or nacyso@aol.com (email); 1025 Vermont Ave. NW, Suite 200, Washington, DC 20005.

National Network for Runaway and Youth Services. The National Network works to ensure that youth in high-risk situations can be safe and grow up to lead healthy and productive lives. The National Network actively engages in public education efforts, promotes youth/adult partnerships, and strives to strengthen staff and community-based organization capacity to provide effective programs and services to youth in high-risk situations. Training and technical assistance is provided in a variety of areas, including the professional development of youth workers, youth leadership, peer education, HIV/AIDS and substance abuse prevention, grant writing, and community and youth development. The National Network is a membership organization that represents over 1,200 constituents, primarily community-based youth-serving agencies. The National Network is a Prevention Collaborative member. Call 202/783-7949.

National Parent and Teacher Association, a Prevention Collaborative member, has information on parents' roles in HIV prevention, resources for establishing community education events, and how-to materials for discussing HIV/AIDS with children and teens. *How to Talk to Your Teens and Children about AIDS* is a brochure for parents that presents HIV/AIDS facts, guidelines for discussion, and recommendations for further reading. *Como Hablar con Sus Adolescentes y Niños Del VIH/SIDA* is the Spanish-language version. *HIV/AIDS Education Planning Guide for PTA Leaders* presents the basic facts on HIV/AIDS and guidelines for the development of community-based HIV/AIDS awareness programs; re-

sources are included. Two more brochures, *Talking to Your Child About Sex* and *Talking to Your Teen About Sex*, outline the approach parents can take to have successful discussions with children and young people. Contact Claudia Soldano, HIV Prevention and Education Project Coordinator, or Victoria Duran, Health and Welfare Program Manager, 312/670-6782 (phone) or 312/670-6783 (fax).

National School Boards Association has information and sample policies related to HIV/AIDS to support research and program development for community-based HIV prevention programs involving and/or affecting schools and school-aged children and young people. Contact Brenda Z. Greene, 703/838-6756 (phone), 707/683-7590 (fax), bgreene@tmn.com (email); 1680 Duke St., Alexandria, VA 22314. NSBA is a Prevention Collaborative member.

Youth As Resources. YAR is a Washington, DC-based program that provides small grants to young people to design and carry out projects to meet community needs. With support and funding from local businesses, foundations, and social services agencies, a local board of youth and adults solicits, reviews, and funds proposals written by youth with adult assistance. Call the National Crime Prevention Council at 202/466-6272.

Resources for Partnership

The National AIDS Fund (formerly the National Community AIDS Partnership). The Fund was established by the Ford Foundation in 1987 to support communities by developing resources for HIV/AIDS prevention and care. The Fund has a "challenge grant program" that matches local funds with national dollars. Monies are distributed based on the decisions of local partners. Located in Washington, DC, the Fund currently supports 38 communities in 33 states. Paula Van Ness, the president of the Fund, describes the benefits of partnership

as extending beyond money: "Our community partnerships help shape and support the spectrum of HIV/AIDS care, services, and prevention programs through grant-making, public policy, and capacity-building efforts." The Fund is a Prevention Collaborative member. Call 202/408-4848.

The National Alliance of State and Territorial AIDS Directors. NASTAD members — directors of state and territorial AIDS prevention and service programs — can offer help in coordinating with local HIV Prevention Community Planning Groups. Located in Washington, DC, NASTAD is a Prevention Collaborative member. Call 202/434-8090. (For a complete listing of state and territorial AIDS directors, see pages 111–115.)

TIDES — Funders Concerned About AIDS is a New York-based association of 1,200 individual grant-making executives from foundations and corporations across the United States and in 12 other nations. FCAA was founded in 1987 to mobilize philanthropic leadership and strategic resources to eradicate the HIV/AIDS pandemic and to address its economic and social consequences. Call 212/573-5533.

Research and Evaluation

Why Do Research and Evaluation?

Prevention Collaborative members note that research and evaluation can be intimidating to prevention program designers. This may be a result of negative experiences, a perceived lack of expertise, a belief that behavior change is difficult if not impossible to measure, or the notion that research and evaluation are time-consuming, expensive, and not cost-effective.

But research and evaluation are critical pieces of every program — not just programs based on social marketing — and are increasingly required by program funders from both the public and private sectors.

Research and evaluation are the paths to and from your target audience. Without them, you may well be far off the mark, squandering precious time, resources, and energy.

Research and evaluation don't have to be complex or complicated. Follow the suggestions from the Prevention Collaborative on the next few pages.

Four Key Evaluation Types

Prevention marketing programs rely on research and evaluation at several stages to ensure interventions are on target before widespread implementation, to identify elements that work and those that don't and need to be changed, and to pinpoint the changes that occurred in the target audience (short-term and long-term) as a result of the intervention.

Four key types of research and evaluation can be applied to prevention marketing programs: **formative, process, outcome,** and **impact.**

The purpose of **formative research** is to maximize the chances that your intervention will succeed *before you undertake any program activities.* Formative research, including a needs assessment and research into consumers' knowledge, skills, attitudes, beliefs, and behaviors, must be done before drafting any intervention. Later, it provides vital information on how to refine program design and implementation strategies before programs are implemented. As messages, materials, and strategies are proposed, they must be pretested with the target audience to assess their effectiveness.

According to *Making Health Communication Programs Work* (See Appendix D), pretesting helps fine-tune interventions by:

- **Assessing Comprehension**
- **Identifying Strong and Weak Points**
- **Determining Personal Relevance**
- **Gauging Sensitive or Controversial Elements.**

Pretesting is often accomplished through self-administered questionnaires, phone and intercept interviews (at malls, for example), focus groups, readability testing for written materials, theatre testing for audio or video materials, and gatekeeper reviews. For more information on formative research, see page 42.

As the program moves into the next stage — delivery — additional evaluation is needed. **Process evaluation** answers such questions as:

- What was done?
- To whom?
- By whom?
- To how many?
- How many times?

- For how long?
- How?
- When?
- Where?

Process evaluation tells you whether you are reaching the intended audience. It informs mid-course decisions, allowing you to correct small problems before they become big ones. It tells you about the most cost-effective and efficient way to implement your intervention.

Most prevention programs stop at process evaluation. But **outcome** and **impact evaluation** answer the most important question of all:

What changes happened as a result of the program?

Outcome evaluation documents short-term results of your intervention. It describes short-term quantitative results — for example, how many calls you received after a poster went up. It also describes qualitative results — such as attitudinal changes (the number of people who think delaying sexual activity with a new partner is a good idea); expressed behavioral intentions ("the next time I have sex, I'll use a latex condom"); short-term behavior changes (condom purchases go up); knowledge changes (the percentage change in the number of people who know the effect of oil-based lubricants on latex condoms); and changes in social systems (such as decriminalizing the possession of needles or syringes without a prescription). Note that all these qualitative elements can be — and should be — expressed quantitatively. Based on formative research, program planners should be able to numerically describe percentage change, numbers of people expressing intentions, gains in knowledge, etc.

Evaluating outcomes is not easy. But it's essential. Resources are available in most areas to help. Universities and colleges may be helpful, especially if the data are of interest to graduate students searching for a dissertation topic or to professors who want to publish. Local and state departments of health may also be able to help, or to steer you to consultants in your area.

Impact evaluation is the long-range assessment of your efforts. It provides information about changes in morbidity (disease) and mortality (death), long-term maintenance of the desired behavior, rates of unsafe behaviors, productivity lost or gained, economic increases or decreases, and so on. Impact evaluation involves long-term commitment. It can be costly. And it requires an understanding of all the forces affecting individual behavior, such as policies, government, and laws. For all these reasons, impact evaluation is typically not done for specific interventions. It is generally more comprehensive. Work with your local or state health department to assess whether impact evaluation is possible for your program.

Epidemiologic Definitions

Epidemiology *is the study of health and disease distribution in populations. Epidemiology is the science that underlies the public health practice of disease prevention and control. Epidemiology defines disease by:*

- ***who*** *is affected; who is at greatest risk*
- ***what*** *the behaviors are that put people at risk; what the trends are*
- ***when*** *diseases occur*
- ***where*** *diseases occur*
- ***why*** *diseases occur*
- ***how*** *diseases occur*

Incidence *is the number of new cases of a disease or condition that occur within a given time — for example, the yearly incidence of HIV infections or of AIDS diagnoses. Incidence numbers give us a picture of current trends and suggest possibilities for future trends, if interventions do not interrupt their course.*

Prevalence *is the number of people living with a disease or condition during a given time — for example, the prevalence of AIDS cases or of people who are HIV+. AIDS and HIV prevalence numbers give us a picture of current and future health care and social service needs and populations where future HIV transmission risk could remain high.*

Incidence and prevalence rates *are the number of cases per a standard population size, usually expressed as cases per 100,000 population.*

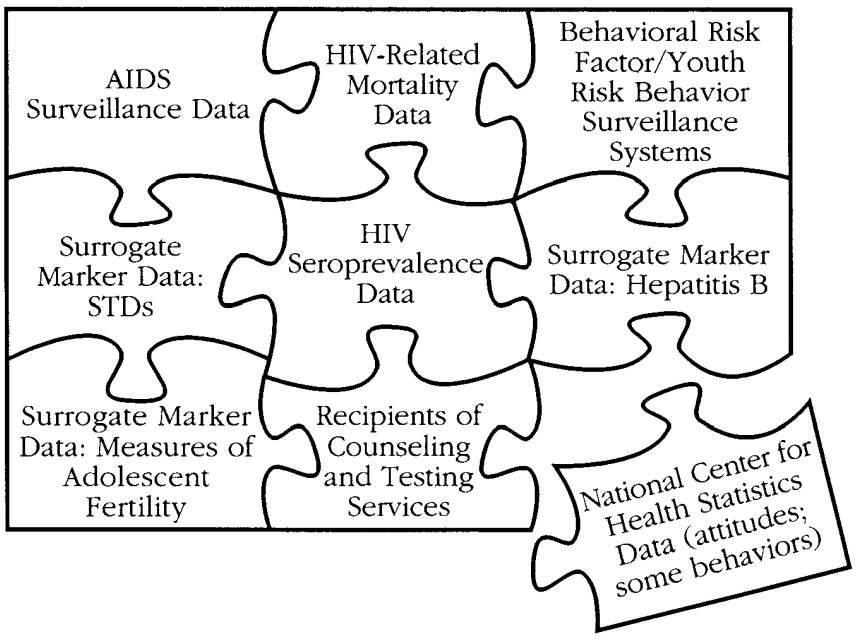
Surveillance *is an ongoing process of information collection, analysis, interpretation, and dissemination to monitor the occurrence of specific health problems in populations. Surveillance is used to guide and evaluate public health policy and programs.*

Research and Evaluation Guidelines from the Prevention Collaborative

Begin the process of ranking HIV prevention program priorities with epidemiologic data.

Epidemiologic data are key to ordering HIV prevention priorities. Using this science-based approach to planning is essential to sound public health practice and to gaining support for prevention programs. If these data are not available, state how they will be developed. Work collaboratively with state and local health departments and fellow service providers. Epidemiologic data are the starting point for programs, but not the final word. Combine epidemiologic data with information from other sciences: behavioral science and communications science. Develop a portrait of risk in your community. Know where risks (and their consequences) are now, where they have been, and where they're going. Ensure that epidemiologic data, communications, and behavioral science are used to direct scarce resources to those whose behavior places them at most risk *and* to those whose behavior you can affect. As

Readily Available HIV-Related Epidemiologic Data



one Prevention Collaborative partner put it, "Water needs to be dumped where the fire is now burning *and* on the dry grass around the fire to prevent it from spreading. A public health approach demands that interventions that benefit the greatest numbers be included alongside interventions targeting those at highest risk. This balance is critical regardless of funding." For more information on formative research in program planning, see page 42. Also see Appendix B for information on epidemiology's role in the HIV Prevention Community Planning process.

Collaborate at the community level to maximize limited resources and avoid duplicating efforts.

Research dollars and expertise are often scarce commodities. An important first step in designing research programs should be a literature review and analysis. Published research may answer key questions. Ideally, these "secondary data" as they are known, are supplemented with "primary data" from qualitative research you conduct, giving you insight into your particular community. Depending on your budget, inexpensive alternatives are focus groups and/or individual interviews. Community organizations with limited resources should combine efforts whenever possible, maximizing research funds, efficiency, and reach. A common private-sector collaborative effort is an omnibus survey, where various product manufacturers or marketers combine resources to commission research about their common target audiences.

Find out as much as you can about the target audience before you begin formal research.

Knowing as much as you can about the target audience — who they are, where they live, what they value, how they can be reached — is important to defining the scope of any formal

Project Action RFP

In Portland, Oregon, Population Services International (PSI) obtained reduced-cost services to support the teen-oriented safer sex promotion media campaign that is one component of the Project Action condom social marketing program. PSI issued a request for proposals, or RFP, to advertising firms in Portland, asking for assistance for the youth-oriented condom campaign. They selected one firm from among several responses. The firm produced three 30-second public service announcements for television and designed a campaign logo, posters, and letterhead. For $435,000 of services and goods, PSI paid only $100,000.

The relationship worked, according to project director Julie Convisser, because requirements and expectations from both sides were discussed thoroughly and frankly at the outset, and because the agency was dedicated to the issue and to making a difference in its community. For its part, Project Action made sure that the advertising agency received ample public recognition and credit for its efforts. Project Action also benefitted from the contributed services of a local market research firm that specializes in polling and surveys. The company conducted a survey of fast-food customers' reactions to condom posters in restaurant bathrooms. The company charged $3,000 for $8,000 worth of services.

For more information, contact Helen Crowley at 202/785-0072

Formative Research

Formative research is conducted during the planning stages of program development. It forms the basis for behavioral goals, interventions, and later evaluation. Formative research can take many forms, including:

- analysis of epidemiologic data;
- literature reviews;
- analysis of demographic and psychographic data;
- focus group discussions, town meetings, or surveys to identify key issues, opportunities, and barriers;
- analysis of marketing data;
- pretesting concepts, messages, and channels of communication with consumers; and
- pilot testing with a small group before implementing a strategy community-wide.

Formative research is critical to successful social marketing programs. It doesn't have to be expensive. Much of the information you need is likely available through state or local health, education, or social services departments, at a local public or university library, or from other service providers. And you may get *pro bono* (free) or reduced cost help from a local market research firm, the research department of a large company, the advertising departments of local media (newspapers, radio, and TV), local advertising and public relations firms, and communications or public health departments at nearby universities and colleges. Many times these firms donate services or reduce costs because they believe in the cause or because they will get positive recognition. Some community groups put out RFPs (request for proposals) for *pro bono* work; others simply seek assistance directly from sources they have cultivated over time. The key, according to Prevention Collaborative partners, is: *Don't be afraid to ask!* The worst that can happen is that someone will say no. And the best is that you'll tap into a source of expertise for free. Also, remember that these nontraditional partners have technical expertise, but you bring HIV/AIDS expertise. It will be very important to act as the "client" and insist on technically correct messages.

research, such as behavioral studies. Examining your proposed consumers will probably pinpoint other groups you need more information about. For example, school-based studies don't include out-of-school or working youth. A prevention program for young people based solely on studies of in-school youth would likely not be effective with out-of-school youth.

Include interested parties in research design.

The target audience is certainly an interested party. But so are representatives of organizations that serve the target audience and policy- and decision-makers who can affect — for good or bad — project implementation. Ask yourself, "Who has a stake in this?" and then get them involved.

Make sure your research is culturally competent.

Involving members of the community in developing research questionnaires, crafting language, and in the interview process will help avoid miscommunication that can derail or invalidate research. Remember that culture can be defined by various criteria: sexual orientation and/or practices, race/ethnicity, gender, age, geography, religion, etc. Survey instruments are available that can be used "as-is" or modified to fit local needs. If you want to modify existing instruments, seek assistance from experienced researchers in how the modifications may affect the survey's credibility. Information about survey development, cultural competence, results of surveys, KABBs, and survey instruments is available through the CDC National AIDS Clearinghouse's Educational Materials Database.

CDC National AIDS Clearinghouse

▮ *Calling 800/458-5231 connects you with reference staff and a wealth of HIV/AIDS information, from research and evaluation to prevention materials in more than 20 languages, to information on care, funding, and technical assistance. The CDC National AIDS Clearinghouse provides quick access to its varied databases through the reference staff or by using the NAC ONLINE Bulletin Board. A reference specialist can give you a free, customized database search on specific topics that interest you. Standard searches and specific bibliographies are immediately available on a variety of topics, such as abstinence programs, condom effectiveness and use, and so on. You can get many of the materials through the Clearinghouse, from publishers, or from the organization that developed them. For a minimal fee, NAC can arrange for permission to reproduce printed materials through its Document Delivery Service.*

Link research to needs and to interventions.

Research should be designed to answer a specific question that relates to a prevention need (known or suspected) and should be an integral part of all interventions subsequently developed and delivered. Formative research will help define the need (for example, how prevalent unprotected anal intercourse is within a given population at high risk), help define the factors that are creating the need (for example, young men aren't using condoms because the perceived social norm doesn't support condom use, condoms aren't available, condoms are perceived as decreasing sensation and pleasure, condoms mean you don't trust your partner), and allow you to create explicit process and outcome objectives (for example, peer-to-peer counseling will reach 100 members of the target population at least three times within a three-month period; of those receiving counseling, 75% will state a short-term intention to use condoms the next time they have intercourse). Ongoing evaluation will help assess how well the intervention is meeting its process and outcome objectives (how many people are actually reached, how many times, the behavioral results of those contacts, etc.).

Disseminate research results.

Sharing results with community members helps develop trust and establish consensus around an issue (such as a specific need or a specific intervention). Sharing results of what works and doesn't work also gives other groups ideas of what they can do. An informed community is better able to support HIV prevention efforts. Researchers and prevention program developers working collaboratively with a targeted audience have an obligation to share information — to work *with* the group, not *around* or *on* it. Nationally, the need for shared information grows as resources constrict, increasing the need for rapid and open dissemination of results. A competitive attitude about research results often defeats

collaborative work. Channels for sharing information vary in sophistication and availability, from scholarly journals and colloquia to public-access electronic bulletin boards. At the very least, all information should be made available to the National AIDS Clearinghouse, for on-line alert and distribution, and to the Prevention Collaborative, for distribution to participating organizations and their constituents.

Selected Readings on Research and Evaluation

AIDS Action Foundation. *A Survey of the HIV Prevention Community Planning Process, Report of Findings.* March 1995. Call 202/986-1300.

AIDSTECH. *A Guide for Evaluating AIDS Prevention Interventions: Tools for Project Evaluation.* Research Triangle Park, NC: Family Health International, 1992. (Available from AIDSTECH, 919/542-7040.)

Andreasen, A.R. *Cheap But Good Marketing Research.* Homewood, IL: Dow Jones-Irwin, 1988.

Crabtree, B.F. & Miller, W.F. *Doing Qualitative Research.* Newbury Park, CA: Sage Publications, Inc., 1992.

Damond, M., Gurvitch, A., Ludlow, N., et al. *Making Evaluation Part of Your HIV/AIDS Education Plan — Methods and Measures.* Washington, DC: American Red Cross, National Headquarters, Office of HIV/AIDS Education, 1993. (A photocopy of this material is available from the CDC National AIDS Clearinghouse Document Delivery Service, 800/458-5231.)

Debus, M. *Handbook for Excellence in Focus Group Research.* Washington, DC: Porter/Novelli. (Copies can be purchased for $10.00 from the Academy for Educational Development, Eileen D'Andrea, 202/884-8882.)

Greenbaum, T.L. *The Handbook for Focus Group Research.* New York: Lexington Books, 1993.

Leviton, L.C., Hegedus, A.M. & Kubrin, A., eds. *Evaluating AIDS Prevention: Contributions of Multiple Disciplines.* San Francisco, CA: Jossey-Bass Inc., 1990. (A photocopy of this material is available from the CDC National AIDS Clearinghouse Document Delivery Service, 800/458-5231).

Leyva, M.A. & McKay, E.G. *Understanding Evaluation Techniques: The Building Blocks of Evaluation.* Washington, DC: National Council of La Raza, Center for Health Promotion, Hispanic Health Liaison Project, 1993. (Available from the National Council of La Raza, 202/785-1670.)

National AIDS Fund. *Evaluating HIV/AIDS Prevention Programs in Community-Based Organizations.* September 1993. (Copies may be ordered through the National AIDS Clearinghouse, 800/458-5231.)

National Council of La Raza, Center for Health Promotion. *Evaluating HIV/STD Education and Prevention Programs: An Introduction.* June 1992. (Copies may be obtained through the National Council of La Raza, 202/785-1670.)

Sarvela, P.D. & McDermott, R.J. *Health Education Evaluation and Measurement: A Practitioner's Perspective.* Dubuque, IA: William Brown Communications, Inc., 1994.

Smith, W.A., Helquist, M.J., Jimerson, A.B., Carovano, K. & Middlestadt, S.E. *A World Against AIDS: Communication for Behavior Change.* Washington, DC: Academy for Educational Development, 1993. (Copies may be purchased through the Academy for Educational Development, Eileen D'Andrea, 202/884-8882.)

U.S. Conference of Mayors. *Evaluation for HIV/AIDS Prevention Programs: Gathering Evidence to Demonstrate Results.* USCM AIDS/HIV Program, Technical Assistance Reports. December 1990. (Copies may be ordered through U.S. Con-

ference of Mayors, HIV/AIDS Division, 1620 I Street, NW, Washington, DC 20006. Fax: 202/887-0652. Free for Health Departments and CBOs, $4.00 charge for for-profit organizations.)

U.S. Department of Education. *Understanding Evaluation: The Way to Better Prevention Programs,* 1993. Free copies are available from the National Clearinghouse for Alcohol and Drug Information (U.S. DOE publication no. ED/OESE92-41), 800/729-6686.

U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. *Handbook for Evaluating HIV Education*, 1992. (Copies available through CDC/NCCDPHP/DASH, 404/488-5330.)

U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention. *Measurements in Prevention: A Manual for Selecting and Using Instruments to Evaluate Prevention Programs.* CSAP Technical Report Number 8, 1993. (Available through the National Clearinghouse on Alcohol and Drug Information, 800/729-6686.)

U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Prevention Marketing Initiative. *Coalitions and Public Health.* Draft, September 1994. (Copies may be ordered through the National AIDS Clearinghouse, 800/458-5231.)

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Cancer Institute, Office of Cancer Communications. *Making Health Communication Programs Work: A Planner's Guide.* NIH publication no. 92-1493, April 1992.

Notes

Linkage and Integration with Existing Health, Education, and Social Services Agencies

How Does Linkage Fit in Prevention Marketing?

Linking with local agencies is a key ingredient in all stages of prevention marketing, from formative research to program evaluation, and is essential to gaining community support for and participation in the program. It is also essential to the HIV Prevention Community Planning process. Linked organizations can provide valuable information in the planning stages about the target audience and their behaviors. Linkages can help agencies identify existing services and gaps in services. Linkages help define who's providing what service to whom, where, and how. Linkages can help agencies identify or establish effective channels for delivering prevention messages and assist in reaching audiences that are rarely reached. Linked organizations can help monitor the program's effects and provide input for alterations. They don't have to be HIV-specific: family planning clinics, youth-focused self-esteem programs, drug treatment clinics, STD clinics, and others are all possible collaborators.

What Are the Benefits of Linkage with Health, Education, and Social Services Agencies?

In developing, delivering, and evaluating HIV prevention programs, linkages with health, education, and social services agencies are essential. The expertise and services these particular organizations have are vital to:

- coordinate and improve individual and collective HIV prevention services;
- best serve individual and collective consumers;
- decrease duplication and increase tiered services to ensure a continuum of care and services for clients; and
- make maximum use of limited resources.

Linkage Guidelines from the Prevention Collaborative

Start with your HIV Prevention Community Planning group.

If you are not currently part of an HIV Prevention Community Planning effort, contact your state AIDS director to get information on efforts in your community. These groups have developed prevention plans with priorities for target audiences and interventions. You need to know about and coordinate with these plans. (A list of state AIDS directors is in Appendix B.)

Develop a coordinated community program approach.

To coordinate effectively with others, start with an organization that is already a recognized leader in the community, and one whose structure and resources allow it to take the

lead. Most often, these agencies include the local public health department; established CBOs and ASOs; educational agencies, including public and private schools, colleges, universities, and trade schools; and social services agencies. Coordinating your approaches to HIV prevention and to community involvement in your activities will build a base from which to reach out to others, including nontraditional partners.

If it doesn't exist, develop an infrastructure that fosters inclusive partnerships in the community.

The limited resources of many community-based organizations preclude them from assuming leadership roles, but may not completely prevent them from participating. It is critical that leading organizations, like the ones mentioned above, actively pursue partnerships with other community groups and make every effort to build an infrastructure that fosters inclusion, not exclusion. Community organizations including religious groups, schools, correctional facilities, and others should play a role. Include anyone who has a stake in the well-being of the target audience. For more information on broader coalition building, see the next section.

Share resources, including information, technology, funds, program elements, and staff.

Community linkages are ultimately successful to the degree that they share resources to deliver the most effective programs possible. This kind of power-sharing requires tremendous trust. Linked or collective program plans that transcend the goals and objectives of any one agency are essential.

Hold joint trainings.

To support a cohesive prevention program, training and other skills-building resources must be available to all community partners. Current and accurate information on behavioral science, social marketing, HIV education, and other program-specific topics are essential to individual and collective success. Systems of communication, training, and information-sharing should be jointly developed at the outset to ensure that they are rapidly disseminated and that competencies are built effectively and efficiently.

Develop consistent, clear, accurate messages about HIV prevention.

Linked organizations must develop a shared understanding and common language about HIV prevention for their community. Linked agencies have access to the target audience at different points — for example, in schools, clinics, or through child welfare services. It is vital that all these different contacts deliver the same message. *(This concept is critical to the success of any broader coalition that might develop. See pages 61–62.)* Because discussions about HIV prevention can trigger intense emotional responses — particularly if the target audience is youth — it is critical that linked organizations speak with one voice. Determine common ground and stick to it, so that all the consumers of your messages — the target audience, the broader community, key stakeholders such as the media, government, and others — get the same message.

Resources on Linkages

American Asssociation for World Health offers a resource booklet and poster to help you increase community awareness and understanding of HIV/AIDS issues — including prevention — around World AIDS Day, December 1 every year. AAWH is a Prevention Collaborative member. Richard L. Wittenberg, Director, 1129 20th St., NW, Suite 400, Washington, DC 20036; 202/466-5883 (phone) and 202/466-5896 (fax); AAWHSTAFF@AOLCOM (email).

CDC funds national and regional minority organizations (NRMOs) to provide technical assistance to community-based organizations to help with linkages, coalition building, and other activities. For a complete list, see page 118.

The National AIDS Fund (formerly the National Community AIDS Partnership) has a "challenge grant program" that matches local funds with national dollars. Monies are distributed based on the decisions of local partners. The Fund currently supports 38 communities in 33 states. The Fund is a Prevention Collaborative member. Telephone: 202/408-4848.

TIDES-Funders Concerned About AIDS (FCAA) links funders who collaborate on HIV-related grants. The organization represents over 1,200 grant-making executives from 42 states. Over 70 grant-makers throughout the country serve on committees that examine grants in different areas. The organization's objectives are to encourage funders to incorporate HIV/AIDS into their grant-making agenda; to produce materials on strategic philanthropic opportunities, and to involve grant-makers in efforts to improve public policy on AIDS-related matters. Telephone: 212/573-5533.

United Way. Local United Way organizations take leadership and support roles in the creation of local coalitions and partnerships to address community issues. Numerous United Way organizations have embarked on HIV/AIDS partnership initiatives as recipients of grants from The National AIDS Fund (formally the National Community AIDS Partnership). Because United Way organizations have proven track records and raise funds on the local level from public, private, and voluntary sectors, they are adept at pulling together players from all different segments of society to help build stronger communities. United Way of America, the national service and training center that supports local United Way organizations, is a Prevention Collaborative member. Telephone: 703/683-7835.

Coalition Building

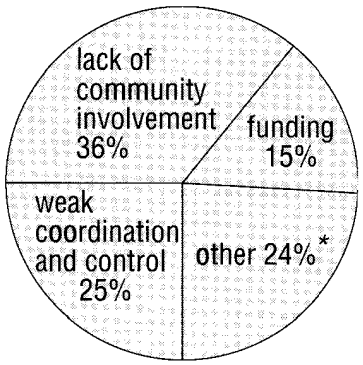
How Do Coalitions Fit Into Prevention Marketing?

Broad community action is one of the three essential elements of a successful prevention marketing program and of HIV Prevention Community Planning. Building coalitions among varied organizations is one aspect of community participation. Coalition building usually happens before or during the program planning stage, but coalition membership and focus may change over time, as broad planning gives way to more targeted planning and then to intervention and evaluation. Potential coalition members will become apparent as your target audience is narrowed and defined. Any group in your community that has a stake in the well-being of your target audience — even if (*perhaps especially if*) their opinion differs from yours — should be considered as a potential member of the coalition. Diversity enriches the coalition, makes it multi-dimensional, and enhances its ability to serve the full spectrum of consumers.

Coalition building requires a commitment to shared decision-making, shared responsibility and accountability, and shared resources to respond to mutually agreed-upon community needs. It requires a formal commitment to work together, perhaps expressed as a common mission statement, a common vision, or even a legal contract. It doesn't require that everybody agree on everything all the time.

What Are the Benefits of a Community Coalition?

According to a Strategies *newsletter reader poll, these are the major barriers coalitions face (other than lack of funding) to planning and implementing successful community-level prevention programs.*



** other barriers (such as turf issues, lack of parental involvement, and community denial) 24%*

Source: Strategies *vol. 3 no.2 (Summer 1994) 6.*

A coalition that functions well offers many benefits, according to the National Assembly of National Voluntary Health and Social Welfare Associations (a Prevention Collaborative member). A community coalition can:

- identify gaps in current services (a key part of needs assessment) and cooperate to fill those gaps;
- expand available services by cooperative programming and joint fundraising;
- provide better services through interagency communication about referral programs;
- develop a greater understanding of community needs by seeing the whole picture, not just a part of it;
- identify similar concerns and, at the same time, be strengthened by diverse perspectives that different members from varied backgrounds bring to the joint effort;
- reduce interagency conflicts and tensions by squarely addressing issues of competition and turf (especially important in a time of reduced resources);
- mobilize community action to effect needed changes through collective advocacy and the strength of individual organizations' constituents;
- achieve enhanced visibility and credibility with decision- and policy-makers, funders, the media, and the broader community;
- enhance staff skills by sharing information and holding joint training programs;
- conserve resources by avoiding duplication of services; and
- decrease costs through collective resource-saving opportunities.

Coalition Building Guidelines from the Prevention Collaborative

Form alliances with nontraditional partners to broaden the coalition's reach.

Private- and public-sector institutions in your community have a stake in HIV prevention — even those that don't yet know it! Cast your net as widely as possible to include nonhealth partners. For example, actively recruit area businesses who will directly benefit from HIV prevention by having a healthy workforce now and in the future, cutting health care costs, and contributing to the community's overall health and well-being.

Develop a shared vision and clear mission to succeed in coalition building.

As you begin forming a coalition, give special attention to developing common goals. It is essential to take the time to explicitly lay out the coalition's purpose, its vision, its mission, and how that mission will be achieved. As a group, review your joint vision, the common mission, and your collective progress regularly and make changes as needed to address changes in community needs, coalition membership, or other external or internal factors that can affect how the group functions.

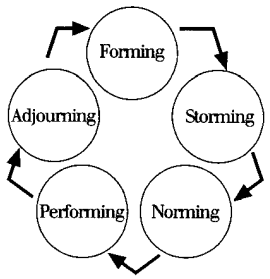
Define roles and responsibilities for each participating organization.

All roles and responsibilities — as well as accountability — must be defined and agreed upon at the beginning. Taking the time to detail these elements will reduce conflict later. Be aware, though, that roles and responsibilities can and will change over the life of the coalition. Staff changes (burnout, turnover, change in skills, etc.), changes in participating

Another Look at Coalition Building

Most of us are accustomed to looking at coalition building as linking with groups. But coalition building is also about linking and mobilizing individuals around an issue. For example, the Latinas: Partners for Health *network has become a catalyst for uniting thousands of women around HIV/AIDS. Since 1990, more than 1,200 women nationwide have given their time and resources to HIV education and prevention. Careful planning set in motion a two-track strategy linking community and national leaders to share resources and strategies. The project also generated sorely needed resources:* The Latina AIDS Action Plan and Resource Guide, Latinas: Partners for Health Partnership Directory, *and* Latinas: Partners for Health HIV/AIDS Partnership Plan. *For more information about the network, contact HDI Projects in Washington, DC, at 202/452-3750.*

Stages of Coalition Development



Forming. *As a coalition comes together, feelings can range from excitement and enthusiasm to fear and resistance. The overriding tone is usually cordial.*

Storming. *After the formative stage, issues and agendas begin to surface. Slight to severe differences in the perception of facts, goals, methods, values, etc., are uncovered. Responses can range from withdrawing to overt fighting. The atmosphere is often chaotic.*

Norming. *Members stop talking* at *each other and start listening* to *each other. Needs, benefits, and limitations of collaboration are realized. Roles and responsibilities are determined; agreements are made concerning ground rules and group procedures. Constructive compromises are found. The tone is usually relieved and hopeful.*

Performing. *In this stage, the group produces. Members honor boundaries and agreements. Balance is maintained between content and process. Tone is characterized by appropriate participation, respect, and commitment.*

Adjourning. *In the final stage, the group disbands as its collaborative mission is accomplished or changes. Feelings can range from pride and a sense of accomplishment to relief or sadness that the group is separating. If a core group remains to address a new mission, new members will be recruited and the cycle will begin again.*

organizations (for example, reduced or increased funding, new or changed program focus), and external changes (such as new school board members or other factors affecting the targeted audience or the broader community) can change participating organizations' functions within the collaboration. Take time to review roles and responsibilities periodically and modify as needed.

Educate each member organization's constituents about the coalition and its purpose.

Ensure that stakeholders in each member organization — board members, management, clients, funders, and so on — understand the nature and purpose of the coalition, and their organization's role in the coalition. This can help avoid conflicts that can arise when constituents don't perceive benefits to the coalition, perceive conflicts of interest among member organizations, or have had past negative experiences with other participating groups. Open or "under the table" divisiveness can thwart the coalition's success. Every member organization's constituents have a stake in the coalition's success, and every effort should be made to secure their buy-in and support.

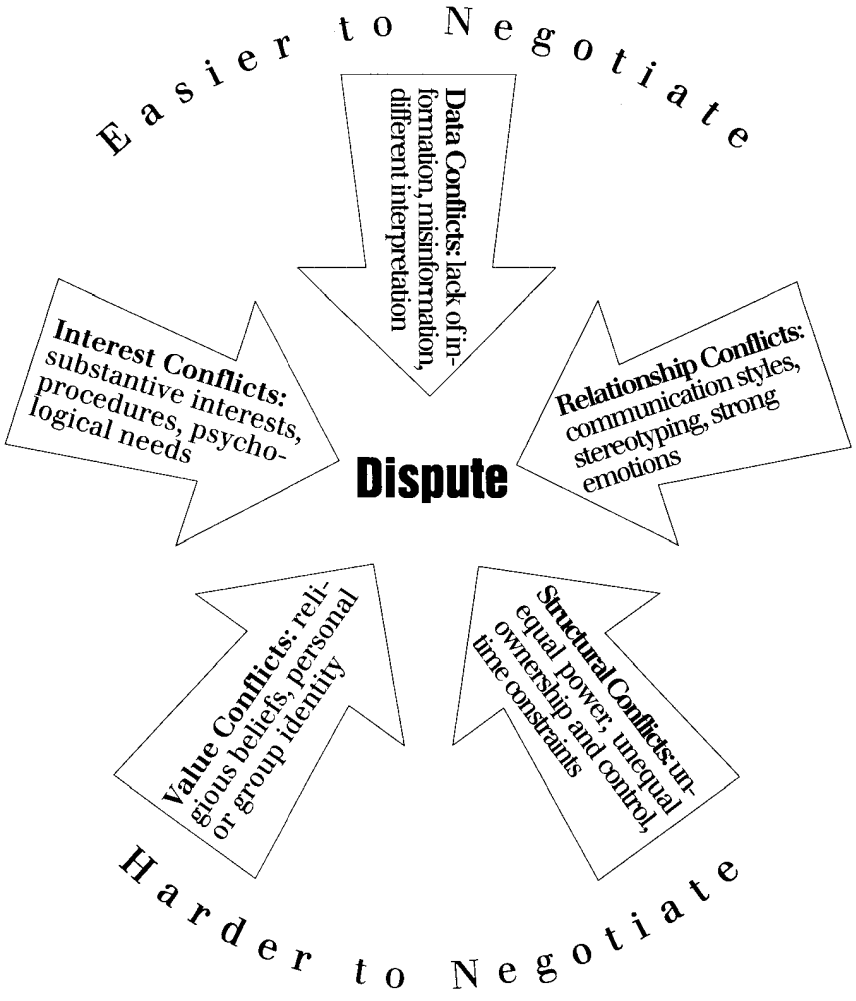
Obtain substantive input from the target audience.

Clearly, the target audience is a special constituency for the coalition and its members. If target audience members are not part of the staff of member organizations, consider including them in the coalition or as invited speakers or guests, as appropriate, at coalition business meetings. The approach will vary by community, but substantive consumer participation, through whatever channel, is vital to program success.

Clearly lay out plans for resolving conflicts, because disagreements are inevitable.

Lay out a process at the beginning to air grievances and resolve conflicts. Plan for compromise. Your goal is to avoid disintegration at the hour of greatest need, when members must pull together and not apart. If necessary, seek mediation from an outside source; try to agree upon this source as you form the coalition — don't wait until you're in the middle of a conflict to come up with an objective facilitator.

Sources of Group Disputes



Academy for Educational Development. *Handbook for HIV Prevention Community Planning.* Page 3–6, April 1994.

Arrange for consistent representation from each coalition member.

Active participation in the coalition may require a dedicated staff member or at least that a staff member's job responsibilities specifically include these duties. Member organizations should assess their ability to participate and adjust staff workloads as needed. Discuss representation at the beginning — as a group, determine the participation ground rules: what is acceptable in terms of missed meetings, sending substitutes, and so on.

Share information among member organizations to strengthen coalitions.

Information is power. Successful coalitions function on trust and shared power. Lack of trust, resulting in information isolation and power imbalances, can be deadly to a coalition. Lines of communication should be fluid and reflect the unique nature of your coalition — some member organizations will naturally be in closer contact than others, but make attempts to be inclusive. Sometimes, informal communication among the leadership will be enough. Other situations may require more formal channels. Whatever the process, it should be frank and open. Remember, though, that communication about specific clients will require their informed consent. Lay out the ground rules for communication about clients at the beginning.

Make sure the coalition is prepared to speak as one voice.

It is vital that coalition members deliver the same message and reiterate core messages over and over. The unified voice of various organizations can reorder community thinking. Conversely, if your members are delivering essentially the

same message, but slightly differently, this can create the impression that unity is lacking. And remember the importance of repetition — over time, many drops of water created the Grand Canyon!

Selected Readings on Coalition Building

General Readings

Amherst H. Wilder Foundation. *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey.* (Call 612/642-4000.)

Community Anti-Drug Coalitions of America. *Community Coalitions: Developing a Public Relations Plan.* CADCA Strategizer No. 4. Alexandria, VA: CADCA, 1994. (A photocopy of this material is available from the CDC National AIDS Clearinghouse Document Delivery Service, 800/458-5231.)

Feighery, M.S. & Rogers, T. *Building and Maintaining Effective Coalitions.* Palo Alto, CA: Stanford Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, Stanford University School of Medicine, 1990.

Kreitzmann, J.P. & McKnight, J.L. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets.* Chicago, IL: Center for Urban Affairs and Policy Research, Northwestern University, 1993. A collection of case studies of successful interventions in troubled communities nationwide. The theory of this book is that individuals, associations, and institutions have unique assets that can be used to better communities.

The National Assembly of National Voluntary Health and Social Welfare Organizations. *The Community Collaboration Manual.* Washington, DC: The National Assembly, 1993. (Copies available for $10.95 + $3.00 shipping and handling from the National Assembly, 202/347-2080.)

The National Council of La Raza. *Do's and Don'ts For An Inclusive HIV Prevention Community Planning Process: A Self-Help Guide.* Washington, DC: NCLR, 1994. (For more information, call 202/785-1670.)

Strategies, a quarterly newsletter published by Join Together, a national resource center for communities fighting substance abuse, Boston University School of Public Health; 421 Stuart St., 6th Floor, Boston, MA 02116; 617/437-1500. Although this newsletter specifically focuses on substance abuse programming, articles can apply to HIV prevention. Articles include topics such as putting public policy issues on coalition agendas, tools for social change, lessons from MADD (Mothers Against Drunk Driving) on changing public policy, case studies, and resources.

Special Topic: Conflict Resolution

Fisher, R. & Ury, W. *Getting to Yes: Negotiating Agreement Without Giving In.* New York: Penguin Books, 1983.

Fisher, R. & Brown, S. *Getting Together: Building Relationships As We Negotiate.* New York: Penguin Books, 1989.

Susskind, L. & Cruikshank, J. *Breaking the Impasse: Consensual Approaches to Resolving Public Disputes.* New York: Basic Books, Inc., 1987.

Weeks, D. *The Eight Essential Steps to Conflict Resolution.* New York: G.P. Putnam & Sons, 1992.

Health Communications

Health communications is the portion of prevention marketing programs that deals with messages, their delivery, and their evaluation. Because health communications is often the most visible part of prevention marketing, the terms are often used synonymously. But health communications messages and channels of delivery — street outreach, health fairs, peer counseling, safer sex workshops, public service announcements, and so forth — are not the only component, or even the most important component, of an integrated prevention marketing program. Each of these components is the result of research with intended consumers and reflects a thorough understanding and appreciation of the target audience's needs, beliefs, behaviors, lifestyle, demographics, psychographics, and other characteristics.

Health Communications Guidelines from the Prevention Collaborative

Include the target audience in message and materials development, pretesting, pilot testing, delivery, and evaluation.

Consider — and include — consumers in all stages of health communication program design, especially in formative research that influences message content and delivery channels. For example, youth can become involved through a variety of sources, including collaborating educational, civic, social, and governmental organizations and institutions. It is critical to ensure that target audience members are adequately prepared to participate meaningfully. Traditionally disenfranchised and/or marginalized target audiences —

including people who are young, economically disadvantaged, of color, gay, lesbian, bisexual, transgendered, drug-using, homeless, jobless, etc. — may not have the background and experiences that coalition members have, may not be prepared to operate in a group that runs on Robert's Rules of Order, or may not see the benefits to structuring discussions in the way the coalition does. Coalition members must consider the desired outcome/s of including the target audience and then structure opportunities for involvement that allow participating consumers to feel successful, useful and not used, and valued. These opportunities should also capitalize on target audience members' existing skills, talents, and aptitudes, while offering them challenges to grow. This is not easy. Coalition members may require education and training in working "outside the box" and in perceiving consumers as colleagues rather than as a group of people simply to be targeted for interventions.

Create and deliver messages that are clear, direct, and appropriate to the target audience.

To be effective, messages must speak to the target audience in language and a context they will understand and appreciate. The dialogue of a target audience — particularly young people — can change quickly, so messages must be adaptable, without jeopardizing their credibility. Message pretesting and pilot testing will shed light on the target audience's reaction before a program is delivered. As the program is underway, ongoing evaluation will pinpoint language, content, channels of communication, or other aspects that need to be adapted based on the current situation.

Look to consumer research to guide message content and style. A general rule of thumb: *Fear-based messages will probably not be effective.* Based on target audience research, consider embedding HIV prevention messages in a comprehensive approach to health and well-being. Research may indicate

that the target audience will respond well to prevention messages incorporated into positive concepts that may include self-esteem, self-respect, healthy mind/healthy body, sexuality and sex, as well as other health-related topics such as nutrition or exercise. Research will guide whether messages should be direct and didactic (e.g., "Use latex condoms.") or less direct (perhaps a skill that is modeled by a peer, such as talking with a partner about condoms). Research will reveal the target audience's practices, beliefs, attitudes, skills, and knowledge. For example, it may indicate that abstinence, often shunned by prevention program designers as unrealistic for young people, is a desired option and is a prevention message that should be included in your communications.

Use research to guide decisions about messengers.

It is important to remember that the messenger is as important as the message. Formative research with the target audience will spotlight individuals and/or groups they find credible and whose word they will act on. This investigation is crucial, because it may reveal target audience values that can surprise planners. For example, national research with young adults (18 to 25) on HIV prevention messages has shown that effective messengers need not mirror the target audience in terms of race/ethnicity, gender, sexual orientation, or other traits program planners would often suspect. Instead, the research showed that the single most important characteristic for messenger credibility is age — young adult target audience members want to see and hear people their own age talking about HIV prevention. In your community, it is possible that age may be an important characteristic, but not the *most* important. Your research may show that another characteristic — sexual orientation, gender, race/ethnicity, etc. — may be more important to your chosen target audience. Let research with your target audience guide your

choices of credible messengers, messages, channels of delivery, etc.

Programs should demonstrate their cultural competence by clearly incorporating the target audience's values into campaign materials and activities. Target audience members can provide insights into messages that are sensitive to culture, race/ethnicity, gender, sexual identity, age, and other characteristics.

Work with the target audience to ensure linguistic accuracy.

Develop messages and materials for non-English speakers and readers. Translations of English to other languages usually do not convey the desired messages and are often insensitive, if not offensive. Other groups that have their own language — for example, young people, drug users, sex workers, etc. — should also be involved in message development.

Consider the various needs and behaviors of the entire range of target audiences when developing HIV prevention interventions.

Audience segmentation is a key principle of prevention marketing. Broad segmentation — for example, along the lines of age, gender, race/ethnicity, or sexual orientation — will not capture the differing needs and perspectives of subgroups within these categories or the cross-cutting perspectives that may be found in varied demographic groups. Many consumers belong to more than one potential target audience. For example, a well-known athletic gear marketer segments according to innovators (the first to try a new product) and across demographic lines — young and old, of varied races and ethnicities, of both genders. The salient characteristic is whether the target audience member is game for new things and can diffuse the innovation to others

in his or her segment. In HIV prevention programs, bartenders in gay and lesbian bars have been targeted because patrons perceive them as opinion leaders/style setters. The bartenders' race/ethnicity, gender, age, socioeconomic status, etc., are not the most important characteristics in their ability to promote safer behaviors successfully.

Armed with formative research into varied target audiences and weighing program resources and priorities, focused communications should be developed as specifically as possible for each consumer group. Only after research is done can messages be focused. For example, research will show whether a single message will suffice for all female adolescents, or whether messages should be different for those who are sexually active now, were sexually active in the past but are not now, or will be sexually active; for those who are straight, bisexual, lesbian, or questioning; for those who use condoms consistently for vaginal intercourse (and/or oral and/or anal intercourse), those who occasionally use condoms for vaginal intercourse, or those who have never used condoms for vaginal intercourse; and so on.

Work to develop community support for prevention.

Communities may be reluctant to provide programming for those most at risk because they and their behavior are controversial — this may be especially true for young people who are gay, bisexual, lesbian, or transgendered, or who engage in other behaviors such as drug use outside the mainstream of the broader population. The prevailing climate in a community will affect the community's acceptance of specific messages. But you should make every attempt to ensure the climate does not deter the development of health messages for any group. It is vital to have community support for prevention messages and materials that may be viewed as controversial. Careful and thorough community involvement

through linkages, coalition building, seeking out stakeholders and gatekeepers, and other preparatory work may ease the way. Having a solid science base for your program — in epidemiology, behavioral science, and communications science, as demonstrated by formative research results — will help ensure that public discussions (and debates) don't simply boil down to what one side feels or believes versus what the other side feels or believes. For more information on formative research, see page 42; for more information on linkage and coalition building, see pages 55–62.

Pursue partnerships with a broad range of community organizations.

Partnerships, coalitions, and cooperatives extend the reach of prevention messages. Nontraditional partners, such as local marketing firms, public relations and advertising agencies, and even local media all bring valuable skills and expertise to the collective table.

Large and small Media

Traditional "mass" media channels such as network television and national consumer magazines continue the recent trend of splintering into smaller and smaller niche markets. The big three networks are now fighting for survival with other growing free and for-fee networks, giving viewers hundreds of channels to choose among. Broadly defined publications such as *Life*, *Time*, *Reader's Digest*, and *TV Guide* once dominated the magazine industry. But a proliferation of narrowly targeted titles such as *Cooking Light*, *Organic Gardener*, *Soap Opera Digest*, and *Country Woman* now share the shelf. Both TV and print media are being muscled by online communications offered to consumers through subscriber services such as America OnLine and Prodigy. National programs like the Prevention Marketing Initiative make use of general mass media as well as targeted mass media — for example, PMI public service announcements run on network and affiliate TV channels; the show "SMART SEX" ran on MTV.

At the community level, focusing on "small" media channels has become an important strategy for designing and delivering public health interventions. These so-called "personal" media will likely be more effective on a local level than focusing on national, broad demographic audience publications and shows. Small media can range from the obvious (local newspapers, community newsletters, local radio) to the less conventional (posters, seminars and workshops, special events, contests, booklets, brochures, door hangtags, "baseball" cards).

Conduct research with your target audience to determine the best channels through which to reach them.

Carefully select media and other channels of distribution to most effectively reach consumers.

What has your target audience told you about credible messages and messengers? About where, when, and how messages should be delivered? Any chosen health communications component should be thoroughly supported with research with the target audience, not just the "gut feelings" of coalition members or program staff. *"I think..."* isn't sufficient to justify using scarce and precious resources.

In proposing possible channels of communication to the target audience, think creatively. Prevention marketing emphasizes using the most effective channel for reaching the target audience, and that may not be PSAs. Television, radio, and other mass media may not always be the best ways to reach certain groups. Interactive video, peer educators, street outreach, electronic bulletin boards or "talk" forums, hotlines, improvisational theater, and other possibilities should be considered. In particular, evaluate niche media, like alternative newspapers and the so-called "'zines," very specialized publications that have small but extremely dedicated markets.

Evaluate both the process and behavioral outcomes of your health communications efforts.

All prevention program elements should include both process and outcome evaluation. Measurable results of successes, near-misses, and failures should guide future activities.

Media Relations at the Local Level

As print and electronic media cut budgets and downsize, it's up to community groups to provide reporter-ready information in the form of facts, stories, and articles. Even the television media will be more interested in something you prepare that's ready for broadcast. This air-quality tape is called "B-roll" (for background) and generally shows generic visuals relevant to a story. For example, for a story on preventing perinatal HIV transmission, you might show pregnant women with health care providers, mothers and babies, and infants in hospital isolettes. You might also include brief comments from your organization's staff or clients.

Planning and research are the keys to success in placing your story. Find out what the media want, what format they prefer, and the angles they might cover. Make it as easy as possible for reporters to use your information. Materials should get to the point quickly — consider fact sheets, information kits with relevant articles and photos or other graphics, and posters. Personal follow up is extremely important. Don't send your ideas into a void — call ahead to let reporters know what's coming and why they need it and follow up to encourage coverage. Use the information you get from these interactions to fine-tune your future efforts.

Many tools are available to help local groups organize their media relations effort. PMI recently published two technical assistance documents: Media Relations *and* Issues Management, *available through the National AIDS Clearinghouse, 800-458-5231. And PMI partner HDI Projects in Washington, DC, has published* HIV/AIDS Media Action Guide: A Planning and Promotions Guide for Community Leaders; *call 202/452-8750.*

Selected Readings on Health Communications

Backer, T.E., Rogers, E.M., & Sopory, P. *Designing Health Communication Campaigns: What Works?* Newbury Park, CA: Sage Publications, Inc., 1991.

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Bracht, N., ed. *Health Promotion at the Community Level.* Newbury Park, CA: Sage Publications, Inc., 1990.

Edgar, T., Fitzpatrick, M.A., & Freimuth, V.S., eds. *AIDS: A Communication Perspective.* Hillsdale, NJ: Lawrence Erlbaum Associates, 1992.

Freudenberg, N. & Zimmerman, M.A., eds. *AIDS Prevention in the Community: Lessons from the First Decade.* American Public Health Association, 1995. To order, call 202/789-5667.

Gross, G.M. *Active Communities, Healthy Families.* Madison, WI: Center for Public Representation, 1987.

Kotler, P. & Roberto, E.L. *Social Marketing: Strategies for Changing Public Behavior.* New York: The Free Press, 1989.

The Marin Institute for the Prevention of Alcohol and Other Drug Problems. *Advocating for Policy Change*, a 16-page workbook available free. Write to: 24 Belvedere St., San Rafael, CA 94901.

Morris, L.L. & Fitz-Gibbon, C.T. *How to Measure Program Implementation.* Newbury Park, CA: Sage Publications, Inc. 1978.

National Library Service for the Blind and Physically Handicapped. *Reaching People.* Washington, DC: Library of Congress, 1980.

Peter Glenn Publications. *National Radio Publicity Directory.* New York: Peter Glenn Publications, 1982.

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Sage Publications, Inc. *Media Advocacy and Public Health.* Explains the concepts of media advocacy through eight case studies and gives practical advice on using media advocacy to effect policy change. Available in hardback ($36) and softcover ($16.95) from Sage Publications, Inc., 2455 Teller Rd., Newbury Park, CA 91320-2218; 805/499-9742 (phone) and 05/499-0871 (fax). There's a $2 handling charge per order.

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U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Health Information Center. *Working with the Print Media* (for the Healthy Older People Program), DHHS publication no. Y0182. Washington, DC: U.S. Dept. of Health and Human Services, 1982.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health. *Making Health Communication Programs Work: A Planner's Guide*, NIH Publication No. 92-1493. Washington, DC: U.S. Dept. of Health and Human Services, 1992.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Heart, Lung, and Blood Institute. *Churches as an Avenue to High Blood Pressure Control*, NIH publication no. 87-2725. Washington, DC: U.S. Dept. of Health and Human Services, 1987.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Heart, Lung, and Blood Institute. *Community Guide to High Blood Pressure Control*, NIH publication no. 82-2335. Washington, DC: U.S. Dept. of Health and Human Services, 1982.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Heart, Lung, and Blood Institute. *With Every Beat of Your Heart: An Ideabook for Community Heart Health Programs*, NIH publication no. 87-2641. Washington, DC: U.S. Dept. of Health and Human Services, 1987.

Health Communications Resources

Emerson-Tufts Program in Health Communication offers information on effective health communications programming, including written materials (*Health Communication Journal* and *AIDS: Effective Health Communication for the 90s*, edited by Director Scott E. Ratzan, M.D.) and a Worldwide Web page. Contact 617/578-8745 (phone) or 617/578-8749 (fax).

National Organization of Black County Officials, NOBCO, a Prevention Collaborative member, provides capacity building and programmatic technical assistance to increase the level of knowledge and skills in HIV/STD prevention among staff of CBOs, health and human services agencies, and national programs targeting ethnic minority youth. Maria D. Lopes, Executive Director, and Patricia Carter, Project Coordinator; 420 First St., SW, Suite 500, Washington, DC 20001; 202/347-6953 (phone), 202/393-6596 (fax).

AIDS Foundation of Chicago maintains a prevention/education committee of HIV health educators from throughout the Chicago metropolitan area. Contact David Ernesto

Munar, 312/922-2322 (phone); 312/922-2916 (fax); 11 S. Wells, Suite 300, Chicago, IL 60607.

Cultural Competence Resources

A Prevention Collaborative partner, the Filipino Task Force on AIDS, Daniel E. Toleran, Executive Director, offers ethnic-specific HIV/AIDS education and care programs and services. They also have a locally produced documentary called "Celebrating Our Lives" about Filipinos living with and affected by HIV/AIDS, and written materials on product development and market testing for small print media (posters, condom kits, and brochures). Call 415/703-9880; fax 415/864-7482.

Cultural Awareness and Sensitivity: Resources for Health Educators. From the Association for the Advancement of Health Education (a Prevention Collaborative member), Reston, VA. Call 703/476-3437; fax: 703/476-6638

La Guia, A Resource Guide for Gay, Lesbian and Transgendered Latinas/os. Published by the National Latino/a Lesbian and Gay Organization (LLEGO), a Prevention Collaborative partner, and the CDC National AIDS Clearinghouse, May 1995. Call 800/458-5231.

U.S. Conference of Mayors. *Assessing the HIV Prevention Needs of Gay and Bisexual Men of Color.* June 1994. Call 202/293-7330. *Also HIV Prevention Community Planning Profiles: Assessing Year One.* Fax request to 202/887-0652. USCM is a Prevention Collaborative partner.

Wandering Star Productions. *Training for Cultural Competence in the HIV Epidemic* (video with booklet). University of Hawaii-Manoa, Kapiolani Medical Center, AIDS Education and Training Center, 1992. To order, call 808/737-0934.

Notes

Community Implementation

The Community Is Part of the 4 Ps

In prevention marketing, the community is one part of the "place" that prevention program developers must consider in selecting their marketing mix. (The four Ps are product, price, promotion, and place. For more information on the four Ps and the marketing mix, see pages 22–25.) Community can mean a geographic location and a group of varied people living and working in that location — a town or neighborhood, for example. In the more focused sense, it may be a specific target audience that considers itself a cohesive unit — for example, a group of students who have decided to remain virgins and promote that choice to others.

Community participation and action are crucial to the success of your prevention effort. Prevention marketing relies on broad community mobilization and action to design, develop, deliver, and evaluate programs. Communities are experts in what their needs are and, when equipped with supportive resources, are the best people to address those needs. The value for a community — in the broad or narrow sense — in acknowledging and acting to address a problem or need cannot be overstated. In far too many instances, public health needs have worsened because the community was unable or unwilling to acknowledge the problem and act to correct it. Sometimes inaction is a result of inadequate resources — human or fiscal — to address the problem. Sometimes it results from other internal issues. In the social marketing paradigm, these impediments are barriers to a behavior you want the community to adopt. Work at understanding why the barriers exist and how they can be minimized or eliminated.

A 5th P to Consider

Social marketing experts often talk about a fifth P: politics or policy. *Clearly, community, state, and national policies can and do affect prevention programming — and, sometimes, the opposite is true. Prevention programs can affect policy. That is why a crucial element of CDC's prevention marketing framework is community action. By involving the broad community in your efforts, you enhance the likelihood that the fifth P will be a facilitator and not a barrier to your activities.* Issues management *is integral to successful community mobilization. Issues management (often called* media advocacy*) works to assure that news and entertainment media carry needed messages and information to audiences, including policy makers. Competing, conflicting, and misunderstood messages can cripple community participation and stymie policy change. Prevention marketing depends on constituents understanding issues and acting on them.*

In addition, consider the community factors that support the desired behavior and work to enhance them.

Failing to adequately consider the community as a factor in program design and delivery can result in serious implementation difficulties, including:

- **Significant changes in an intervention because of community resistance or rejection.** For example, efforts to reach the African-American gay community in the early 1980s failed for one San Francisco AIDS service organization because staff didn't include the target audience in materials development. This resulted in a product that community members perceived as lewd and offensive — counter to their community norms and standards. The well-intentioned material developers assumed that all gay men would find sexually explicit materials desirable and, therefore, the materials would be effective. They were wrong.
- **Barriers or restrictions placed on promotion efforts.** The community at large has a significant stake in messages and their delivery. This is most commonly seen in schools, with barriers or limitations placed on who can receive messages (age of consumers), the kinds of messages they can receive (such as abstinence only), where they can receive them (only in certain classes), the channels of delivery (only by certain teachers or outside speakers). PSAs and ads (electronic and print) also often have time and location restrictions placed on them — such as only after 10 p.m. and before 6 a.m., or only in bars serving an over-21 crowd.
- **An unnecessarily high price for the product.** Community resistance to a desired behavior (product) may be so strong that the price will be seen as too high. Consider needle-exchange programs. Communities undoubtedly want to reduce HIV infections. But they don't want to condone or encourage drug use, and many people believe

needle-exchange programs encourage or at the very least condone drug use. Although needle-exchange programs may reduce HIV infections and are therefore perceived by some as good, they are perceived by others as facilitating drug use and therefore bad. These two opposing notions of good and bad often result in impasse. In such an environment, even if needle-exchange programs are established, the cost to consumers can be too high for them to afford (emotionally and psychologically).

Community Implementation Guidelines from the Prevention Collaborative

Collaborate with the HIV Prevention Community Planning group in your area.

Many communities are now participating in CDC's HIV Prevention Community Planning process to design comprehensive HIV prevention plans. Make sure your efforts are coordinated with this group. Contact your state or territorial AIDS director for more information. (See Appendix B for more information on HIV Prevention Community Planning and contact lists.)

Conduct a situation analysis of your community.

Just as they would for the target audience, prevention program planners should review what they know about the larger community's knowledge, attitudes, beliefs, and behaviors about sexuality, sexual orientation, drug and alcohol use, and other prevention-related issues. Consider broad demographic data, such as cultural diversity, socioeconomic status, gender, relationship status (single, married, divorced, partnered but not married, etc.), religious affiliations, education levels, and labor statistics. As with research conducted with the target audience, these secondary data give you a

broad-brush portrait of your community; you can then fill in the details as needed with focus groups, community surveys, and other information-gathering techniques. Evaluate potential barriers to and supports for prevention efforts. Devise steps to address barriers and shore up supports in advance of taking any action, including research with the target audience. Before you can begin that essential formative research, you will need to influence stakeholders and gatekeepers who control access to that population.

Gain local support and buy-in for prevention activities.

As much as possible, the broader community should be involved in prevention program development. Certainly, the community should be kept informed. Withholding information (deliberately or not) will breed wariness and skepticism and undermine community support for your efforts. Research findings and in-process lessons learned should be shared so the entire community benefits, learns, understands. It is important at the outset to educate the community about the principles and process of prevention marketing, which will be a new way of thinking about problems and problem-solving for most.

Support and stimulate other grassroots efforts.

HIV prevention professionals should serve as resources for grassroots organizations that are addressing other community problems and populations. These same organizations can serve as resources for HIV prevention groups. The work each does — reaching "hard-to-reach" populations, gathering data, conducting innovative interventions — can transcend the specific issue each addresses. At first, collaborating with nontraditional partners may not seem practical or worth your time. It may be difficult. But networking throughout the

Be sure to evaluate the success of your implementation efforts.

Include both process (how many did we reach?) and outcome (what was the behavioral impact?) measures. Modify your intervention based on what you learn from this evaluation. References on evaluation are listed in the section on Research and Evaluation, pages 45–47.

Resources on Implementation

CDC funds national minority organizations (NMOs) and regional minority organizations (RMOs) to provide technical assistance to community groups, with the aim of strengthening and increasing the effectiveness of HIV/STD prevention efforts for racial and ethnic groups at high risk, including gay-identified, bisexual, and other men who have sex with men; substance abusers; those with repeated STDs; women in high-risk situations; youth in high-risk situations; sex partners of those at high risk for HIV infection; and people who live in areas with a high seroprevalence of HIV. NMOs and RMOs offer technical assistance in three key areas:

- **Capacity building and training** in grant-writing; fiscal management; board development and training; networking and collaborating with local health departments, other CBOs, and other local and state agencies and organizations; and staff and volunteer recruitment and retention.
- **Programmatic technical assistance** in planning, integrating, implementing, and evaluating programs and program components, including quality assurance.
- **Identifying and disseminating information** on prevention technologies and successful/unsuccessful HIV/STD interventions for racial and ethnic minorities through case studies, workshops, and other channels.

See Appendix B for a list of RMOs and NMOs.

community will create an interdependent web that pays off. Area employers, informal social groups, civic organizations, arts-related groups, activist organizations focusing on other issues (for example, environmental racism), religious institutions and groups, and other formal and informal structures are all potential allies.

Address the complexity of changing behaviors and develop interventions accordingly.

Behavior change doesn't happen overnight. Be sure your collaborative partners and the broader community understand that HIV prevention is a long-term commitment. At the same time, it's important to see success in even small steps toward an objective. Combined, small steps add up! Consider the benefits of reaching a smaller audience with a sustained and extensive intervention, as opposed to reaching a large audience in a more superficial way. Local interventions offer opportunities to address site-specific audiences that large-scale national programs don't have. Consider national programs directed at your target audience and how you can enhance those locally.

Don't Reinvent the Wheel

When the Episcopal Church wanted to develop an AIDS prevention curriculum for its young people, it turned to Prevention Collaborative partner Advocates for Youth and its already-developed guide, Teens for AIDS Prevention (TAP). *Working with Advocates for Youth and the AIDS Ministries Program of Connecticut, Inc., the Church "Episcopalized" the* TAP *curriculum by adding additional theological information, resources, and commentary. "One of the significant lessons of the age of AIDS is that reinventing the wheel is unnecessary, unwise, and wasteful," the Episcopal manual says. "Therefore, this* Episcopal Guide to TAP *is actually a gathering and adapting of models and resources that have been used successfully both within the Church and beyond it."*

Tap the expertise of community, state, regional, and national organizations.

Larger and/or more established organizations can mentor newer agencies in the areas of grant-writing, training, technical assistance, funding, and other needs. Look beyond your community to CBOs in other areas and contact state, regional, and national groups as well. Collaboration will help sustain your program over time, reduce competition and in-fighting, increase community support, and, ultimately, enhance client services. See the Resource listing on page 61–62 for ideas.

Be sure to evaluate the success of your implementation efforts.

Include both process (how many did we reach?) and outcome (what was the behavioral impact?) measures. Modify your intervention based on what you learn from this evaluation. References on evaluation are listed in the section on Research and Evaluation, pages 45–47.

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See Appendix B for a list of RMOs and NMOs.

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Appendix B

Prevention Marketing and Community Planning Are Complementary

Many HIV Prevention Community Planning Groups use elements similar to social marketing in developing their plans. They use epidemiologic and demographic data and information about possible audiences gleaned through focus groups and other means to help better define priority groups and their needs and to guide decisions about interventions. What social marketing offers is a systematic way to design, deliver, and evaluate prevention programs that are focused on behavioral goals.

Some Background on HIV Prevention Community Planning

The widespread adoption of participatory community planning marks an important change in the way HIV prevention programs are being developed in states and localities across the country. Beginning in January 1994 — at the same time CDC's Prevention Marketing Initiative was launched — state, local, and territorial health departments that receive HIV prevention funding from CDC were asked to seek significant and meaningful involvement of their communities in developing comprehensive HIV prevention plans.

CDC has advocated community input in past HIV prevention funding cycles, and many project areas have involved community participants in various aspects of program planning and delivery. Previous CDC funding guidelines have also specified the kinds of interventions to be undertaken — such

as counseling and testing — and the relative allocation of resources to each program activity. The new HIV Prevention Community Planning initiative provides more flexibility as well as specific guidance and support to project areas to establish a participatory process in identifying appropriate program priorities for each area.

HIV Prevention Community Planning is an ongoing process by which public health agencies (grantees) share responsibility with other state/local agencies, nongovernmental organizations, and community representatives for identifying needs, determining priorities, and developing comprehensive HIV prevention plans. Participatory community planning recognizes that, although grantees are responsible for and accountable for public health in their jurisdictions, they may be limited in their scope and ability to solve on their own complex health, social, economic, and environmental problems. HIV prevention programs developed without community participation and a sound scientific basis are unlikely to be successful in preventing the spread of HIV infection or in garnering the necessary public support.

Community Planning and Prevention Marketing Share Essential Elements

CDC's brand of social marketing — prevention marketing — relies on three key elements: social marketing, behavioral science, and community action. Throughout this document, these building blocks and the components that create them have been described.

Many aspects of prevention marketing are also components of the HIV Prevention Community Planning process — information about epidemiology and behavior, individual and community-wide interventions, research and evaluation, community participation and action, coalition building, power sharing.

In the example format for a comprehensive HIV prevention plan (mailed to all HIV Prevention Project Directors/Coordinators and HIV Prevention Community Planning Co-Chairs on August 10, 1994), CDC suggested that a typical comprehensive HIV prevention plan would include these sections — note the similarities with information used for prevention marketing programs

I. Introduction and Overview of the Community Planning Process

This section would include information about the structure of the community planning process, such as criteria for nomination, recruitment, and selection of Community Planning Group (CPG) members, including specific collaboration with governmental and nongovernmental organizations and affected communities. The process for obtaining community input to ensure participation in the process for all interested parties and the process of conducting CPG meetings (dispute resolution, meetings held, etc.) would also be included.

The activities required to complete this section are also required for a community-level prevention marketing program. Like CPGs, program planners using the prevention marketing framework need to think about who should be involved in program design, delivery, and evaluation and how the target audience will be included. They need to be clear about the extent of inter-agency collaboration, how disagreements will be decided, who is responsible for what and why, skills that are needed by program planners, etc. See "Define the Problem" and "Assess the Marketplace," page 19, and Prevention Collaborative partners' recommendations for linkage and integration with existing agencies on pages 49–54.

II. An Epidemiologic Profile

The extent, distribution, and impact of HIV/AIDS should be described by county, groups of counties, census tracts

or zip code areas. The basic components are: reported and projected AIDS cases in defined populations; reported and projected HIV infections; HIV serosurveillance data; HIV-related mortality data; data on HIV risk behaviors; data on recipients of testing and counseling services; estimated HIV incidence; surrogate indicators; and, based on this information, the specific target populations for interventions.

Formative research like this is vital to the success of any prevention marketing program. See "Define the Problem," page 19 and "Segment Audiences," page 20. Also see pages 37–47 for recommendations.

III. Area Needs Assessment and Prioritization

This section would include an HIV prevention resource inventory describing the number and type of HIV/AIDS service providers, the scope of their activities, service area, clients (current, projected, potential), fiscal and personnel resources, client profiles, and program referrals and linkages. It would also profile target populations with information on their risk behaviors, values, and norms; barriers to prevention services; and attitudes and preferences for services. Finally, this section would describe and prioritize unmet/well-met HIV prevention needs for each target audience.

Formative research should include information about what's currently available because services are one of the key external determinants of behavior. See "Assess the Marketplace," page 19, "Segment Audiences," page 20, and "Plan a Program with Specific Behavioral Goals," page 20–21 for more information. For suggested strategies from the Prevention Collaborative, see pages 37–47.

IV. Intervention Assessment and Prioritization

This section would detail and rank potential interventions for each priority unmet need, including information on

potential impact/outcome effectiveness; cost effectiveness; availability of other, related resources; the theoretical basis of each intervention (such as social marketing); and the interventions' responsiveness to the target audience's values, norms, and preferences.

This section corresponds to the prevention marketing step "Plan a Program with Specific Behavioral Goals." Additionally, CPGs that choose to implement prevention activities or that choose to review proposals submitted by potential grantees should be familiar with the steps that follow planning: "Develop and Pretest Materials and Strategies," "Determine the Marketing Mix," "Deliver the Program," and "Evaluate and Alter." See pages 20–25. See also recommendations from the Prevention Collaborative, pages 63–73.

V. Recommendations and Conclusions

The final section would include HIV prevention goals and measurable objectives for each target population, along with priority strategies and interventions. It would also include recommendations for linkages and collaboration among community agencies; recommendations regarding epidemiologic and behavioral surveillance, program evaluation, and assistance needs of community-based providers (such as grant-writing or formative research); and an evaluation of the planning process itself.

Developing the prevention plan is the first step. Then the plan has to be put into action. Most CPGs are not implementing activities themselves nor reviewing the activities of funded organizations. Their role is strategic planning. However, CPGs might be interested in what follows planning. For information on prevention marketing-based intervention delivery, evaluation, and alteration, see pages 37–47.

Special Considerations for Community Planning Groups

Using the Prevention Marketing Framework

No matter what planning stage a CPG is in — for example, determining target populations, researching needs, picking interventions, making recommendations for ongoing behavioral surveillance or service linkages — it can use prevention marketing as a framework to guide its efforts. The examples below show how a CPG that chose to use this tool could apply prevention marketing to problem-solving.

- A CPG that is determining priority populations might apply the initial prevention marketing step — **Define the Problem** — to begin the process of sifting through available information and gathering needed information. For example, epidemiologic and demographic information might be readily available. Some marketing information about consumers in the community might be available. But the CPG might need to know more about populations to make the best decisions about where to target interventions. See page 19.
- To get that needed information, the CPG would **Assess the Marketplace**, a step similar to HIV Prevention Community Planning area needs assessment. During its target population prioritization process, the CPG would begin to **Segment Audiences** based on lifestyle factors and behaviors. See pages 19 and 20.

For example, the CPG might know from epidemiologic data that HIV infection rates are rising among women. In its own community, a review of the past five years might show that African American women, who represent 4% of the community's total population and 15% of the total female population, account for 55% of the reported AIDS cases in

women and 45% of the newly reported HIV infections in women. In reviewing the data, the group learns that, over the past five years, heterosexual transmission has surpassed injecting drug use as the most common mode of HIV infection among Black women in the community. Unprotected sex with a male partner who is an IDU, who has sex with other men, who has full-blown AIDS, or whose HIV status is unknown to his partner accounts for 55% of these women's infections. Injection drug use accounts for another 30%. About 15% of the women report no known risk factors; the CPG suspects this figure is inflated due to the way questions are asked and confusion on the part of the women responding. From its provider survey, the CPG knows about the HIV prevention services offered to women at the community health clinic, where many black women receive their primary health care. They also know that many private physicians do not routinely counsel their female patients about HIV prevention. From CPG members who are representatives of local CBOs, the group knows about other services aimed at black women, for example, a breast cancer awareness project, a Mothers of Murdered Children chapter, and a Mother 2 Mother program that matches older women with teen moms. The CPG knows that two community churches have afterschool programs for children and the Muslim temple has a tutoring and GED program. The mean education level for all women in the community is one year of college; there is no further breakdown along racial/ethnic lines. The average income for the community is $32,000 for a family of four; no further information is available. The CPG has information gaps it needs to fill. It still needs to —

- identify and consult with CBOs, ASOs, and other community organizations, to get a better idea of the breadth and depth of services for women and for African American women in particular;

- assess local HIV prevention programs to learn about who they serve, what their services are, where the gaps in services are, and what resources are available to fill the gaps; and
- analyze what it knows and what it needs to know about the audience of African American women to design an audience-centered prevention program. For example, the CPG knows that not *all* black women are at risk; their race and gender do not automatically equate with risk. But the group doesn't know which black women *are* at risk because of specific behaviors. It needs more information about surrogate indicators of HIV risk (STDs, teen pregnancies, etc.); about black women's education level and socioeconomic status within the larger community; about the average age of infection and of the women as a whole; about where their community's African American women work, what they do for leisure and recreation, how they view themselves in the world, their dreams and fears; about their media habits and lifestyles (in particular, are there obvious similarities or dissimilarities in lifestyle among the community's African American women?); about the social networks and social systems that influence them and how; and about their knowledge and skills, attitudes, beliefs, and behaviors related to HIV prevention. All this information will combine to segment the broad potential audience of African American women into appropriate segments for prevention programming. See page 21 and the Research and Evaluation section beginning on page 39 for more information on these steps.

After the CPG has a detailed definition of the problem, has assessed the marketplace, and has segmented audiences, the group is ready to conduct its intervention assessment and prioritization. To do this, the CPG might use the fourth prevention marketing step, **Plan Behavioral Goals.** For each

market segment, the CPG will set measurable, realistic, and prioritized goals. For example, if the broad target population was injecting drug users, the CPG might segment users by drug of choice and their social network, by location/s where users congregate and inject, and/or by related risk factors (such as users who turn tricks to get money for drugs). Audiences are segmented based on their unique characteristics as revealed by formative research. For each audience segment, the group would set goals based on knowledge, skills, attitudes, beliefs, and/or behaviors:

- By [DATE], 90% of the heroin injectors who regularly inject at the abandoned warehouse on Third Avenue and Pine will correctly demonstrate the skill of cleaning works on three successive occasions with no prompting from the outreach worker. (Knowledge/Skills)
- By [DATE], 80% of the sex workers who work along Pine Street from First to Fifth Avenues will ascribe personal value to using latex condoms with clients, coupled with short-term intention to do so. (Attitudes)
- By [DATE], 90% of teen mothers will express the belief that they can negotiate condom use with their partners. (Beliefs)
- By [DATE], 85% of the MSM who patronize [NAME OF SEX CLUB] will use latex condoms during anal intercourse. (Behaviors) For more information, see pages 20–21.

If a CPG chooses to design interventions, it might **Develop and Pretest Materials** with targeted audiences and **Determine the Marketing Mix** to correctly balance the four Ps: product, price, promotion, and place. CPGs that are not designing interventions, but choose to review proposals, might want to look for these prevention marketing steps to be detailed in program plans. For more information, see pages 22–25 and guidelines on pages 29–36, 37–47, 63–73.

- When implementers **Deliver the Program**, process indicators should track program success. Along with process indicators, behavioral outcomes should be assessed as implementers **Evaluate and Alter As Needed.** CPGs that choose to review proposals might want to look for these prevention marketing steps to be spelled out in program plans. See pages 45–47 for resources on program evaluation.

Resources on HIV Prevention Community Planning

Training and technical assistance are currently available to CPGs in six areas:

- parity, inclusion, and representation;
- conflict of interest and dispute resolution;
- surveillance and uses of epidemiologic data;
- community planning processes and models;
- evaluation of effective and cost-effective HIV prevention efforts; and
- access to behavioral, social science, and prevention marketing expertise.

CPGs wanting technical assistance in any aspect of community planning should contact their health department co-chair or CDC project officer. Lists of state AIDS directors and CDC project officers follow.

Written Resources

Guidance and Supplemental Information, Non-Competing Continuation of Cooperative Agreements for Human Immunodeficiency Virus (HIV) Prevention Projects, Announcement Number 300, FY 1995, dated June 15, 1994.

The Academy for Educational Development. *Handbook for HIV Prevention Community Planning.* Washington: AED, April 1994.

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502 Grantees

CDC funds programs in three key areas — health communications, health communications/ behavioral/social science evaluation, and technical assistance — in support of its prevention marketing and health communications efforts. The following organizations are funded under Program Announcement 502.

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Appendix C

The Prevention Marketing Initiative

CDC's Prevention Marketing Initiative (PMI) is based on social marketing, behavioral science, and a third critical component, community action. The first phase of PMI focuses on young adults, age 18-25, and aims to reduce sexual transmission of HIV and other STDs.

PMI's mutually reinforcing program components focus on national leadership, changing social norms, and supporting communities' abilities to design, deliver, and evaluate effective HIV prevention programs. There are four program components: National Health Communications, the Prevention Collaborative, Local Demonstration Sites, and Collaboration with HIV Prevention Community Planning.

National Health Communications

Public service announcements (PSAs), launched in January 1994, are one of the most visible aspects of this component of PMI. The series of PSAs promote PMI's behavioral objectives: refraining from or delaying risky sexual activity and, for those who are sexually active, consistently and correctly using latex condoms. Other activities include working with entertainment media to affect social norms, model prevention behaviors, and build skills and self-efficacy, and supportive issues management and media advocacy to clarify public debate about condom effectiveness. Also through this component, CDC provided technical assistance to Lucky Duck Productions during development of the groundbreaking TV show "SMART SEX," which premiered on MTV on September 27, 1994. "SMART SEX" role-modeled healthy sexual behaviors to its target audience of 18- to 25-year-olds.

Prevention Collaborative

The Prevention Collaborative is a unique public-private partnership designed to make HIV prevention activities at all levels — federal, regional, state, and local — more effective and efficient. The Collaborative includes people infected and affected by HIV and AIDS, young people, community-based organizations, AIDS service organizations, state and local health and education departments, professional associations, religious groups, and others. Collaborative members share expertise, technical assistance, materials, strategies, and technologies to advance prevention efforts nationwide. This document is an example of the kind of technical assistance the Prevention Collaborative provides. CDC has provided other technical

assistance, including documents and workshops on media relations, issues management, coalition building, promoting abstinence, and condom effectiveness.

Local Demonstration Sites

PMI funds five community-based efforts to apply prevention marketing at the local level. The five communities are: Sacramento, California; Phoenix, Arizona; Nashville, Tennessee; Northern Virginia; and Newark, New Jersey. Interventions are being developed by the communities with intensive, ongoing technical assistance from CDC. As the five sites move through the prevention marketing process, the lessons they learn will be shared with the Prevention Collaborative, HIV Prevention Community Planning groups; other local, state, and national organizations; and the National AIDS Clearinghouse to facilitate the development and/or enhancement of similar programs across the country.

Collaboration with Community Planning

HIV Prevention Community Planning is the process through which CDC provides funding for state and local health departments. This document has been designed to complement that process and to assist community planning groups in implementing prevention marketing programs. CDC will provide technical assistance to community planning groups in prevention marketing and its specifics, such as formative research components, marketing mix selection, and intervention evaluation.

Appendix D

Selected Annotated Bibliography

Andreasen, A. "Social Marketing: Its Definition and Domain." *Journal of Public Policy and Marketing*, vol. 13, no. 1 (1994):108–114.

In this article, Andreason, one of the pioneers of social marketing theory and still one of the most respected authorities on its practice, raises concerns that the fundamentals of the discipline have been ignored as it has evolved and that some earlier definitions need to be revisited. The author proposes a new definition and a set of criteria for accurately labeling a program a social marketing program.

Auerbach, J., Wypijewska, C. & Brodie, K., eds. *AIDS and Behavior: An Integrated Approach.* Washington: National Academy Press, 1994.

This volume summarizes recent information about the behavioral and mental health aspects of HIV and offers recommendations for research directions. A report of a 12-person Institute of Medicine committee, the book covers the sexual and drug-use behaviors that facilitate the spread of HIV, and reports on recent knowledge in how and why risky behaviors occur.

Barbas, A. & Horn, B. *Marketing Traffic Safety.* Organization for Economic Co-Operation and Development, 1993.

The authors are employed by a British government agency involved in promoting safety in countries throughout the British Commonwealth. This article in the agency's official publication provides an overview of social marketing, gives examples of successful programs for a variety of safety-related topics throughout the Commonwealth, and urges program planners to use social marketing disciplines to improve their safety campaigns.

Bayer, R. "AIDS Prevention and Cultural Sensitivity: Are They Compatible?" *American Journal of Public Health*, vol. 84 (1994): 895–897.

The author is in the School of Public Health at Columbia University and with the HIV Center for Clinical and Behavioral Studies, New York, NY. In this article, he challenges some widely held assumptions about cultural sensitivity in program planning for HIV

prevention. Concerned that some previous edicts based on cultural sensitivity are actually counterproductive in preventing the spread of HIV, he proposes new ways of looking at sensitive issues.

Brodie, K. "Opening Statement." Public Briefing on *AIDS and Behavior: An Integrated Approach.* Washington: National Academy of Sciences, July 1994.

As Chairman of a congressionally-mandated study to assess the balance between biomedical and behavioral research among three government institutes, Brodie summarizes the 20-month study in this statement. The committee concluded that the specific acts for transmitting HIV were inadequately researched. His statement highlights some of the most important findings of the research reviewed by the committee, for example, that significant behavior change can be achieved in even the most "hard-to-reach" audiences. The committee states that more research is needed to determine if behavior change can be maintained over time.

Coyle, S. L., Boruch, R. F. & Turner, C. F., eds. *Evaluating AIDS Prevention Programs.* Washington: National Academy Press, 1991.

This 376-page book summarizes the report of a panel convened by the National Research Council to evaluate AIDS prevention programs. The 18-person panel, comprised primarily of university-based evaluation and statistics experts, examines in detail various methodologies of measuring exposure to messages and behavior change. The volume provides a technical view of statistical methods. It discusses inherent difficulties in evaluation of AIDS programs, and offers a brief, concluding recommendation for improving evaluation efforts.

DeJong, W. "Condom Promotion: The Need for a Social Marketing Program in America's Inner Cities." *American Journal of Health Promotion*, vol. 3, no. 4 (1989): 5–16.

The author, Director of Research at the Harvard School of Public Health Center for Health Communication, identifies the need for condom social marketing programs to prevent transmission of STDs and teen pregnancy in "poor minority communities." He gives examples of successful condom social marketing programs implemented around the world for family planning purposes, even in countries in which religious and cultural mores make conditions difficult. DeJong outlines how the "four Ps" apply in condom social marketing, and outlines key elements in the process of creating a social marketing program.

Fine, S. *Social Marketing: Promoting the Causes of Public and Nonprofit Agencies*. Boston: Allyn and Bacon, 1990.

In one of the more recent textbooks on social marketing, Fine, a marketing professor at Rutgers University, updates the familiar process with recent case studies from around the world. The book acknowledges the major role of "independent sector" organizations (i.e., non-government, nonprofit groups) as practitioners of social marketing, and examines ethical issues in using marketing techniques to shape attitudes. The book gives practical examples and guidance for implementing social marketing programs.

Flora, J., Schooler, C. & Pierson, R. *Effective Health Promotion Among Communities of Color: The Potential of Social Marketing*. Washington: National Academy of Sciences, 1994: Section 4.

In this 40-page monograph prepared for the Institute of Medicine, the authors propose social marketing as a way to close the widening gap in health status between Anglo Americans and people of color. They provide a definition and history of social marketing, filled with examples of successful and unsuccessful attempts to change health behaviors through a variety of methodologies. The authors provide a step-by-step plan to use social marketing to design programs for culturally diverse audience groups, with suggestions for new ways to view the well-known process. For example, in a section on audience segmentation, they discuss immigration status, family structure, degree of assimilation, language use, religion, and educational aspirations as important factors.

Kotler, P. & Andreasen, A. *Strategic Marketing for Nonprofit Organizations*, 3rd edition. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1991.

First published in 1987 and most recently revised in 1991, this classic textbook urges nonprofit organizations to do long-term, strategic planning to achieve their objectives. It stresses the importance of developing a consumer orientation and a marketing mindset, with entire chapters devoted to guiding organizations through the process of raising funds and finding volunteers. The book offers extensive help in designing the marketing mix, or the "four Ps" of product, price, place, and promotion.

Kotler, P. & Roberto, E. L. *Social Marketing: Strategies for Changing Public Behavior*. New York: The Free Press, 1989.

Kotler (Distinguished Professor of Marketing at Northwestern, and one of the "founding fathers" of social marketing) and Roberto (Professor of International Marketing at the Asian Institute of Management in Manila) capture the last 20 years of evolving marketing theory in this 390-page text. They discuss the many uses of social marketing, its role in

changing public behavior in a larger context, and guide the program planner through the planning process with many examples from "real world" programs, both domestic and international. The book provides many analytical models as well as some practical guidelines for program development.

Maibach, E. and Parrtt-Louiselle, R., eds. *Designing Health Messages: Approaches from Communication Theory and Public Health Practice.* Newbury Park, CA: Sage Publications, Inc., 1985.

This book offers commentary on message design from both theoretical and practical perspectives. The editors demonstrate the necessity of basing message design decisions on theories of human behavior and communication effectiveness.

Manoff, R. "Developing the Social Marketing Plan." *Social Marketing: New Imperative for Public Health*: New York: Praeger, 1985: 99–142.

The author begins this chapter of his book with an admonition to social marketers to bridge any gaps with community organizations and invite them to participate in program planning. His emphasis on collaboration runs throughout the chapter. Manoff details a step-by-step approach to the social marketing process, with a section on choosing and working with an advertising agency. Inherent in the advertising discussion is a focus on more traditional communications tactics of television, radio, and print advertisements. The chapter closes with an explanation of the Pooled Rating Index for Social Marketing (PRISM), a rating scale for evaluating programs.

McDermott, J. & Kitchen, H. *Global HIV/AIDS: A Strategy for U.S. Leadership.* Washington: The Center for Strategic and International Studies (CSIS), 1994.

This consensus report was developed by CSIS with funding from foundations and private sources to provide national policymakers with a view of HIV/AIDS as a global economic and security issue as well as a health issue. The report examines worldwide statistics, pointing out issues in discrimination and human rights. The committee, chaired by U.S. Congressman McDermott and CSIS Director of African Studies Kitchen, presents six recommendations for the United States to take a leadership position in slowing the spread of HIV, and details seven "myths" about global HIV/AIDS.

Moorman, C. "The Effects of Stimulus and Consumer Characteristics on the Utilization of Nutrition Information." *Journal of Consumer Research*, vol. 17 (1990): 362–374.

The author, an assistant professor at the Graduate School of Business at University of Wisconsin, developed a study to differentiate the various effects of two factors in influencing consumer decision-making about nutrition: the characteristics inherent to the

consumer, and the characteristics inherent in the message delivery system. Study results suggest that both factors are important, and the article highlights nuances of the study findings.

Moorman, C. & Matulich, E. "A Model of Consumers' Preventive Health Behaviors: The Role of Health Motivation and Health Ability." *Journal of Consumer Research*, vol. 20 (1993): 208–228.

The authors developed a model to test the effects of individual and combined factors on various health-related behaviors, and this journal article summarizes their study, which was conducted with 404 consumers. The article includes a chart summarizing health models and an extensive listing of consumer characteristics as they relate to health behaviors across a variety of public health issues, such as smoking, physician use, nutrient intake, and high blood pressure knowledge.

PHS Committee to Coordinate Environmental Health and Related Programs, and Subcommittee on Risk Communication and Education. *Recommendations to Improve Health Risk Communication.* Washington: U.S. Department of Health and Human Services, October 1993.

This 61-page report prepared by an 18-person committee reviews programs managed by various agencies within the Public Health Service. The committee measures each program against the "seven cardinal rules" in risk communications put forth by the Environmental Protection Agency, and deems seven programs effective and three programs less effective. One HIV-related case, implemented by National Institutes of Mental Health, is reviewed. The report concludes with recommendations to improve health risk communication, and presents several practical charts that can be used as program planning tools.

Ramah, M. & Cassidy, C.M. "Social Marketing and Prevention of AIDS." *AIDS Prevention Through Education: A World View*. New York: Oxford University Press (1992): 75–102.

In this book chapter, the authors provide a basic overview of the social marketing process and how it can be used in HIV prevention programs. Included is a graphic of the Fishbein Consumer Decision Model and Debus' Behavior Change Continuum Model, among other program planning tools. A case history of a successful AIDS social marketing project in Mexico illustrates the social marketing process at work.

Rice, B. & Parsons, M. "Federal AIDS Research, Prevention Efforts Must Focus on Drug Use, Sexual Behavior." Washington: Institute of Medicine, July 1994.

In this news release from the Institute of Medicine (IOM) announcing the final report of the committee mandated by Congress to assess various HIV/AIDS research efforts conducted at three federal institutes, the authors reveal the commitee's major recommenda-

tions. Chief among them is the need for more behavioral research, specifically on sexual behaviors. The IOM committee also praised needle exchange programs as promising, and identified social science research as the most underfunded of all AIDS research activities. The release outlines seven major recommendations of the committee.

Rudd, R. et al. *Social Marketing and Adolescent Populations.* Washington: Institute of Medicine, National Academy of Science, (1994): Section 3.

In this 41-page report to the Institute of Medicine, the authors respond to serious health concerns among youth. They provide an overview of current attempts to "market" health behaviors to youth in a social marketing framework, and on societal structures that influence this audience. They posit that programs may be more effective among adolescents if they include family, community, school and worksite efforts as well as focusing on individual behavior change.

Smith, W.A. et al., eds. *A World Against AIDS: Communication for Behavior Change.* Washington: Academy for Educational Development, 1993.

This book summarizes six years of experience of the AIDSCOM program funded by the U.S. Agency for International Development to prevent the spread of HIV in developing countries worldwide. The 284-page book introduces the Applied Behavior Change (ABC) Framework and overviews of ten program examples. The book includes statistical data, expressed graphically throughout, as well as illustrations and examples of program materials. An extensive glossary of terms is included.

Sutton, S., Balch, G. & Lefebvre, C. *Strategic Questions for Consumer-Based Health Communications.* Sharyn M. Sutton, PhD, Building 31, Room 10A03, Office of Cancer Communications, National Cancer Institute, National Institutes of Health, Bethesda, MD 20892.

The authors are program planners in cancer prevention. In this 15-page monograph they present a consumer-based approach to crafting health messages, which they label "consumer-based health communication" (CHC), carefully differentiating it from other methods and terminology used in health promotion. The CHC process they outline relies heavily on the "R.O.I." process developed by William Wells of the advertising agency DDB/Needham, which requires the planner to answer six key questions to develop an appropriate strategy. The authors examine each of the six questions, using health communication examples.

Taylor, D. W., & Muller, T. *Eco-literacy and Environmental Citizenship: A Social Marketing Challenge for Public Sector Management.* Canada: Ministry of Supply and Services, 1992.

Wayne Taylor, PhD, is Assistant Professor of Business, Public and Health Policy and Thomas Muller, PhD, is Professor of Consumer Behavior and Market Research at McMaster University in Canada. The authors implore the Canadian public sector to use the principles of social marketing to change consumer consumption patterns to become less detrimental to the environment. Citing examples of successful Canadian social marketing programs addressing high-risk sexual behavior and smoking, they outline a program to increase the "eco-literacy" of Canadians, leading to changing consumer demands to influence the entire commercial sector.

U.S. Department of Health and Human Services, National Institutes for Health. *Making Health Communication Programs Work.* NIH publication no. 92-1493. Washington: U.S. Dept. of Health and Human Services, 1992.

This 130-page handbook, subtitled "A Planner's Guide," has been considered by many program planners to be indispensable. In clear and simple terminology, it explains step-by-step how to conduct each stage of the six-stage "marketing wheel." Illustrated with graphics, photos, and helpful "sidebars," it covers such practical topics as "How to Make Print Materials Easier to Read" and "Writing an Evaluation Report."

Appendix E

Glossary of Terms

Audience segmentation — subdividing an overall population into homogeneous subsets of target audiences in order to better describe and understand a segment, predict behavior, and formulate tailored messages and programs to meet specific needs.

Behavioral science — an area of social sciences research that examines individuals' behaviors in depth; it explores what people do and why they do it.

Channels of communication — the ways in which individuals receive information; includes large and small media, one-on-one communication, and live entertainment.

Communications science — systematic, informed creation, dissemination, and evaluation of messages to affect knowledge, skills, attitudes, beliefs, behaviors, and, ultimately, health outcomes.

Cultural competence — cultural sensitivity combined with the ability to successfully intervene in a specific population.

Demographics — statistics relating to human populations, including size and density, race, ethnicity, growth, distribution, migration, births, deaths, and their effects on social and economic conditions.

Determinants of behavior — the external and internal factors that may determine or influence individuals' actions.

Epidemiology — the study of the patterns and determinants of health and disease in populations.

Evaluation — a systematic process that records and analyzes what was done in a program or intervention, to whom, and how (process), and what short- and long-term behavioral effects (outcome) were experienced as a result.

External determinants of behavior — those forces outside the individual that affect his or her behavior (e.g., availability of condoms; laws governing sexual activity).

Force field analysis — an analysis of the forces in a community that may inhibit, impede, or assist a program or course of action.

Formative research — systematic investigations during the development phase of a program or intervention that deepens the planners' understanding of the audience and the environment and that assists in subsequent planning and evaluation.

Gatekeepers — influential individuals who serve as access points to the target audience, e.g., school teachers, doctors, or public service directors at local television stations.

Incidence — the number of new cases of a disease or condition that occur within a given time, often one year.

Internal determinants of behavior — the forces inside the individual that affect his or her perception of a behavior (e.g., the belief that condoms are not "cool").

Key informants — individuals who are knowledgeable about and influential with particular segments of the population.

Large media/mass media — media channels that reach large or nationwide audiences, such as the three network television networks or national magazines.

Lifepoints — key places individuals visit in their daily lives, e.g., school, stores, restaurants.

Marketing mix — the balance of components in a marketing strategy that reflects the different needs of a given audience; the "4 Ps": product, price, promotion, and place.

Needs assessment — the process of obtaining and analyzing information from a variety of sources in order to determine the needs of a particular population or community; similar to "marketplace assessment."

Niche media — media targeted to small, specialized audiences.

Outcome evaluation — a type of evaluation that determines whether a particular intervention had a desired impact on the targeted population's behavior; whether the intervention provided made a difference in knowledge, skills, attitudes, beliefs, behaviors, and health outcomes.

Prevalence — the number of individuals living with a disease or condition during a given time.

Prevention marketing — CDC's "brand" of social marketing, which incorporates behavioral science and community participation into the principles and processes of social marketing.

Primary data — qualitative or quantitative data that are newly collected in the course of research.

Process evaluation — a descriptive assessment of the implementation of program activities; what was done, to whom, and how, when, and where.

Psychographics — statistics relating to the spheres of influence on a target audience and their behavior; includes information about target audience's work and leisure activities, associations with peers, willingness to try new things, social norms, and hopes, fears, and dreams.

Secondary data — published, already available data.

Self-efficacy — an individual's belief that he or she can do a desired behavior.

Seroprevalence — the percentage of individuals infected with HIV in a given population at a specific point in time.

Situation analysis — review and analysis of the community's current environment with regard to HIV and HIV prevention, including support for and potential barriers to prevention efforts; this information is used in making decisions about target audiences, behavioral objectives, geographic area to cover, and players to involve.

Small media — often called "personal media"; media targeted to relatively small, specialized audiences and interests, e.g., seminars and workshops, door hangtags.

Social marketing — the use of modern marketing principles and methodologies to increase the use of a socially beneficial idea, product, or practice; key features include a thorough understanding of the target audience, creation of beneficial exchange relationships to influence audience behaviors, and a management approach characterized by continuous monitoring and alteration of interventions as needed.

Social norms — perceived standards of behavior or attitude accepted as usual practice by groups of people.

Stakeholders — those who have an interest in and can affect implementation of an intervention or program; key players; influentials.

Surrogate indicators — data such as STD or hepatitis B rates, which do not directly measure HIV infection, but that may indicate unsafe sexual behavior that can put people at risk of HIV infection.

Surveillance — an ongoing process of information collection, analysis, interpretation, and dissemination to monitor the occurrence of specific health programs in populations.

'zines — specialized publications that have small but extremely dedicated markets.

Appendix F

Checklists and Worksheets

Overview: The PMI Design Process

Key Questions Communities Must Answer

This first worksheet provides an overview of questions communities need to think about in order to plan, design, and monitor effective HIV Prevention Programs. The worksheets that follow provide more detailed steps in these different processes.

How will the project be managed locally? What organizations and individuals need to be involved in initial planning?

- Which organization is responsible and accountable for managing the project?
- Who is the key contact person?
- Who needs to be involved in the different phases of project planning?
- What staff resources are available to contribute to project planning?
- How will the planning process identify and include agencies serving the target population?

What processes will be used to determine priorities for segmenting populations?

- What combination of criteria will be used to identify population segments to target for intervention (e.g., potential number of people reached; current risk behavior profile; demographics)?
- What services and prevention programs are currently targeting identified segments?
- Based on identified segments and current services provided, which segments remain underserved?
- For underserved segments, what combination of resources, political climate, and other programming considerations will determine resource allocation?

What is the current environment in each community with regard to HIV prevention among the target audience?

- What are the HIV prevention problems and issues among young people in each community?
- What is the extent of the problem?
- Who is affected?

- What needs to be, or can be done, about the problems?
- What programs are currently addressing these issues?
- What forces are working against solving these problems in the community? What are the barriers and obstacles to implementing programs?
- What forces are working toward, or are available to, support programs? What aspects of the community will help programs succeed?
- What are the community priorities with regard to HIV prevention among the targeted population?

What are the identifiable channels or settings where the target audience is currently accessible?

- What community social service agencies, clubs, or programs serve them?
- What institutions serve them (e.g., colleges, trade schools, youth detention centers, military)?
- In what work sites can youth be found?
- What health services agencies serve them?

Within the identified channels or settings, what are the profiles of the target audience in those settings?

- What are numbers of the target population served by each channel?
- What are the target audience demographics of those served by each channel?
- What are the risk behavior profiles of the target population in each channel (e.g., according to household survey data, local data, anecdotal/case study data)?
- What is the current health status by channel (e.g., STD rates, seroprevalence data, pregnancy rates, injectable drug use)?
- What other qualitative profiles might exist in your community to describe the target population in each channel?

What target audience segments does each community want to reach and what behaviors are to be influenced?

- Who matters most in solving the problems?
- Of those who matter most, can they be reached effectively, given available resources?

What do we know about the target audience?

What is the target audience doing now and what is required to change their behavior?

- What do they like about what they are doing now?

- What aspects of what they are doing now bother them?
- What kinds of things could they do to solve the problem?
- What barriers would they meet in trying to change their current behavior?
- What can communities do to facilitate change? To make the new behavior fun, exciting, entertaining, rewarding (that is, to overcome perceived costs with perceived benefits)?

How much does the target audience know, and what beliefs do they hold?

- What misconceptions do they have?
- What fears or barriers do they perceive?

What skills do they need to change their behavior?

What are the perceived social norms regarding the new behavior?

- How important is it to them to do what communities want them to do, compared to other problems they face?
- Do they think that others they admire and respect want them to do something useful?

Who influences the target audience? On subjects such as this, who do they look up to, trust, and believe? What social systems and social networks need to be engaged?

To what channels of communication do they pay attention, what services do they use, to what groups do they belong?

What does the target audience do with free time — after school or work? Where do they go?

How can representatives of the target audience be meaningfully involved in program planning, implementation, and evaluation?

What strategies can the community employ to influence behavior change in the target audience?

- What products, services, or information are needed for the target audience to change its behavior?
- Where and when can program products, information, and services be offered so they will be easily accessible and appealing to the target audience?
- What barriers must be removed to make the products and services desirable to the target audience?
- What aspects of the products and services are perceived as benefits by the target audience? Are these benefits important enough to the target audience for the audience to desire the products or services? How will these benefits be communicated?
- What resources exist in the community to support these programs? Are additional resources necessary?

- What community organizations will participate and support the programs and services? What are appropriate roles for each?

What assessment and evaluation programs will guide the development and monitor the ongoing implementation of prevention marketing strategies?

- How will focus groups, key informant interviews, and other group processes be used to ensure that the program progresses toward identified goals?
- How will risk behavior data be collected and used in the program planning process?
- What other data collection will be needed to ensure program success?

Defining the Health Problem

Use epidemiologic, demographic, and behavioral information — and, if you have it, information about population knowledge and beliefs — to define the problem you want to address.

The definition will be based largely on secondary data — information already available about HIV/AIDS and surrogate indicators like STDs, unintended pregnancies, and other health-related issues in your area. You may gather some information to fill important gaps. For example, you might conduct a service provider survey to learn more about what services are available, what populations are served, what needs are not being met, and so on.

Your initial description of the health problem will guide the more comprehensive formative research that follows. This first phase is not as complete, for example, as the audience profile drawn after formative research is done.

Follow five key steps in defining the problem:

- *Determine what you know and need to know;*
- *Assess your resources (internal and external) and the task, develop a plan of attack;*
- *Gather secondary data;*
- *Determine what you still need to know, how you will find that information, and then obtain the information;*
- *Use all this information to define the health problem you want to address.*

Step 1: Determine What You Know and Need to Know

A definition of the health problem should answer as many of the following questions as possible. Much of this information is available from your state and local health departments.

- What are the morbidity and mortality levels associated with AIDS?
- What are the trends in AIDS cases? HIV infections?
- Are there any recent changes in characteristics of people with AIDS? Among those infected with HIV?
- Who is getting infected now?
  - Age?
  - Gender?
  - Sexual orientation?
  - Race/Ethnicity?

Education level?

Socioeconomic status?

Geographic location?

Chief behavioral risk factors?

What other risk-related factors can be determined at this time?

Social?

Cultural?

Other?

- What is the current knowledge level of the at-risk groups regarding HIV transmission?
- What beliefs/attitudes can be identified that are barriers to new behaviors? That facilitate the new behaviors?

Step 2: Assess Internal and External Resources and the Task

Remember that collaborating with other organizations can stretch your resources.

Person with overall responsibility:

Name:_____

Organization:_____

Phone:_____

Other participants:

Name:_____

Organization:_____

Phone:_____

Name:_____

Organization:_____

Phone:_____

Name:_____

Organization:_____

Phone:_____

Name:_____

Organization:_____

Phone:_____

Name:_____

Organization:_____

Phone:_____

Financial resources available? [ ] yes $_____

[ ] no — Ideas for securing needed funds:_____

Should an outside consultant be hired to manage this?_____

[ ] yes — budget ceiling $_____ [ ]no

Are resources allocated for this step sufficient to gather primary data if necessary, or should secondary data only be used?

[ ] secondary data only

[ ] can gather primary data if needed — budget ceiling $ _____

Step 3: Gather Secondary Data

Check data available. Data should include epidemiologic, demographic, and behavioral information and, as much as possible, information about beliefs and attitudes.

- **AIDS Surveillance Data**

  [ ] yes [ ] no *Source of data:*_____

  Name:_____

  Organization:_____

  Phone:_____

Note: Data about people with AIDS are the only HIV/AIDS data on a population-wide basis in all states by sex, race/ethnicity, age, and mode of HIV exposure. AIDS case reports represent people in the later states of HIV infection, and so they may not represent the characteristics of those who are becoming infected now. Over time, changes in the characteristics of people infected with HIV are mirrored by changes in AIDS trends.

- **HIV/AIDS-Related Morbidity (Illnesses) Data**

  [ ] yes [ ] no *Source of data:*_____

  Name:_____

  Organization:_____

  Phone:_____

■ **HIV-Related Mortality Data**

[ ] yes [ ] no *Source of data:*_____

Name:_____

Organization:_____

Phone:_____

Note: Mortality data are independent of definitions used for AIDS reporting because they represent deaths attributed to HIV infection. Mortality data do not provide information on modes of HIV transmission. Also, mortality data underestimate the impact of HIV in communities more recently affected by HIV.)

■ **HIV Seroprevalence Data**

[ ] yes [ ] no *Source of data:*_____

Name:_____

Organization:_____

Phone:_____

Note: These surveys measure the level of HIV infection among selected populations that have been targeted for information. Virtually all states should have access to data on HIV prevalence among childbearing women, military recruits, Job Corps applicants, and blood donors. A number of Seroprevalence surveys have been conducted in clinic settings. The Survey of Childbearing Women was the only population-based survey (it was suspended in 1995). Almost all the others are based on "sentinel" populations. The greatest power of these data is in documenting the extent and potential impact of HIV that is not yet manifest as severe disease. Remember that all data will have limitations. For example, military recruits and Job Corps applicants may not mirror the young adult population as a whole, because of "self-selection" — that is, people who know they are HIV+ or think they could be might not seek entry into these programs, knowing that they will not be accepted if they test positive. Work with epidemiologists to understand the strengths and weaknesses of the data you use.

■ **Behavioral Risk Factor Surveillance**

[ ] yes [ ] no *Source of data:*_____

Name:_____

Organization:_____

Phone:_____

Note: The Behavioral Risk Factor Surveillance System (BRFSS) is a telephone-based survey conducted by nearly all states. Questions about HIV focus on the respondent's understanding of how HIV is transmitted, how transmission can be prevented, and on

self-perceived risk. The Youth Risk Behavior Surveillance System (YRBSS) includes national, state, and local school-based surveys of adolescents. These surveys are aimed at the general population and provide information about knowledge and behaviors.

- **Surrogate Marker Data: STDs**

  [ ] yes [ ] no *Source of data:*_____
  Name:_____
  Organization:_____
  Phone:_____

Note: Syphilis and gonorrhea are reportable diseases in all states; reporting requirements for other STDs vary. Reporting is likely to be most complete for those who receive STD services in publicly funded clinics. While STD rates provide a measure of unsafe sexual behaviors, they do not necessarily correlate with HIV risk, which depends both on the level of unsafe sexual activity and the level of HIV infection among networks of sexually active people.

- **Surrogate Marker Data: Hepatitis B**

  [ ] yes [ ] no *Source of data:*_____
  Name:_____
  Organization:_____
  Phone:_____

Note: Hepatitis B is a reportable disease in nearly all states. Like HIV, hepatitis B is transmitted by sexual contact, through exposure to blood, and perinatally. Hepatitis B case reports may also provide information on exposure risks. Thus, trends in hepatitis B cases may reflect changes in behavior associated with HIV risk.

- **Recipients of Counseling and Testing Services**

  [ ] yes [ ] no *Source of data:*_____
  Name:_____
  Organization:_____
  Phone:_____

Note: Information about people who receive HIV counseling and testing services, including the number of positive tests, should be available from local counseling and testing services; they may be centrally compiled by the health department. These data can provide information on the number of HIV tests conducted, the characteristics of

people who use these services, and the percentage of tests that are positive. Based on interviews of people reported with AIDS cases, these sites account for less than a third of HIV. Other sites include hospitals and private physicians' offices.

- **Illicit Drug Use/Alcohol Use**

  [ ] yes [ ] no *Source of data:*_____
  Name:_____
  Organization:_____
  Phone:_____

Note: Information on illicit drug and alcohol use may be available from state or local alcohol and drug agencies. This may include estimates of the number of drug injectors, the number of abusive drinkers, the number of treatment slots available (inpatient and outpatient, drug and alcohol), the length of waiting lists, and patterns of drug and alcohol use.

- **Surrogate Marker Data: Measures of Adolescent Fertility**

  [ ] yes [ ] no *Source of data:*_____
  Name:_____
  Organization:_____
  Phone:_____

Note: Measures of adolescent fertility (abortion and birth rates) can estimate the level of unprotected intercourse among heterosexual teenagers. However, these measures do not necessarily predict the risk of disease transmission.

- **Other Data — Type:**

  [ ] yes [ ] no *Source of data:*_____
  Name:_____
  Organization:_____
  Phone:_____

Step 4: Determine What You Still Need to Know, How You Will Find That Information, and Then Obtain the Information

- Were multiple sources of quantitative data looked at?

  [ ] yes [ ] no

- Has qualitative data been used to ask targeted questions of specific populations and help fill gaps?

  [ ] yes [ ] no

- Is additional information needed?

  [ ] yes — type/s:

  [ ] no

- How can needed information be gathered?

  Ideas:

Person with overall responsibility:

Name:_____

Organazation:_____

Phone:_____

Other participants:

Name:_____

Organazation:_____

Phone:_____

Name:_____

Organazation:_____

Phone:_____

Name:_____

Organazation:_____

Phone:_____

Name:_____

Organazation:_____

Phone:_____

Name:_____

Organazation:_____

Phone:_____

Plan for gathering needed information:

[ ] developed [ ] needs to be developed

Date:_____

Step 5: Define the Health Problem You Want to Address

Use the information you have gathered to write a statement of the health problem you want to address. Be as specific as possible about who is currently affected, who is most at risk for future HIV infection, what the chief risk factors are, what your geographic boundaries will be, and other defining qualities.

Problem Statement:

Conducting Formative Research

What is Formative Research

"Formative research" is research used to help develop or "form" the program. (See also pages 20 and 44.) Formative research is sometimes called the "situational analysis." It may be called a "needs assessment" or "marketplace assessment." And the research may consist of several parts. This worksheet describes four kinds of research—

- Audience Research,
- Environmental Profile,
- Community Resource Inventory, and
- Condom Audit.

A formative research package need not include all of these. Your program should decide what areas are research priorities. However, some research into **audience knowledge, attitudes, beliefs, and practices, and into the environmental context** in which the program will operate, is essential. This research is combined with information already collected about the health problem to help **segment the audience and to define goals and strategies.** It's also important to note that much of this information may already be available; you don't have to reinvent the wheel. Be sure to check for data before you begin research that may duplicate previously completed investigations.

Focus on the Goal of Your Research

The goal of formative research is to understand the causes (or determinants) of risky behaviors among the target audience, and investigate what might influence them to change. Every question asked should be aimed at answering these two basic questions. Research also helps you understand how the population can be divided into different groups, or segments, that tend to act or think similarly, or are affected by similar influences. Program strategies should eventually address a carefully defined audience segment.

Determine the Scope of Your Work

Date formative research package must be available_____

Resources available (budget and human resources)_____

Types of research planned:

[ ] Audience Research

[ ] Environmental profile

[ ] Community Resource Inventory

[ ] Condom Audit

Audience Research

Audience research focuses on the knowledge, attitudes, beliefs, and practices or behaviors of the target audience, in relation to the health problem. (Audience surveys are often called KAP or KABB studies.) Audience research also looks at how the target group receives information — the media that reach them, the people who influence their decisions on important questions, and the spokespeople they consider credible.

Step 1: Managing the Audience Research

Who is responsible for managing the audience research?_____

What funds are available for the research?_____

What secondary data are already available?_____

_____

What resources are needed/who will conduct the research?_____

(See also worksheet on *Managing Research.*)

What is the schedule for conducting the research?_____

Step 2: Outline the Information You Need and How You will Get It

Several different kinds of information about the target audience will be useful. The list of possible questions below is provided just to give some ideas. As you create your own list of priority research questions, check off the basic categories of information in your package.

[ ] **Knowledge about the Health Problem**

How much do targeted segments know about the health problem?

What are their misconceptions?

How will we find out?

[ ] **Attitudes/Beliefs About the Health Problem**

What are the perceived social norms regarding the new behavior?

How important is it to them to do what communities want them to do, compared to other problems they face?

Do they think that others they admire and respect want them to do something useful?

How will we find out?

[ ] **Behaviors/Practices**

What are the current behaviors of the target audience in relation to this health problem

What are the benefits to the target audience of these behaviors? (What do they like about what they are doing now? What are the rewards they are receiving?)

What bothers them about their current behaviors?

Have they attempted the recommended behaviors? At what stage of "adoption" are they? (haven't considered change, have considered change, have tried to change, are trying to maintain change)

What barriers do/would they run into in trying to change their current behavior?

How could these barriers be offset or lessened?

What facilitates the desired behavior? How could those facilitators be strengthened?

What benefits would they get from the recommended behavior that would be important to them?

How could these benefits be increased?

Does the audience need new skills in order to change their behaviors?

What is the current skill level? How might this be improved/increased?

How will we find out?

[ ] **Communication Channels and Influence**

How could this audience be best reached with information?

Who influences the target audience? On subjects such as this, who do they look up to, trust, and believe? What social systems and social networks need to be engaged?

To what channels of communication do they pay attention?

What media are preferred/most powerful?

What are the most popular times the audience listens or views this media?

What services do they use?

To what groups do they belong?

What does the target audience do with free time—after school or work?

Where do they go?

What/who do they find credible as a source of such information?

What type of words, phrases, can be most useful in communicating?

What is the literacy level of the audience? the preferred language?

What tone would be most effective?

How will we find out?

[ ] **Community Participation/Involvement**

How can representatives of the target audience be meaningfully enrolled in program planning and implementation?

How will we find out?

Step 3: Select Research Methods

Methods for collecting information about the target audience will probably include collection of secondary information as well as collection of some new, or primary, data. Research should be both quantitative and qualitative. (It should both measure how many people know, believe, or do a certain thing, and it should probe in-depth the reasons for these beliefs and behaviors.) Decide which methods your package will include.

- **Quantitative Methods (to count or measure)**
  - [ ] Knowledge, attitudes, beliefs, practices surveys

- **Qualitative Methods (to probe for the reasons)**
  - [ ] Focus groups
  - [ ] Ethnographies (in-depth case studies)
  - [ ] Behavioral observations
  - [ ] Intercept surveys (with in-depth/open-ended questionnaires)
  - [ ] Opinion leader/gatekeeper interviews

Environmental Profile

The environmental profile provides information on the environment in which the target audiences lives, works, and plays, and in which the program will operate. It helps fill out the "picture" of the target audience.

Step 1: Managing the Environmental Profile

Who is responsible for creating the environmental profile?_____

What funds are available for the research?_____

What secondary data are already available?_____

_____

What resources are needed/who will conduct the research?_____

(See also worksheet on *Managing Research.*)

What is the schedule for conducting the research?_____

Step 2: Outline the Information Needed

Information for an environmental profile can be divided into several broad areas. Develop a guide with specific questions which you think will give you the most valuable clues into how your target audience is affected by their surroundings. The list below will provide some general ideas. As you develop a question guide, check off the categories completed:

- **Geographic Environment**
  - [ ] Residential and commercial areas?
  - [ ] Schools?
  - [ ] Recreational areas? (including "hang out spots," bars/nightclubs, parks, etc.)

- **Social Environment**
  - [ ] General social environment, recent trends of changes?
  - [ ] Local leaders' beliefs toward issues related to youth and HIV prevention?
  - [ ] Policies related to condoms and condom distribution?
  - [ ] Policies related to sex and HIV education?
  - [ ] Local neighborhood leadership structure (politician, business person, etc.)
  - [ ] Organized groups or individuals who might oppose your program?

- **Socioeconomic Environment**
  - [ ] Average income?
  - [ ] Average educational attainment?

[ ] Other household information?
[ ] Social services?
[ ] Housing assistance?
[ ] Other?

- **Educational Environment**
  [ ] Number and types of schools?
  [ ] School board issues?
  [ ] School policy regarding sex education and HIV/STD education?
  [ ] In-school vs. out-of-school and drop-out rate?

- **Media Environment**
  [ ] Number and positioning of articles and editorial with mentions of key words (such as HIV/AIDS, adolescents, sexual behavior, condoms, etc.) in mainstream and alternative press?
  [ ] Number and type of advertisements and PSAs (including CDC spots)?
  [ ] Any ongoing effort through local media monitoring?

Step 3: Select Methods, Outline Procedures

Much of the information for the environmental profile can be collected very simply from available sources. Key informant interviews are conversations with community experts — people who do not necessarily have academic degrees or hold public offices, but rather are those you think can provide reliable information about some aspect of the environment. Interviews can be in person or over the phone, and would loosely follow a prepared question guide.

Check those methods you will use to create the environmental profile:

- **Secondary Data**
  [ ] Existing information from resource lists and databases?
  [ ] Newspaper indices or clipping services?
  [ ] Library or online databases?
  [ ] Information supplied by local chamber of commerce, school systems, or real estate firms?
  [ ] Other sources?

- **Primary data**
  [ ] Key informant interviews with community experts
  [ ] Other methods?

Community Resource Inventory

A community resource inventory provides information on relevant program-related services available to the population in a given geographic area. The inventory provides an idea of who is already being served and how. It pinpoints the gaps in services. It helps identify potential partners for your program efforts. Designing a community resource inventory can be a small or a large job, depending on the scope you decide will be useful to your program.

Step 1: Managing the Resource Inventory

- Who is responsible for overseeing the resource inventory?
- What funds are available for the research?
- Are any similar or partial inventories already available?
- What resources are needed/who will conduct the research?
  (See also worksheet on *Managing Research.*)
- What is the schedule for conducting the research?_____

Step 2: Outline the Research and Carry Out Steps

Information for the resource inventory is gathered by contacting representatives of identified agencies. Check off these basic steps as you define the scope of your inventory; gather the information; and produce the final product.

[ ] Define geographic area for inventory.
(Several block area? city? county? state?)

[ ] Define level of analysis for inventory.
Simple agency locator and key representative data?
More extensive profile:
Categories of target populations serviced?
Types of services provided?
Service capacity?
Client eligibility requirements?
Demographics of clients?
Languages spoken by clients and staff?
Availability of print/audiovisual materials?

[ ] Determine categories of service provider agencies.
Local health department
Drug abuse treatment facilities?
Educational institutions?
Community based organizations?
Health care providers?
HIV counseling and testing sites?
STD clinics?
Youth organizations/facilities?
Service organizations for special populations?

[ ] Select specific service provider agencies for inventory.

[ ] Identify service provider representatives for survey.

[ ] Contact service providers and conduct inventory.

[ ] Compile and analyze inventory data.

[ ] Prepare summary report of information.

Condom Audit

Many HIV prevention programs focus on reducing risky sexual behaviors, and condoms are an integral part of their overall prevention efforts. If you intend to focus on sexual behaviors, consider the need for a "condom audit."

Step I: Assess Whether a Condom Audit is Needed

Begin by asking these two questions:

- Is promotion of condoms likely to be a part of your program?
- Is condom availability, access, or price a problem for your target audience?

If you answer yes to both questions, then your program should consider conducting a condom audit as part of the formative research package. Before conducting research on condoms, see what information is already available and decide if you need to answer additional questions. Only collect information you need.

Step 2: Outline Research Needed

Decide which questions you need to answer. Ask only the questions which will be useful. Probe further into these questions only if you think you can affect the situation. Useful questions might include the following. Check which ones you want to investigate:

[ ] Is it difficult for those who are sexually active to get condoms?
[ ] What are the barriers? (both actual physical barriers and psychological barriers)
[ ] How does the target audience acquire condoms?
[ ] Do they buy them or get them free?
[ ] Does the target group find price to be a barrier?
[ ] Are they embarrassed to get condoms?
[ ] Are condoms placed behind counters in stores so customers must ask for them?
[ ] Are there restrictions on sales to those who are underage?
[ ] Are attitudes of condom providers a barrier?
[ ] What are attitudes of the target audience toward acquiring condoms?

List other major questions to investigate:

1._____

2._____

3._____

4._____

Step 3: Select Methods

Decide which methods will be useful for gathering information. These might include the following. Check off which ones you want to use:

[ ] Survey a sample of stores (drug stores, markets, etc.) to observe condom brands, price, and placement.

[ ] Explore free sources of condoms (community-based organizations? schools? clinics?) Interview health workers and target audience members to assess possible barriers.

[ ] Interview pharmacists, store clerks, or health providers to assess attitudes. Do they see themselves as educators? Which brands are purchased the most? Stolen the most? Who determines condom placement?

[ ] Interview members of your target audience to see if they carry condoms, and if they don't have them, if they know where to get them. What attributes do youth give to free condoms? To various brands for sale?

Other Methods?

1._____

2._____

3._____

Step 4: Managing the Condom Audit

Who is responsible for overseeing the condom audit?_____

What funds are available for the research?_____

What resources are needed/who will conduct the research?_____

What is the schedule for conducting the research?_____

Will conducting this research in your community draw any attention or create any special issues? What might be these problems, and what steps need to be taken to prepare for or manage these?

_____

_____

_____

Segmenting the Audience

The Goal of Audience Segmentation

Audience segmentation is the process of dividing a large potential audience into smaller groups, or segments, that have similar characteristics. The goal of this process is to develop clear and specific pictures of your target audience members. Audience segmentation is often done along obvious lines, like age or gender or sexual orientation or income. Prevention marketing uses these demographic characteristics as well as lifestyle factors, psychographic information, epidemiology, and information about knowledge, attitudes, beliefs, and behaviors to draw a sharper picture of the target audience. *(See also page 20.)*

Defining the Primary Audience

The major purpose of audience segmentation is to define the primary audience — the group whose behaviors you want to influence. Results of the formative research should guide you in answering:

- Who is at risk? What is their level of risk?
- What behaviors put them at risk?
- Who is responsive to changing their behaviors?
- Who can be reached? How?

Defining the Secondary Audiences

In addition, audience segmentation identifies the secondary audience(s) — those who can influence the audience and the effectiveness of the program. Your research should guide you in answering:

- Who directly influences the primary audience?
- Who are potential allies in reaching program goals (decision-makers, community leaders, etc.)?
- Who are potential critics of the program who should be "won over?"

Step 1: Managing the Process, Reviewing the Research

Audience segmentation should be the result of open discussion and broad consensus in your project. Keep in mind that your choice will have social implications in the community. You should be able to document the reasons for choosing a target group, and should also be able to document the process by which your program came to its decisions. Your selection of a target audience should be firmly grounded in the results of your formative research.

Who will be in the decision-making group for selecting the target audience?

_____

_____

What process will be used?

- Small-group meeting with results shared and discussed/approved by full committee?
- In-house workshop with full committee participation?
- Workshop attended by members of the community?
- Workshop facilitated by outside expert?
- Other? _____

List the research that will form the basis of your decision-making:

1. _____
2. _____
3. _____
4. _____

Step 2: Decide Segmentation Criteria for Primary Audience

What are the best ways of defining your target audience? There are numerous ways to segment target audiences for a public health program. Epidemiology and demographics provide the foundation. However, your "picture" of the target audience should build upon many other criteria, including behaviors, psychographics, attitudes, etc.

Note that your target segment should be a "target of opportunity" as well as a "target of risk." That is, in addition to considering the target audience's level of risk, you must also consider readiness to change, likelihood of being reached within your program's fiscal and staff constraints, and other factors. Check off the categories below that you decide are most helpful for defining your primary target group. (The characteristics listed here under each are just broad guidelines. Your research provides appropriate factors.)

[ ] **Epidemiology**

The group with the highest seroprevalence of HIV?

The group among which the incidence of HIV is rising fastest?

[ ] **Demographics**

A specific age?

Male or female?

A specific ethnic/racial group or groups?

A specific geographic area of residence?

A specific income level?

A specific educational level?

[ ] **Behaviors**

Those who are not yet sexually active?

Those who are sexually active but not at sexual risk (monogamous, always use condoms)?

Those who are sexually active and at sexual risk (multiple partners, inconsistent or no condom use)?

Heterosexuals (male and female)?

Men who have sex with men (gay-identified or not, bisexual)?

Women who have sex with women?

[ ] **Stage of "Readiness" for behavior change**

Those who are unaware their behaviors are risky?

Aware their behaviors are risky?

Knowledgeable of a solution/alternative behavior?

Contemplating trying the new behavior?

Intending to try the new behavior?

Trying the new behavior?

Committed to maintaining the behavior?

[ ] **Benefits and barriers**

Those whose behavior is influenced by a commonly perceived benefit (for example, similar reasons for having sex with several partners)?

Those whose behavior is influenced by a commonly perceived barrier (for example, those who don't use condoms because they feel unable to negotiate this with their partner)?

Those who are influenced by similar social norms (for example, those who think all of their peers are sexually active)?

[ ] **Psychographics**

Those who are "innovators," willing to take risks, engage in new behaviors?

Those who tend to "follow the crowd"?

Those who have similar hopes or images of themselves for the future?

Those who have similar fears or concerns about their lives?

Those who view themselves as part of a similar social group?

[ ] **Lifestyle**

Those who enjoy similar kinds of entertainment?

Those who get their information from similar channels?

Those who are in/out of school?

Those who use similar services (visit STD clinics, for example)?

Step 3: Identifying Behavioral Determinants

As you begin to get a picure of your target audience, it is important to identify what makes them different from those you are not targetting. In other words, what are the defining causal elements that lead one group to "do" or "accept" your target attitude, beliefs, or behaviors, and anohter group not to do or accept them?

Determinants, or causes, of what makes a person a "doer" or "acceptor" of a particular behavior can come from both external or internal sources:

Internal Determinants	External Determinants
Knowledge	Environment/Culture
Beliefs	Access to key products
Concern, fear	Access to key services
Motivation	Social support or pressure
Skills	Policy
Perceived self-efficacy (belief that one can do what is required)	
Perceived social norms	

- Describe any internal determinants the research has revealed are crucial to performance of your selected behavior.

1. _____
2. _____
3. _____

- Describe any external determinants the research has revealed are important to performance of your selected behavior.

1. _____

2. _____

3. _____

Step 4: Refine Your Audience "Picture"

Review your preliminary audience "picture." Is this a homogenous group? That is, does it describe "one person" or does it really have important subgroups within it? Can your program reach this entire target audience with a single message strategy, for example, and with the same information channels or services? *Or, will key segments of your audience require unique program elements?*

You may decide your program needs to address more than one distinct audience segment with separate or "overlapping" strategies.

If you decide to address more than one segment, describe the key difference between the groups that requires separate strategies:

_____

_____

Step 5: Define Your Primary Audience Segment(s)

Now describe your primary audience segment(s) in as much detail as possible.

Segment 1:_____

_____

_____

(Segment 2:)_____

_____

_____

Step 6: Define Your Secondary Audience(s)

Your audience research helps you determine what groups influence the primary target audience you have selected.

Describe who directly influences the primary audience.

Will your program also target potential allies in reaching its goals (decision-makers, community leaders, etc.)? If so, who are these groups?

Will your program also target potential critics of the program who should be "won over?" If so, who are these groups?

Setting Behavioral Objectives

What Are Behavioral Objectives?

The overall goal of an HIV prevention program is to reduce the rate of infection in a given population. Prevention marketing focuses on changing risky behaviors and reinforcing safer behaviors in a target audience to achieve this goal. Primary program objectives are therefore the near-term or intermediate accomplishments having to do with target audience behaviors, which program planners select as the focus of the program and the measure of its effectivness. Prevention marketing also relies on community mobilization to promote safer behaviors. Consider secondary program objectives in light of attitudes, beliefs, knowledge, skills, and behaviors of people who directly influence your target audience and their behaviors. *(See also page 20.)*

Effective behavioral objectives are:

- **Specific:** (Identifies who will change, what they will change — particular attitudes, behaviors — and where the change will take place)

- **Measurable:** (Identifies how soon change will occur, and how many people will change, and by how much)

- **Reasonable:** (Can be achieved within a specified time period using available resources)

Step 1: Managing the Selection of Behavioral Objectives

Like the process of choosing the target audience, your selection of behavioral objectives for the project should be the result of broad consensus. Your choice may have social implications in the community. Your selection of behavioral objectives should be firmly grounded in the results of your formative research.

Who will be in the decision-making group for defining the behavioral objectives?

What process will be used?

[ ] Small-group meeting with results shared and discussed/approved by full committee?

[ ] In-house workshop with full committee participation?

[ ] Workshop attended by members of the community?

[ ] Workshop facilitated by outside expert?

[ ] Other? _____

Step 2: Start with Broad Objectives

If your prevention efforts are focusing on sexual behavior, you might consider starting with broad objective statements like the following.

Target audience members who are —

- not sexually active will continue to abstain.
- sexually active but are in a mutually faithful relationship with an uninfected partner or use condoms consistently and correctly will maintain those behaviors.
- sexually active and not in a mutally faithful relationship with an uninfected partner will

  refrain from sexual activity, or

  choose nonpenetrative sex, or

  use condoms consistently and correctly.

Look at these broad objectives in relation to your program's selected target audience and refine them in terms that are **specific, measurable, and reasonable.**

Step 3: Narrow the Options

[ ] Identify options.

Given the audience segment you have chosen as a priority, which behaviors are relevant?

Are there compelling data to focus on a single behavior?

[ ] Narrow these to a few priorities.

Using the criteria below, examine the potential impact and feasibility of each option.

[ ] Focus on a specific measurable behavior.

Can your target behavior be observed and measured? Do you need to define intermediate behaviors that are linked to the target objectives, and that can be measured?

(Sexual behaviors are hard to observe and even harder to measure, for example — "Target group uses condoms correctly and consistently." Your program needs to define behaviors it can measure, for example — "Target group respondents report using a condom in their last sexual encounter.")

Step 4: Criteria for Defining Objectives

In looking at options, consider the following criteria:

- **Potential for Impact**
  How effective is this behavior at reducing risk?
  What proportion of the audience is currently practicing the proposed behavior?
  How much of this audience's risk is eliminated if they adopt the proposed behavior?

- **Operational feasibility**
  How possible is it to influence this behavior, among the selected target audience, given available resources?

- **Behavioral feasibility**
  Is the audience likely to make the change?
  Does the audience consider the behavior acceptable and achievable?
  How great are the costs of doing the proposed behavior (in terms of time, money, emotions, social acceptance)?
  How great are the costs of switching from the current risky behaviors to the proposed, safer behavior?
  How frequently must the proposed behavior be performed?
  How complex does the audience consider the proposed behavior?
  How compatible is the proposed behavior with current lifestyle and practices?

- **Social feasibility**
  Will the community support the choice of audience?
  Will the community support the choice of behavior?

Step 5: Write Your Statement of Objectives

Who (and how many)_____

will do what _____

by when _____

by how much_____

Step 6: Review Your Objectives

Does your statement of behavioral objectives:

- [ ] Specify a single key result?
- [ ] Specify a target date?
- [ ] Use terms that are specific and quantitative?
- [ ] Tell what and when (not why and how?)
- [ ] Use words that are readily understood by those involved?
- [ ] Describe something realistic, attainable, yet a challenge?
- [ ] Provide limits to expenditures of time and effort?
- [ ] Identify criteria to evaluating achievement?
- [ ] Direct and focus program efforts?

Marketing Strategy

What is the Marketing Mix?

The marketing mix is usually described as the four "Ps" of commercial marketing: product, price, place, and promotion. Sometimes, a fifth P — politics or policy — is added. The marketing mix provides the basis for your overall program strategy. The Ps are linked together in a mutually reinforcing way. They are not individual "steps" in a program, but rather together they define your program strategy. (See also page 22.)

Defining the Product

The product is whatever your program decides to offer the target audience. It is the new information, beliefs, attitudes, or behaviors you would like them to accept. However, your program cannot simply ask the audience to accept them. Your program must also offer benefits that mean something to the target audience. It must offer something positive in exchange for giving up old beliefs or behaviors and to off-set or overcome the costs of the new ones. For example, people often cite the loss of sensation as a cost of using condoms; this cost may be overcome by the assurance of protection from HIV and other STDs. (Cost is discussed below under "Compensating for the Price.")

Your Primary Offering

- Describe what you are asking your audience to do. (Adopt specific new attitudes, beliefs, behaviors, or accept new information?)

_____

_____

_____

- Describe the key benefit (or "positive consequence") of the product/new behavior that will have meaning to your target audience.

_____

_____

_____

- Outline a support statement (or "convincing explanation") for the key benefit. (A rationale/explanation? epidemiological data? experience of other credible individuals?) Ask yourself, "What would convince the target audience to 'buy' our product?"

Identifying Competing Products

Every product has "competition." Your audience is currently engaged in a competing belief or attitude or behavior. They are benefitting in some way from this current belief or behavior.

- Describe the current competing behavior(s) of your target audience.

- Describe the key benefits to the target audience of their *current behaviors.* (The benefits offered by your program must be equal to or greater than those offered to the audience in their current situation.)

Identifying "Determinants"

Another way of thinking about what will help your audience accept the product is to look at the behavioral "determinants" you discovered as part of your audience research and in segmenting your audience. What are the chief differences between "doers" and "nondoers" of the behavior — or those who accept the product, and those who do not? Some of the behavioral "determinants" you discovered can be influenced, and some cannot.

- Describe any internal determinants the research has revealed are usually associated with acceptance of your product (or performance of your target behavior.)

1.
2.
3.

- Describe how these might be influenced in your target audience. (For example, if skills are lacking — in using condoms or in negotiating with partners — would workshops be helpful?)

1. _____
2. _____
3. _____

- Describe any external determinants the research has revealed are usually associated with acceptance of your product (or performance of your target behavior).

1. _____
2. _____
3. _____

- Describe how these might be influenced in your target audience. (For example, if condoms are not accessible to your group, how could your program influence their availability? If perceived social norms undermine monogamous relationships, could you influence peer attitudes toward monogamy?)

1. _____
2. _____
3. _____

NOTE: You now have the "seeds" of some promotional activities identified. You have also begun to think about some "intermediate products" or behaviors for your target audience that will help achieve your program's overall behavioral objective. (These intermediate products might be new skills, or workshops, or informational hotlines.)

Compensating for the Price

Price refers to all the major costs the audience might associate with the product. These costs might be:

- Monetary
- Psychological
- Social
- Time

Every product has a price. And this price varies with the target audience. Your audience research should help you understand what costs are important enough that the program needs to address them as part of its overall strategy.

One way to think about price is in terms of the barriers and facilitators your audience will encounter when they consider adopting the beliefs or behaviors your program has identified. Barriers increase the price they must pay. On the other hand, facilitators reduce the price.

- What are the chief obstacles or barriers to the audience's acceptance of your product? (Peer pressure to continue current practices? Psychological barriers to discussing condoms? Logistical and social costs of getting condoms at the local pharmacy? Financial costs?)

1._____

2._____

3._____

- Describe what you can do to overcome any of the barriers or obstacles which are a major problem for your audience. (Media messages using audience peers to influence what is "acceptable"? Programs with pharmacists to encourage more accessible condom displays?)

1._____

2._____

3._____

- What would be the most effective facilitators to new behaviors for this target audience? What might encourage people to adopt new behaviors? What might help them maintain safer behaviors? (Focusing on key opinion leaders? Perceived social norms? Community support?)

1._____

2._____

3._____

NOTE: As you develop your promotional strategies, keep in mind that "intermediate products" also have prices. For example, attending a counseling session may present both time and psychological costs to the target audience. Many products or activities also present costs to the service providers or trainers. All of these costs must be "reasonable" in the mind of the person you want to engage in that new behavior or activity.

Defining the Place

Place refers to the locations where your target audience engages in behaviors you are trying to influence. It takes into account that people may have made a decision elsewhere — for example, not to engage in sex — and then examines how a given location, such as a bar, might affect that previous decision. Your analysis of the effect of place is really an

analysis of how locations affect the target audience's action. Does the place encourage safer behavior? risky behavior? The fundamental question is, "What can the program do to make the place where people act on their decisions more likely to prompt the desired behavior?"

Access points: Where do target audience members hang out? What effects do these places have on their behaviors? What groups are they in contact with — gangs, churches or temples, sports teams, etc.? Can any of these access points be used for reaching your target audience?

- Describe any "access point(s)" to your target audience that should be a priority for your program activities.

1._____

2._____

3._____

Planning the Promotional Strategy

The promotional strategy to support your "product" with the target audience may actually consist of several sub-strategies, depending upon the needs of your audience and the resources available to your program. Remember that a media strategy by itself *is not likely to change behavior, beliefs or attitudes. Media communication is only one piece of an effective promotional strategys. Substrategies might include:*

- Service/support strategy
- Training strategy
- Message strategy
- Media strategy
- Launch strategy

Service/Support Strategy

- Describe the activities you plan in support of your program goals (peer-to-peer counseling? workshops at schools or local organizations? activities for pharmacists or other providers?)

Activity _____

Date(s) _____

Place _____

Person (group) in charge _____

Activity _____

Date(s) _____

Place _____

Person (group) in charge _____

Training Strategy

- Describe the training needed in support of these activities.

Type of Training _____

Persons to be trained _____

Dates of training _____

Person/group in charge _____

Type of Training _____

Persons to be trained _____

Dates of training _____

Person/group in charge _____

Message Strategy

Your program should have a message strategy whether you decide the appropriate way of conveying messages is through traditional media or through services or support activities, or all of these. You will have a main message which captures the thematic content of your program. In other words, it promotes your product and its benefit in language tested with your target audience. You may also have various tactical messages (telling where and when) which direct the audience to services.

- Describe your Main Program Message

Content_____

Tone (emotional context) _____

Source of information (or spokesperson) _____

Your main message might be cast into several "phases" over a period of time. For example, phase I would be promotion of awareness; phase II would be creation of demand or motivation to act; phase III would be reinforcement of behaviors or a "reminder."

- Describe the "phase(s)" of your main message. If you have one main message, identify its "phase."

1._____

2._____

3._____

- List your tactical messages (telling where, when, how)

1. _____
2. _____
3. _____

Media Strategy

The media selected to deliver your message(s) should be chosen balancing several factors:

Reach to the target audience
Frequency of message delivery
Credibility with target audience
Relative cost and your program's resources

List your messages and the medium/media selected to deliver these.

	Message	Target Audience	Medium	Period of Delivery
1.				
2.				
3.				
4.				
5.				

Launch Strategy

The program "launch" is a special phase between planning and implementation. The launch serves to give initial momentum to activities, energize everyone involved, and inform the press and political figures, as appropriate. Decide whether your program should have "launch" activities and what these will be.

[ ] Press briefings?
[ ] Press information kit?
[ ] Community briefings?
[ ] Community information kit?
[ ] Other media event?
[ ] Other events/materials?_____

Planned Date of "launch"_____

Person/group in charge _____

Considering Policies and Politics

Policies and politics are sometimes crucial in the marketing mix. If policies do not provide a supportive environment for your program, a "policy strategy" can be considered. What written and unwritten policies support or undermine your program activities? Can these policies be changed? How? Policy is often closely connected to another P — Politics. A supportive political environment within the community is a necessary foundation for any effective HIV prevention program.

- What policy issues will be central to your program?

_____

_____

_____

- What is your program's strategy for dealing with these?

_____

_____

_____

- What political issues will be central to your program?

_____

_____

_____

- What is your program's strategy for dealing with these?

_____

_____

_____

Pretest

Project:_____

Manager:_____

Date of this planning session:_____

Checklist

Communication Objective/s:_____

Target Audience:_____

Behavioral Objectives:_____

Check all items that apply:

[ ] Self-Administered Questionnaires

[ ] Instument

[ ] questionnaire developed	[ ] needs to be developed who:_____ by when:_____
[ ] pilot tested (report attached) date/s:_____ number of respondents:	[ ] needs to be pilot tested who:_____ by when:_____
[ ]revised (copy attached) date/s:_____	[ ] needs to be revised who:_____ by when:_____

[ ] location/s selected
where:_____

[ ] needs to be selected
who:_____
by when:_____

[ ] conducted
date:_____

[ ] needs to be conducted
who:_____
by when:_____

Results:

[ ] complete (attach report)

[ ] needs to be completed
who:_____
by when:_____

[ ] Readability Testing

[ ] complete (attach report)
results:_____

[ ] needs to be done
who:_____
by when:_____

[ ] copy revised
date/s:_____

[ ] needs to be revised
who:_____
by when:_____

[ ] Gatekeeper Review

Interview Script

[ ] developed

[ ] needs to be developed
who:_____
by when:_____

[ ] pilot tested (attach report)
date/s:_____
number of respondents:____

[ ] needs to be pilot tested
who:_____
by when:_____

[ ] revised (attach)
date/s:_____

[ ] needs to be revised
who:_____
by when:_____

Interviews

[ ] scheduled

[ ] needs to be scheduled
who:_____
by when:_____

Results

[ ] complete (attach report)

[ ] need to be completed
who:_____
by when:_____

[ ] Central Location Intercept Interviews

Interview Script

[ ] developed

[ ] needs to be developed
who:_____
by when:_____

[ ] pilot tested (attach report)
date/s:_____
number of respondents:____

[ ] needs to be pilot tested
who:_____
by when:_____

[ ] revised (attach)
date/s:_____

[ ] needs to be revised
who:_____
by when:_____

Interviews

[ ] scheduled

[ ] needs to be scheduled
who:_____
by when:_____

Results

[ ] complete (attach report)

[ ] need to be completed
who:_____
by when:_____

[ ] Focus Groups

Moderator's Guide

[ ] developed

[ ] needs to be developed
who:_____
by when:_____

[ ] pilot tested (attach report)
date/s:_____
number of respondents:____

[ ] needs to be pilot tested
who:_____
by when:_____

[ ] revised (attach)
date/s:_____

[ ] needs to be revised
who:_____
by when:_____

[ ] participants recruited

[ ] need to be recruited
who:_____
by when:_____

Discussions

[ ] location/s selected
where:_____

[ ] needs to be selected
who:_____
by when:_____

[ ] conducted
date/s:_____

[ ] need to be conducted
who:_____
by when:_____

Results

[ ] complete (attach report)

[ ] need to be completed
who:_____
by when:_____

[ ] Theater Testing

PSA or other video programming

[ ] developed

[ ] needs to be developed
who:_____
by when:_____

[ ] pilot tested (attach report)
date/s:_____
number of respondents:____

[ ] needs to be pilot tested
who:_____
by when:_____

[ ] revised (attach tape)
date/s:_____

[ ] needs to be revised
who:_____
by when:_____

Moderator's Script

[ ] developed

[ ] needs to be developed
who:_____
by when:_____

[ ] pilot tested (attach report)
date/s:_____
number of respondents:____

[ ] needs to be pilot tested
who:_____
by when:_____

[ ] revised (attach)
date/s:_____

[ ] needs to be revised
who:_____
by when:_____

Testing

[ ] location/s selected
where:_____

[ ] need to be selected
who:_____
by when:_____

[ ] questionaire developed

[ ] need to be developed
who:_____
by when:_____

[ ] pilot tested (attach report)
date/s:_____
number of respondents:____

[ ] needs to be pilot tested
who:_____
by when:_____

[ ] revised (copy attached)
date/s:_____

[ ] needs to be revised
who:_____
by when:_____

[ ] participants recruited

[ ] need to be recruited
who:_____
by when:_____

[ ] conducted
date/s:_____

[ ] need to be conducted
who:_____
by when:_____

Results

[ ] complete (attach report)

[ ] need to be completed
who:_____
by when:_____

Conducting Process Evaluation

What is Process Evaluation?

Process evaluation (What did we do?) and outcome evaluation (Did we make a difference?) — as well as impact evaluation (What long-term change resulted?) — are designed to measure progress toward meeting your program objectives.

Process evaluation measures task completion, quality, and efficiency. It should be focused on answering three broad questions:

- What services and interventions were actually delivered?
- How were the interventions carried out?
- How many people were reached and who are they?

Process evaluation generally describes:

- Program implementation,
- Administrative and organizational structure,
- Procedures,
- Accomplishments.

Process evaluation measures progress in terms of explicitly stated objectives. The results should be used to improve services and interventions. Research should:

- Identify differences between actual and planned services,
- Explore why differences occurred,
- Measure program quality in relation to standards and expectations,
- Make recommendations for changes in delivery strategies or program objectives.

Step 1: Assess Resources and the Scope of Evaluation Needed

Some degree of process evaluation is essential in every program. It is important to decide the scope of process evaluation before program activities begin, because some data might be appropriate to collect at the beginning of the program, or at various points during delivery, rather than only at the end. The program needs to decide how extensive the evaluation should be and what areas it should emphasize. Begin by asking these questions.

- Is the evaluation for internal program use only?
  [ ] yes [ ] no

- Are others outside the project interested in the results?
  [ ] yes [ ] no
  What information do they want?_____
  _____

- Is some aspect of the program new or untested?
  [ ] yes [ ] no

- What resources are available for process evaluation?
  - Financial?_____
  - Human resources?_____
  - In-kind?_____

- Will an outcome evaluation also be conducted?
  [ ] yes [ ] no

(See the checklist on "Outcome Evaluation" for more information.)

Step 2: Outline Questions to be Addressed

Make a list of specific program-related questions that will help answer these broader questions:

Programs and Activities

- Who is delivering the intervention?
- What media, if any, are delivering messages?
- Are activities being carried out as planned?
  - If no, what was different?
- Have intervention support activities been carried out as planned (training for providers or researchers, for example)?
  - What have been the constraints?

Procedural Issues

- Is the program or intervention protocol being implemented correctly?
  - If not, what have been the weak areas, and what have been the constraints to appropriate implementation?
  - Are these issues correctable?
  - Have proposed systems been followed?
  - Have needed records been kept?
  - What are the gaps?
  - Implications for program implementation or evaluation?

Audience

- Are planned activities (programs, messages) reaching the desired target groups?
  - How do you know?
- Are the projected number of individuals being reached and served?
  - How do you know?
- Is it possible to determine why certain groups have been reached more than others?
  - How?
- How do clients feel about the program?
  - Is the location and setting appropriate?
  - Do clients feel comfortable in discussing the topic?
  - Has the number of clients using your services increased since the implementation of the new prevention program?
  - How do you know?
- How has the audience responded to messages?
  - What is the level of message recall? Mark the continuum:

Low Medium High

- Are there differences among target audience segments (for example, by gender, sexual orientation, age, socioeconomic status, etc.)?
- Are any unintended messages being conveyed?
- Can statements be made about any changes in knowledge?

- About change in beliefs?
- About change in attitudes?
- About change in intended behaviors?

Quality Questions

- Are providers sensitive to the target audience's needs?
- Are their interactions effective?
- Are there barriers to optimal performance (e.g., lack of support and training, lack of cultural sensitivity, homophobia among staff, lack of sufficient and/or types of staff, staff stress and burnout)?
  - Are these correctable?
  - How will they be corrected? Who is responsible? By what date?
- Do products meet planned standards?
  - What have been the weak links in the design, production, and delivery processes?
  - Are these correctable?
  - How will they be corrected? Who is responsible? By what date?

Step 3: Set Up a Timetable for Evaluation

Decide whether data collection should be:

[ ] Post-intervention only?
Date/s: _____

[ ] A tracking/monitoring study? (data collection at specified intervals?)
Date/s: _____

[ ] A pre- and post-intervention study?
Date/s: _____

[ ] A combination (certain questions asked post-intervention only, others asked at specified intervals)?
Date/s: _____

Step 4: Designing a Research Package

For each category of information needed, select appropriate data collection method/s. Common methods for process evaluation include the following. Check the ones you will use.

[ ] Key person interviews to assess whether intervention protocols have been followed and to investigate constraints;

[ ] Assessment of designated indicators (such as numbers of persons trained, use of AIDS hotlines, use of HIV/STD testing sites, level of condom distribution and sales);

[ ] Pre- and post tests (to assess knowledge or beliefs of clients served, providers trained, etc.;

[ ] Audits of materials at representative distribution points;

[ ] Monitoring of broadcasts to ensure media messages are aired at the contracted hours (through volunteer listeners, for example);

[ ] Central location intercepts at ask for recall or perception of media messages;

[ ] Regular visits (or spot checks) to distribution sites to check on availability of products or supplies;

[ ] Observations at service delivery points or training sessions using monitoring guides;

[ ] Focus group discussions to investigate the impact of messages and to detect possible confusion;

[ ] Review of administrative record-keeping;

[ ] Other method/s we will use:_____

Step 5: Designate Roles

Most likely you will select a range of different methods to gather information on diverse questions. Some data collection systems can be designed quite simply by in-house staff. Others may require assistance from an evaluation expert. If the process evaluation includes measurement of interim effects (on knowledge, attitudes, beliefs, or intended behaviors), more complex questionnaire designs will be necessary. Determine how the process evaluation will be managed:

- Who will manage the overall process?
- How many individuals will be needed to manage each research task, and for what period of time?
- Will outside consultants be needed to assist with particular data collection methods?

  [ ] yes [ ] no

(See the checklist on "Managing Research" for more information on selecting outside researchers.)

- Will any training of staff be necessary in order to carry out in-house portions of the data collection?

(See the checklist on "Managing Research" for more information on selecting outside researchers.)

- Will any types of data collection require volunteers (for example, listeners to monitor broadcasts?) How will volunteers be recruited?_____
- Who will be responsible for producing the final report?_____
- How will the report be reviewed/approved before distribution?_____
- Who should receive the report?_____

Step 6: Using the Information

Process evaluation should be used to make improvements in the current and all subsequent programs. For example, if monitoring/tracking data has been collected, information should be fed back immediately into the program so that materials, trainings, services, or logistical systems can be refined as appropriate.

Discovering constraints to program effectiveness as well as discovering what works should be disseminated so that future programs can benefit. Others can — and should — benefit from what you learn about what worked and didn't work in your program.

Ask these two key questions.

- How will we apply what we learned to our program/s?
- How will we inform others?

Considering Outcome Evaluation

What is Outcome Evaluation?

Outcome evaluation should show if a program had the intended effects on behavior and health. Intended program effects might also include changes in knowledge, beliefs, and attitudes, all of which affect behavior. Outcome evaluation focuses on the program's stated behavioral objectives and should, as far as possible, demonstrate that the program — and not anything else — caused a specific change. This is often very difficult, particularly with media-based social marketing efforts, because so many other things may affect the target audience: school programs, parents' involvement, information target audience members may get from the Internet, services available to them, and so on.

Outcome evaluation should answer these broad questions:

- What behavioral outcomes were observed?
- Does the intervention make a behavioral difference?
- Which variations work best?

More specifically, an outcome evaluation should answer these five questions:

- What changed as a result of the program?
- Why did it change?
- In what groups did it change?
- In what groups did it not change?
- What are the reasons for these differences?

These deceptively simple questions can require complex research designs, and for this reason, many community-based groups decide to work with outside researchers. Academic researchers are often willing to donate time and expertise, or reduce their fees, if they will have the opportunity to investigate an issue and publish on it. (See "Managing Research: In-House Skills or Outside Contract?" for more information about working with outside researchers.)

Special considerations for outcome evaluation:

- Outcome evaluation measures change — over a period of time, and as a result of specific activities. The decision to conduct outcome evaluation must be made long before the launch of a program, so that the situation before the intervention can be assessed, to compare with measurement afterwards.
- True outcome evaluation can be expensive, especially because planners usually need to know if any changes resulting from the intervention are statistically significant, which means the sample size has to be large enough to make that determination.
- In HIV prevention programs, intended outcomes (such as changes in behavior) can be very difficult to measure. Very often, evaluation will measure "complementary behaviors" that are presumed to be linked to certain "primary behaviors" (such as buying condoms, which might be linked to using condoms).

For these reasons, although every project can and should include process evaluation, outcome evaluation may be difficult. However, even very basic outcome evaluation is vital. Too often, in the second decade of the AIDS epidemic, prevention programmers are unable to answer the question, "What works?"

Step 1: Assess Needs and Available Resources

See "Managing Research: In-House Skills or Outside Contract," for more information on this step.

After assessing your evaluation needs and resources, you may consider alternatives to a full study. Ask yourself these questions.

- As an alternative to primary research, could outcome measures be assessed through some other ongoing research (for example, through the BRFSS survey, which has an AIDS module that can be used to track knowledge, attitudes, and beliefs in the general population, or omnibus surveys about attitudes? [ ] yes [ ] no

  If yes, who should you contact?_____
  Research project:_____
  Name:_____
  Organization:_____
  Phone:_____
  Research project:_____
  Name:_____
  Organization:_____
  Phone:_____

- Can other measures be used as proxy information for primary behaviors (for example health outcome data on STDs and pregnancy rates)? [ ] yes [ ] no

  If yes, who should you contact?_____

  Research project:_____

  Name:_____

  Organization:_____

  Phone:_____

  Research project:_____

  Name:_____

  Organization:_____

  Phone:_____

- Can existing contacts with clients be used to collect limited additional information (for example, short interviews with clients in health facilities)? [ ] yes [ ] no

  If yes, what is the next step?_____

- How large does the evaluation have to be in order to serve our purposes? (How large a numerator, or survey sample?) #_____

- Can the evaluation be done with in-house staff? (skills are available, results will be considered "trustworthy") or is an outside, "independent" team essential?

  [ ] in-house [ ] outside

  If an outside contractor is needed, who will manage the contract — write requests for bids, oversee the selection process, oversee the contract, and so forth?

Person with overall responsibility:

Name:_____

Organization:_____

Phone:_____

Other participants:

Name:_____

Organization:_____

Phone:_____

Name:_____

Organization:_____

Phone:_____

Name:_____

Organization:_____

Phone:_____

Name:_____

Organization:_____

Phone:_____

- What will be the cost of outcome evaluation? $_____
- What time will be required?_____

Step 2: Managing an Outcome Evaluation

(See "Managing Research: In-House Skills or Outside Contract" checklist.)

To manage a contract for outcome evaluation, those responsible in-house should be familiar with certain concepts and issues, and be able to ask the important questions of their contractors.

- Which design is appropriate?

[ ] Comparative A/B designs compare baseline/intervention or "A/B" measurements before and during or after the program.

[ ] Pre/post research designs compare target audiences before the program with the target audiences after the program.

[ ] Post research/control group designs compare the target audiences after the program with similar groups not exposed to the program.

[ ] Pre/post research/control group designs compare the target audiences before the program with the target audiences after the program, and with similar groups not exposed to the program.

- Have important assurances been made?

[ ] If the research needs to produce statistically significant results, the contractor should assure that the sample size is appropriate.

[ ] The contractor should discuss study reliability — in other words, the measurement procedure should yield the same number assignment every time.

[ ] The contractor should discuss validity — in other words, the measurement procedure should assess the variable it is supposed to assess.

[ ] The study should assure "internal validity" — in other words, the evaluation should examine and eliminate competing explanations for outcomes you would like to ascribe to the intervention.

[ ] The contractor should assure the confidentiality of study participants through appropriate letters.

[ ] The program should address concerns about interventions using "human subjects" (in other words, if an intervention is once found to be effective, study participants cannot be excluded from receiving services as part of the research design).

Step 3: Using the Information

Outcome evaluation identifies underlying causes and possible solutions. It helps program planners find out if an intervention was more or less effective under varying circumstances — with different populations or in different sites. For this reason, the insights provided by outcome research can be invaluable to others who are designing programs. Results should be disseminated as widely as possible.

Discovering constraints to program effectiveness as well as discovering what works should be disseminated so that future programs can benefit. Others can, and should, benefit from what you learn about what worked and didn't work in your program. Ask these two key questions.

- How will we apply what we learned to our program/s?
- How will we inform others?

A Note about Impact Evaluation

Impact evaluation measures the long-term impact of a program on the health problem, expressed in terms of morbidity and mortality. Such evaluations for HIV prevention programs are usually impossible for a variety of ethical, financial, and logistical reasons. It is virtually impossible to measure the impact of a specific prevention program on HIV morbidity and mortality rates.

Managing Research: In-House Skills or Outside Contract?

Assessing Resources and Research Tasks

Ask yourself the following questions to get a sense of your organization's ability to design, carry out, and evaluate formative research. You can also use this list to guide your discussion with researchers you may work with.

What do you want to know?_____

Statement of research objective/s:_____

_____

All important decisions regarding research design and implementation should support the objective/s of that research. With those objectives in mind, answer these questions.

How complex does the research package have to be in order to answer required questions?_____

How large must each research part be (number of respondents) to be reliable?

_____

- What are the in-house resources for conducting and analyzing the research?
  Are skills of in-house staff adequate for the task?
  [ ] yes [ ] no

  Would some additional training be adequate to help them manage the task?
  [ ] yes [ ] no

  Are staff available for sufficient time to meet the research schedule?
  [ ] yes [ ] no

  See Option A below for more "in-house" questions.

- What needs to be considered in selecting an outside group?_____

  _____

  _____

- Is outside help necessary to assure "trustworthiness" or "independence" of the research to funders or the public?
  [ ] yes [ ] no

- Is the budget adequate to hire an outside firm?
  [ ] yes — budget ceiling: $_____ [ ] no

- Is *pro bono* assistance an option? [ ] yes [ ] no

  See Option B below for more "outside researcher" questions.

For each research task decide whether—

- Research can be managed and conducted with in-house resources;

- Research can be managed/conducted in-house after some training in needed skills;

- Research will be conducted by an outside group after soliciting bids.

Option A: Organizing/Managing Research In-House

Step 1: Set up a Research Team

- How many individuals are needed for the overall task?_____
  For how long?_____

- Who is available and when?
  Name:_____
  From:_____ To:_____
  Name:_____
  From:_____ To:_____
  Name:_____
  From:_____ To:_____

- Are additional staff needed for field work? [ ] yes [ ] no
  If yes, who? [ ] volunteers [ ] staff
  Names:_____

- Who will ...
  Manage the overall process?_____
  Design the research?_____
  Design the instruments?_____
  Supervise the research in the field?_____
  Train staff and/or volunteers for field work?_____
  Conduct the research in the field?_____
  Analyze the data?_____
  Write the report?_____

- Are those involved fully trained or is additional training necessary?
  [ ] fully trained [ ] need training
  What kind of training is needed?_____
  Who can conduct the training?_____
  When?_____
  What are the costs involved? $_____

Step 2: Set Up a Timetable/Carry Out Research

Set up a week-by-week timeline for the following activities.

- **Overall Design and Recruitment**

Date	*Activity*
_____	Propose research design.
_____	Determine the number of individuals required for the sample.
_____	Determine where they will be found and how they will be contacted.
_____	Determine the number of individual/group interviews to be conducted each day.
_____	Determine the number of researchers/interviewers necessary and available. Always recruit more than the number you need!
_____	Select the researchers; choose individuals you think are most appropriate for the particular interview approach selected.

■ **Design/Finalize Instruments**

Date *Activity*

_____ Draft questionnaire/focus group guide.

_____ Pretest and revise instrument/s.

_____ Reproduce the guide and questionnaires based on the number of individuals in the sample.

_____ Identify logistical needs (transportation, per diems, supplies).

_____ Train the researchers in the application of the research instrument.

_____ Write, obtain approval for client confidentiality form.

■ **Conduct and Analyze Research**

Date *Activity*

_____ Gather the information.

_____ Analyze the data.

_____ Prepare the draft report.

_____ Make revisions.

_____ Prepare final report.

Option B: Working with Outside Researchers

Step 1: Set Up a Management/Review Team

Using an outside research group (either a private firm or academic researchers) usually implies a complex research task and a major investment of funds, if *pro bono* assistance is not available. Knowledgeable oversight of the process is essential. In-house and local experts in research should be charged with selecting the research group and overseeing completion of their deliverables.

Who has overall in-house management responsibility?_____

Who are the in-house members of the research team? _____

Who are the local experts who can participate?_____

Step 2: Draw Up Initial Screening Criteria

The research management team should draw up initial selection criteria. Ask questions such as these to get an idea of the group you want to work with.

■ Does the group have expertise in conducting research on health topics?

[ ] yes [ ] no

- Have they conducted research similar to ours (similar audiences and methods)?
  [ ] yes [ ] no

- Are they available during our timeframe?
  [ ] yes [ ] no

- Will they work within our budget?
  [ ] yes [ ] no

- Do they have a history of working well with clients (project references)?
  [ ] yes [ ] no

- Do they have the technical and computer capacity to do the analyses we need?
  [ ] yes [ ] no

- Do they react positively to our information needs and corresponding choice of research methods?
  [ ] yes [ ] no

Step 3: Write a Letter Soliciting Interest

Send out a letter to multiple organizations soliciting their interest and outlining the screening criteria. The letter might also include the following information.

- An introduction to the project,
- Your definition of the health problem,
- Decisions to be made on the basis of the research,
- General questions to be investigated,
- The methods proposed,
- "Stop points" for review and requested interaction with the staff,
- Proposed calendar.

Who will write the letter?_____

First draft (date):_____

Revisions (date)_____

Final version (date):_____

Mailed out (date):_____

Step 4: Solicit Proposals

Screen initial applicants and request full proposals from those who meet initial criteria. Give deadline for responses. The letter might request:

- Description of firm's experience in related subjects and methods,
- Description of firm's experience conducting research with this audience,
- Detailed description of research design/process,
- Problem statement,
- Research purpose and objectives,
- Research methodologies,
- Research audiences,
- Sampling plan(s),
- Analysis plan,
- Outline of research report,
- Roles and responsibilities,
- Proposed calendar,
- Résumés of proposed individuals,
- References,
- Budget.

Who will write the RFP?_____

By (date):_____

Issued (date):_____

Proposals due back (date):_____

Step 5: Review Proposals and Select Research Group

Management committee meets and selects researchers according to determined criteria. Proposals are usually reviewed with pre-established points for different areas such as:

- Technical quality,
- Understanding of the project,
- Relevant past experience,
- Proposed personnel,
- Budget (often considered as an issue separate from technical merit).

Date of selection meeting:_____

Group selected:_____

Step 6: Writing and Managing the Contract

The contract should outline expectations and establish roles, responsibilities, and deliverables. It should include "stop points" for review, as well as any requested interaction with the staff. The time table should be detailed. Final report format should be clearly outlined. The contract should include as an attachment the proposal submitted by the selected firm.

"Stop points" in the research assure interaction with the in-house management team at critical points. Sometimes funding is dispersed according to completion of these stop points. Stop points might include:

- Approval of the research design and sampling plan,
- Approval of the questionnaires,
- Completion of data collection,
- Submission of draft report,
- Submission of final, approved report.