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Educating People at Risk for AIDS

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INTRODUCTION

Mr. Chairman and members of the Committee:

In response to the Committee's request, I am here to address two questions. First, what lessons for AIDS education can be learned from previous public-health efforts? And second, what is the applicability of those lessons for current efforts to reach people at risk for AIDS?

GAO's study covered AIDS education for three at-risk populations--minority communities, intravenous drug users, and youth. We also examined AIDS campaigns for those populations in the five cities hardest hit by AIDS, plus several other AIDS campaigns nominated to us as exemplary. We will issue a detailed report on our findings later this year.

We have found an impressive range of efforts to disseminate the facts on AIDS and to teach people the skills necessary to avoid it--videos, street outreach, "AIDS socials" in private homes, and many other efforts I will summarize in my testimony. I must also report, though, that systematic information on the effects of these and other efforts is lacking. For that reason, it is absolutely critical that AIDS education efforts be evaluated very carefully in the months and years ahead.

It is, of course, difficult to emphasize strongly enough the seriousness of this disease and the difficulty of trying to change at-risk behaviors that are habitual and quite private.

AIDS is both infectious and, so far, incurable. But it is transmitted only via blood-to-blood or sexual contact, or from

mother to child. Thus, except for the infants of infected mothers, people can avoid AIDS by controlling or changing their own behavior.

Research continues on the nature of AIDS, in the hope of finding a cure or vaccine. At present, however, the best method of fighting AIDS is through education. We know how AIDS is and is not contracted, and detailed, accurate information about it can be provided to the public. Campaigns are already underway, including, of course, the Department of Health and Human Services' brochure now being mailed to every United States household, as well as efforts already mounted in other countries. Our hope for the effectiveness of this type of broadly targeted campaign is tempered, however, by two realizations:

- Some people, such as intravenous drug users and sexually active teenagers, are more at risk for AIDS than is the public in general, so the need to reach these people is especially urgent.
- AIDS education, like any other public-health or marketing campaign, is confronted by difficult challenges--first of access (that is, gaining people's attention) and then of acceptance (that is, getting them to believe and act on the message).

The groups we studied include intravenous drug users, youth, and minority communities. Let me briefly describe some of the group characteristics relevant to AIDS education (though of course

there is much diversity within groups). As table 1 indicates, intravenous drug users may not be consistently or effectively reachable through the print media. Further, drug users have already placed themselves at risk for a variety of illnesses. For many users the additional threat of AIDS may not seem uniquely compelling. Youth, in contrast, may be eminently accessible through the mass media. However, young people often seem to deny their own mortality, to downplay risks of many kinds, and to learn more through direct experience than through surrogate advice. Finally, in some minority communities information moves through specialized media, such as non-English-language radio and newspapers, and the open discussion of sexual matters may be seen as rude and unacceptable, given certain cultural traditions. The challenge for public-health education is to recognize these group patterns, much as market research has learned to do, and to find the most productive routes of access and acceptance for people in each group.

At issue, then, is what can be learned from past research and from experience with other public-health efforts. There is, in fact, a considerable body of knowledge available from antismoking campaigns, drug-use prevention, sex education in the schools, and the like. We have reviewed the research in these areas, and we have talked with many experts in AIDS education and public health (see appendix 1). While some individual findings may not be applicable to AIDS, we believe it is possible to draw on previous research if one looks for lessons at a more general level and then

"fills in" the specific meaning for various target populations. In my testimony, I will first describe the conceptual approach we have derived from prior research and then illustrate it with concrete examples relevant to the three populations of concern here.

AN APPROACH TO EDUCATING PEOPLE AT RISK FOR AIDS

An effective approach to AIDS education probably requires at least seven steps, covering four components: the target group, its relevant characteristics, the nature of the message, and the intended outcomes. (See the accompanying summary.)

Target Group

First, campaign planners need to decide exactly who will be targeted. Is the plan to disseminate a broad message for all adolescents in the United States, or more a particular message for teen runaways; to reach all minority adults in New York City, or mainly those who are at high risk for drug use? In general, past experience suggests that the more precisely the target group is defined, the more effective the campaign is likely to be. Precision makes it easier to mount a campaign that tells people exactly what they need to know, in their own language, through sources they trust and respect.

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Summary Of Seven-Step Approach In AIDS Education

Component	Step	Options to Consider
Target group	Decide exactly who will be targeted	Race/ethnicity Community Age bracket Drug-user friendship network
Group characteristics	Decide exactly why the targeted group needs AIDS education	Risk behavior Capabilities Attitudes Cultural values AIDS awareness
Message		
Medium	Decide which media are more likely to reach the target group	Mass Personal
Information	Decide which facts on AIDS should be included	Transmission Nontransmission Risk reduction methods Effectiveness of methods
Skills	Provide the skills for behavior change	Interpersonal Practical
Motivators	Offer persuasive reasons for reducing risk	Negative Positive
Intended outcomes	Specify the intended outcomes of the effort	Knowledge Behavior change

Group Characteristics

A second step is to decide exactly why the targeted group needs AIDS education. One possibility is a special urgency due to risk behavior--the sharing of drug-use paraphernalia, for example--which may lead to an exchange of contaminated blood; or "survival sex," in which teenagers trade sex for food, money, or a place to sleep.

Another possibility is that certain capabilities might make it easier or more difficult for people to understand a message on AIDS--capabilities such as their educational backgrounds or their familiarity with English.

Research also indicates a need to consider people's attitudes and values. For example, are there many people in the group who may feel unable to manage their lives effectively, as is often the case with runaway youth? Do the people tend to avoid government sources, as with some recent immigrants and users of illegal drugs? And what is their pre-existing knowledge of AIDS?

Some characteristics may be more prevalent or more critical in some groups than in others. The point here is the need to consider very carefully which characteristics--risk behaviors, capabilities, attitudes, values, or AIDS awareness--are the basis for concern, and then weigh their implications for access and acceptance.

Message

Medium

The next steps in educating people about AIDS deal with the message itself. First, achieving access may require the use of specialized media. Planners need to decide which media are more likely to reach the target group. Mass media include radio and television, as well as newspapers, brochures, bus posters, and billboards. More costly, but also at times necessary, is the face-to-face delivery of a message, using, for example, community leaders, celebrities, health experts, actors, classroom teachers, or trained peers.

Much is already known about patterns of media use. According to some research, for example, blacks and Hispanics use television as an information source more than other groups do, and radio is especially effective for reaching teenagers. On the other hand, regardless of the target group, mass media alone may be less effective in promoting behavior change than face-to-face contact or some combination of mass media and personal media.

Factual Information

Planners also need to decide which facts on AIDS should be included. For intravenous drug users, it is probably important to cite modes of virus transmission and, for users interested in treatment, to describe the available options. For young children, on the other hand, it may be appropriate to emphasize modes of non-transmission so that unfounded fears are dispelled.

Older children can benefit from a lesson on various types of illness and the effects of AIDS on the human body, but the same lesson might leave intravenous drug users unimpressed.

Whatever facts are appropriate, they must be presented in a way that is readily understandable. A campaign will not be effective unless people receive and understand the message. As one expert put it, educating young people on AIDS without clearly discussing sex is like "trying to teach kids about baseball without mentioning the ball and glove." Yet the problem is not merely with young people. Reportedly, adults too have misunderstood clinical terms and euphemisms like "bodily fluids," thinking the expression includes sweat and saliva. Because those fluids have not been found to transmit AIDS, this sort of ambiguity directly undermines campaign success.

There is more to this point than simple clarity. While some people may benefit from graphic language, others may be put off. For them, a graphic message may not be readily understandable because it is too distracting. So campaigns must be clear but must also communicate in language that the intended audience is comfortable with--however graphic or subtle that language may have to be.

Use of the group's own language makes a message more attractive as well, which means people are more likely to pay attention. That is why public-health campaigns use symbols and slang that will appeal to a target group--children's faces on the cover of a brochure for children, or a radio spot for black

teenagers in a rap-music format. This is also why a Spanish-language Red Cross brochure provides not one but three words for prophylactic. Among some Hispanics, the recognizable term is condon or preservativo. But for others, the term ule is appropriate, while preservativo is something used to make fruit preserves.

Finally, prior research suggests that one specific piece of information is especially critical. When people are told how to reduce the risk of AIDS--total abstinence from sex and illegal drugs, use of a condom, or use of bleach to clean their drug paraphernalia--they also need to be told how effective those measures are likely to be. This is especially so for people who do not feel in substantial control of their lives or have not had much experience with health care--traits clearly relevant to many people in the groups of concern here.

Skills

A fifth important step in AIDS education is to provide the skills for behavior change. Two sorts of skills are important here. One is interpersonal--how to resist pressure to have sex, especially unprotected sex, or to use illegal drugs. The "just say no" injunction, by itself, is not enough for many people. They need to see and practice how to say no constructively.

The other important set of skills is literally how to reduce risks--how and when the condom should be put on and taken off, and how and when the drug user's paraphernalia should be cleaned.

Much of what I have said has to do with efficacy--facts regarding the efficacy of risk-reduction measures, and personal skills for accomplishing that reduction. Prior research suggests the special importance of efficacy or "empowerment," as it is also called. People need to believe that the recommended skill does in fact reduce risk, and they need to have practiced that skill in advance so they will know they can carry it out successfully. As I have noted, the point is all the more crucial for people whose self-confidence or related experience is limited.

Motivators

A sixth factor that appears critical for public-health education is motivators. Campaigns need to offer persuasive reasons for reducing risk. With respect to AIDS, the degenerative and fatal nature of the illness might seem to be motivation enough. But AIDS and its dire consequences appear quite remote to many people--highly unlikely and far in the future. Moreover, some research suggests that the effectiveness of fear as a universal motivator may be quite limited. Fear of serious illness and death can trigger short-term changes but may not be a factor in sustaining longer-term risk reduction in all populations. And if fear is too high, it can be counterproductive even in the short term; AIDS then simply becomes too frightening for some people to think about at all.

Prior research suggests an effective alternative--positive

motivators, such as social approval for risk reduction, and "eroticized" safe sex. "Eroticizing" is an effort to make safe-sex practices seem more attractive, so that people can more easily substitute safe sex (condom use, for example) for the riskier sex (such as intercourse without a condom) to which they may be more accustomed. Positive motivators can be more tangible as well, such as vouchers for getting into drug treatment programs and prizes for scoring well on AIDS knowledge tests.

Intended Outcomes

As a final step, campaign planners need to specify the intended outcomes of the effort. Sometimes, as with young children, the appropriate outcome is simply more knowledge about AIDS. But for people already at risk, it is vital to effect some change in their behavior. And for people not already at risk, the optimal campaign should include some effort to prevent the behavior in the first place.

Summary of the Approach

Let me sound a note of caution here. The public-health campaigns from which these lessons were derived have been far from 100 percent successful. Some people still smoke, still drive when drunk, still have elevated cholesterol levels, and so on. Moreover, very little information is now available on the effects of AIDS education. It is therefore absolutely critical to evaluate AIDS education efforts as widely and as carefully as

possible. We need to know which campaigns are working, of course, but we also need to know which elements of a campaign--what sorts of information, motivators, media, and so on--are showing the greatest impact, and why.

At this time, working with prior research, we have concluded that a public-health message to any of the three target groups we have studied is more likely to be effective if it is:

- credible--that is, delivered through sources trusted by the target group, and in the group's own words;
- clear--covering information, skills, and motivators neither more nor less explicit than they need to be;
- accessible--combining the mass and personal media that will reach the group; and
- appropriate--relevant and appealing to a well-defined group, and designed with due attention to group values.

I turn now to our second task, which was to determine whether this conceptual approach is applicable to AIDS education. We examined campaigns now underway in the five cities hardest hit by AIDS, plus some additional campaigns suggested by experts as examples of excellent AIDS education.

FIVE-CITY STUDY

The five U.S. cities currently reporting the highest number of AIDS cases are New York, San Francisco, Los Angeles, Houston and Washington, D.C. We asked responsible officials in each city to summarize their AIDS outreach efforts for three targeted

groups--minority communities, intravenous drug users, and young people. Their efforts are, on the whole, entirely congruent with the approach I have just described.

Target Groups

Four cities--New York, San Francisco, Los Angeles, and Washington, D.C.--have mounted some sort of campaign for each group. The Houston schools offer AIDS education in grades 6-12; otherwise, Houston has not targeted any outreach program to minority communities or drug users. Officials told us that neither the city nor the surrounding county has the funds for such efforts.

Campaigns

Tables 2 through 4 indicate the nature of campaigns already mounted in the five cities. Both mass and personal media are used to reach minority groups and drug users. Campaigns targeted to public-school students rely on classroom teachers.

Campaign messages provide a wide range of information, regarding, for example, modes of AIDS transmission and nontransmission and the effectiveness of risk-reduction techniques.

Coverage of actual skills is less uniform. San Francisco and New York show intravenous drug users how to clean their paraphernalia. Washington, Los Angeles, and Houston do not. Three school districts--in Houston, Los Angeles and New York--

have begun teaching interpersonal skills, using, for example, role-play exercises meant to help students recognize and resist peer pressure. Only in the Los Angeles AIDS curriculum are students also taught how to use a condom.

Campaigns offer various motivators for behavior change. All cite the severity of AIDS--the number of deaths, the lack of a cure, the inexorable nature of the disease. Regarding positive motivators, New York, San Francisco, and Washington rely more on symbolic inducements like "eroticized" safe sex and the importance of AIDS prevention for one's family. Other cities offer intravenous drug users more tangible motivators. Los Angeles provides vouchers for drug treatment, and a city-funded program in New York promises its clients entry into some form of drug treatment within two days.

In the time available, we were not able to explore the overall design of each city's campaigns--what group characteristics are being considered, what outcomes are intended, and why programs offer some skills and motivators but not others.

EXEMPLARY PROGRAMS

Accordingly, to investigate program design in greater depth, we asked AIDS-education experts to nominate programs they considered especially well designed and likely to be effective with our target populations. We then visited twelve such programs in New York, San Francisco, and Los Angeles--the cities with the largest caseloads--to learn more about how each critical

step might be brought to life. Table 5 provides a list of programs and their target groups.

For the sake of brevity, I will focus on program messages--that is, the media used, and the information, skills, and motivators offered. When appropriate, I will also offer examples of ways in which target populations are defined and assessed, and which outcomes are intended.

Medium

Several programs produced their own brochures, in each case for the same reason: existing brochures seemed too clinical, dense, vague, or colorless to be readily understandable in their communities. One brochure for drug users, entitled "Free Dope," illustrates how to use bleach and water to "clean your works--fast, easy and safe." (See exhibit 1.) Another provides essential information only--covering modes of transmission and ways to reduce risk; the material is purposely not so dense as to put off low-skill readers. (See exhibit 2.) A similar strategy is to put the bare essentials in headings or photo captions, so people unlikely to read every word will nonetheless get the gist of the message.

The video or telenovela produced by San Francisco's Latino AIDS Project is called "Ojos Que No Ven" or "Eyes That Fail To See." As the story develops, a woman named Doña Rosa copes compassionately with a co-worker who has AIDS and with her own gay son, and she becomes a knowledgeable AIDS educator in her

community. The presumed advantage of a telenovela, with its tangled soap-opera plot, is that it offers AIDS information and skills in a format considered widely popular among Hispanics.

As noted in the conceptual approach, campaigns may use personal media as well as mass media. One personal medium is the AIDS-education skit. The simple fact that actors are amateurs from the community generates considerable interest and good spirit. But the actors can also be trained as AIDS educators, so that after the performance, it is the cast--not outside professionals--who field questions from the audience.

Intermediaries are another personal medium used in AIDS campaigns. Intermediaries can be, for example, religious and political leaders, business persons, and friendship networks. A program in Los Angeles' Hispanic community educates medical technicians, paraprofessionals, and folk-healers, since these reportedly are the health providers most accessible to many members of that community. Here, then, is one example of how programs are designed with specific group characteristics in mind--in this case, the group's health-care habits.

Several drug-user programs leave supplies of bleach, condoms, and other items with welfare-hotel managers, liquor-store clerks, and even proprietors of drug "shooting galleries," so users will have ready access to those supplies when needed. Again, these programs are responding to a specific group characteristic--the presumed low level of health concern among intravenous drug users.

Other programs tap informal friendship networks. One holds "AIDS socials"--invitation-only parties in private homes at which a professional educator offers AIDS facts and safe sex guidelines. AIDS socials have reportedly become quite popular because the home is such a familiar, unthreatening setting and the audience is usually small; as a result, people feel more free to ask sensitive questions.

Another example of tapping informal networks is a street-outreach program in New York City. Program staff fear that their outreach effort will miss drug users who do not spend much time "on the corner." It may also miss many of the users' spouses or sexual partners, most of whom reportedly are not drug users. The program's solution: tap the recovering addicts in its drug treatment center. Clients of the center are actively encouraged to contact and refer friends who still use drugs or who have sex with users. All referrals, even the most tentative, are to be followed up diligently in hopes of breaking into that hidden network of at-risk people who are not otherwise accessible.

In some projects the outreach staff includes people who have AIDS. For obvious reasons people with AIDS are a credible source regarding the consequences of infection. And, most notably with high-school youngsters, they may also evoke compassion and cut through the teenager's presumption of invulnerability. Employing people with AIDS, then, is one example of a strategy meant to address the group characteristics rendering that group at risk.

Another face-to-face medium for AIDS education is, of

course, the peer who speaks in the target group's own idiom, knows the local history, and is easily able to modulate the message, depending on a client's needs and reactions. Many street outreach campaigns employ ex drug-users precisely because they are credible with, and have access to, current users.

Finally, there is the community-based AIDS hotline, combining the efficiency of a mass medium with the ability to modulate the message and to select an idiom suitable to the caller. A further advantage of hotlines is anonymity. While some people can freely discuss AIDS risks and fears face-to-face, others cannot, and hotlines offer immediate answers without requiring self-disclosure. In one exemplary program, hotline operators have a list of alternative expressions for safe and unsafe sex practices, so they can respond properly to various Hispanic nationalities in the area. However, the hotline does not keep operators on call at all times. An answering machine accepts messages during off-hours. This means that callers may be missed. Unable to get an immediate answer but afraid of losing anonymity, many may not leave a phone number so operators can return calls.

Information

Many programs deliberately tap group values and culture to help promote their message. One example is the AIDS community forum at which expert speakers are only part of the program. The forum also includes the AIDS-education skits I have mentioned,

plus gospel music and refreshments. One drug-user program begins its AIDS seminars by showing a popular film. AIDS facts are offered during intermission, with an opportunity for further questions after the second half. The movie attracts spouses, sexual partners, and friends, affording an opportunity to educate them as well.

Programs may also adopt some powerful symbolic content. A black-community brochure cites as one cause for AIDS the "chain of ignorance." Another observes that "our black brothers and sisters need our concern and support." (See exhibits 3 and 4.) The idea, of course, is that the connotations--the resonance--of those words will bolster readers' interest and underscore the very important theme of personal efficacy.

To break through the misconception that AIDS is a disease only of white homosexual men, minority programs often invoke symbols of family. Heterosexual families of color appear in several posters and brochures. (See exhibits 2, 3, 5, 12, and 13.) Even when the target group is drug users or gay men, the context is familial. In Ojos Que No Ven (the telenovela), Doña Rosa's son, who is homosexual, lives at home with his mother and sister. In one Hispanic-community skit, the conversation among teens is dotted with sentences like this: "We're talking about protecting your sister, brother, your family...." And Angie, whose brother has died of AIDS, says: "Before this happened to my family"--not to her brother but to the family--"I never knew that by having sex you could get AIDS."

Finally, there is the device of humor, which can be used to lessen the discomfort associated with subjects like sexuality and death. San Francisco's bus poster reads in part, "You won't get AIDS from this bus or from bathrooms, giving blood, shaking hands, parakeets, old sneakers, microwaves or spring cleaning." (See exhibit 6.) Other printed materials include a brochure with dancing condoms, and "The Works," a comic book featuring talkative cartoon viruses. (See exhibits 5 and 7.) This comic book is meant for drug users with limited reading abilities--an example of how to address a target-group characteristic not by changing it but by circumventing the problem. There is also San Francisco's Bleachman campaign using comics, billboards, and personal appearances by Bleachman--a seven-feet-tall superhero whose head looks rather like a gallon jug of bleach. (See exhibit 8.)

When describing GAO's seven-step approach, I cited the importance of letting people know that recommended risk-reduction efforts really can be effective. Several programs emphasized this point in the information provided to clients. For example, one brochure reads, "Remember! Condoms are not 100 percent perfect. But if you use them properly..., they are very effective." Another brochure--the one called "Free Dope" (see exhibit 1)--says: "The best thing to do is get off the needle.... The next best thing ... [is] don't share your works with anyone.... "You can avoid getting AIDS."

Skills

AIDS campaigns are more likely to work if they help people acquire specific skills, both practical and interpersonal. For people who do not abstain, the important practical skills are how to use condoms and how to clean their equipment. Some programs hand out illustrations of proper cleaning methods. (See exhibits 8 and 9.) Programs also demonstrate these methods for users who otherwise might not understand them. The adoption of such skills is not the only intended outcome for these programs; each recommends abstinence as well. But here is a case in which intended outcomes are being carefully matched to the target group. Some program directors told us that many intravenous drug users will reject abstinence as the solution to their risk for AIDS.

Other skills are interpersonal--resisting pressure to have sex, especially unprotected sex, or to use illegal drugs. A shelter for homeless youth conducts "fishbowl" exercises in which two teenagers role-play pressure and resistance in front of a larger group. Afterwards, their peers comment on the tactics each player used, and the instructor suggests tactics that might be more effective. One New York program distributes a packet called "Use Condom Sense," with condom-wearing instructions, a sample condom, and a section on "how to talk to your partner." This section contains ten arguments against condoms and ten constructive answers. For example,

[Argument] "Condoms are ... fake, a turn-off."

[Answer] "Please, let's try to work this out. An infection isn't so great either."

Outreach workers sometimes sit with a client--in the park, for instance--and together they practice these arguments and answers, to help the client become more self-assured and more familiar with the concepts. Workers also stress the importance of conducting these negotiations before sex is initiated.

Motivators

Previous public-health research shows that behavior is not greatly affected by low-probability events that occur only in the long term. This is especially true for young people, so often heedless of long-term consequences. How then to motivate the behaviors that reduce or eliminate risk?

One strategy is to emphasize the more immediate consequences of AIDS. The teen brochure developed by a community organization called Health Watch warns that "AIDS can really mess you up" and cites as consequences the short-term symptoms and "ugly" lesions that are likely to create serious problems in a teenager's social life. The target group for this program is quite specifically defined--adolescents in the Bedford-Stuyvesant section of Brooklyn. An advantage of such specification is that the message can be shaped for maximum clarity and relevance, as indeed this one was; Bed-Stuy teens were heavily involved in designing the brochure. They were also involved in establishing the program's intended outcomes. During focus-group meetings, it became clear

that these youngsters considered abstinence (that is, risk prevention) an appropriate outcome if the message avoided moralism and emphasized instead the teenager's right to make his or her own choices regarding sex. Despite these features, it appears that the program's implementation may be limited by funding constraints; that is, there may not be enough brochures to cover the community.

Another strategy, again meant to dispel the illusion that AIDS affects only white gay men, is to cite the alarming statistics on AIDS among minorities or to remind people that others nearby--neighbors, friends, or schoolmates--have already contracted AIDS and died. (See exhibit 10.)

I already noted that using fear to motivate behavior change is a complicated matter because excessive fear may only trigger denial. In effect, one drug-outreach program in New York deliberately does not cite the relevant statistics for that community because they are so alarming. (The HIV infection rate among New York's intravenous drug users is reported to be at least 60%.) Instead the program focuses on skills by which risk can be effectively reduced.

On the other hand, for populations not so vulnerable, even a high level of fear may not be counterproductive if immediately paired with facts on risk reduction. In a Los Angeles program, one character in the skit for adults observes graphically, "this illness eats up your insides and then you're gonna dry up slowly.... Before you die, [AIDS] makes sure you remember you

had a choice" [emphasis in original]. In the teen skit, another character says: "AIDS is so scary 'cause any one of us could get it." But her friend corrects her. "No, you're wrong.... If you take care of yourself, you wouldn't have to worry about AIDS killing you." Immediately thereafter, another character advises steps for effective risk reduction--condom use or abstinence.

This focus on personal choice and effective risk-reduction is another example of one of the principles underlying GAO's recommended approach--that raising efficacy is important, especially with people whose sense of efficacy might otherwise be low.

Another means to invoke fear as a motivator is death-related imagery. Exhibit 11 is a poster meant for display in the "shooting galleries" where people can buy and inject drugs, using rented paraphernalia. The open grave in this poster makes the point in no uncertain terms. I should add, though, that some health educators might say the poster will not be effective, for high fear is aroused without also citing ways to reduce risk. Another poster notes in text that people "die" of AIDS but intentionally avoids using images of death in the belief that fear is productive only at a more moderate level. (See exhibit 12.)

The matter is further complicated by cultural differences. In Mexico, skulls and skeletal figures are familiar images in toys, candies, and folk-art objects, notably on the Day of the Dead (Dia De Los Difuntos). Educators designing AIDS campaigns

in Hispanic communities have therefore employed graphic death-imagery. See, for example, exhibit 13, which evokes familiar cultural symbols--El Diablo, the skeleton--in hopes of enhancing the salience of the message for Hispanics.

What about positive motivators for AIDS risk-reduction? Treatment vouchers and other means of expediting entry into treatment may be effective with intravenous drug users. What else can be done, especially when program resources are limited? Another tangible and attractive motivator is a sweepstakes. Brochures may include an AIDS questionnaire by which readers verify what they have learned. Readers may then submit the detachable form as their entry in the sweepstakes. In one of our exemplary programs, winners were awarded prizes such as cash and condoms.

Motivators can also be symbolic, and it may be that long-term behavior change is more likely if the rewards are somehow more deeply felt and lasting than condoms or a television set. Many programs tout risk reduction as a means of protecting one's family and community, not just oneself. Some programs for drug users attempt to set up a personal bond between worker and client so that over time a client becomes more reluctant to engage in risk behavior that would anger or disappoint the worker. This strategy is more likely to succeed the more narrowly the catchment area is defined, and the more often workers visit their clients. This is another reason for carefully specifying the target group, as these programs did. Even so, program directors

did not believe they have enough outreach workers to recycle through the area often enough.

Finally, much has been made of the efforts I mentioned earlier, namely, those to "eroticize" safe sex. For some audiences, as I have noted, this sort of content is and should be explicit; for others, it need not be. One program offers a safe-sex kit that includes not one but three types of condoms. That program also conducts seminars in which the adult audience is encouraged to become more comfortable with condoms by actually handling them. The intention, of course, is that people begin to treat condoms as familiar and routine and as a positive motivator for safe sex.

CONCLUSION

Let me conclude my testimony by citing, first, the approach that GAO has derived from prior public-health research. We believe that AIDS campaigns are more likely to be effective if they cover at least seven steps.

- Decide exactly who will be targeted--the more specific the target group, the better.
- Decide exactly why the group needs AIDS education. For example, are people already engaging in high-risk behaviors, or will they have trouble reading a dense brochure?
- Decide which mass media and/or which personal media are accessible and credible to the group.

- o Decide which facts on AIDS are most relevant and most likely to be clear, familiar, and appealing.
- o Provide actual skills for behavior change.
- o Offer persuasive motivators for risk reduction, including positive ones whenever possible.
- o Finally, specify the outcomes, such as changes in knowledge or behavior, that are most appropriate for the group.

Four cities--Los Angeles, New York, San Francisco, and Washington--have implemented programs targeted to minorities, intravenous drug users, and youth. Houston provides AIDS education for public-school students.

Our study indicates that this seven-step approach to public-health education is eminently applicable with respect to AIDS. Though some steps are not covered in some programs, <u>across</u> programs there is ample evidence that outreach efforts can be designed in accord with the approach I have presented.

On the other hand, our study does not indicate how many AIDS programs around the country actually cover all seven steps, and we do not know whether the programs we examined are truly effective or in any way typical.

Moreover, apparently because of budget constraints, programs are limiting their operations in significant ways. For example, unmet printing costs mean that brochures ingeniously designed for a particular community may not be plentiful enough to cover that community. And without more street workers, drug-user programs

may not be able to recycle their contacts often enough to establish an effective level of rapport with their clients.

Finally, I must emphasize that we do not yet have the data by which to evaluate the outcomes of AIDS education, and I cannot say with certainty which steps in this approach are more critical than others. For most of the programs we visited, evaluation is confined to the informal and occasional review of clients' knowledge or self-reported behavior. Program directors told us they lack the funds to do anything more rigorous. Some additional impediments to evaluating AIDS-education outcomes will be discussed in other testimony from GAO. There are, however, some exceptions to this bleak evaluation picture. Some programs do have a strong evaluation component, but these are large and relatively well-funded efforts, with resources devoted specifically to collecting and analyzing outcome data.

My point here is to stress how critical it is that campaigns build in and carry out a comprehensive plan for evaluating the various features of their approach and for measuring overall campaign outcomes. If they don't, we will be no further advanced a year from now as to which campaigns work and which don't. While it is encouraging to note that some exemplary AIDS campaigns have been designed in accord with the important lessons from previous public-health research, the ultimate question--whether those campaigns are effective--is presently unanswerable and will remain so until evaluations are incorporated into program activities.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions the Committee may have.

Table 1: Group Characteristics Possibly Relevant to AIDS Education[a]

Group	Characteristics possibly relevant to risk behaviors	Characteristics possibly relevant to access or acceptance
Racial/Ethnic Minorities	Preference for not using condoms	Length of time in the United States
	Social and psychological importance of child bearing	Language variability (such as regional dialects and idioms)
		Higher salience of minority identity than of sexual identity
		Use of minority-community mass media
		Less experience with or access to health care
		Greater use of television as a mass-media information source
		Greater reliance on minority-community agencies and friendship networks as personal information sources
		Norms limiting the discussion of sex or drug use

[a]These characteristics have been cited by public-health experts as relevant to AIDS education among racial/ethnic minorities. GAO has not independently evaluated the relevance of these characteristics, and some characteristics may be more relevant to some groups or individuals than to others. They are listed here as possibilities to be considered in designing AIDS education programs.

Table 1: Group Characteristics Possibly Relevant to AIDS Education[a] (cont'd)

Group	Characteristics possibly relevant to risk behaviors	Characteristics possibly relevant to access or acceptance
Intravenous Drug Users	Drug use in group settings	Distrust of public institutions
	Norms or law-enforcement policies that create incentives for sharing drug paraphernalia	Lower levels of education
		High mobility
		Disinterest in treatment for drug addiction
		More reliance on audio-visual than on print media
		Low concern for health risks

[a]These characteristics have been cited by public-health experts as relevant to AIDS education among intravenous drug users. GAO has not independently evaluated the relevance of these characteristics, and some characteristics may be more relevant to some users than to others. They are listed here as possibilities to be considered in designing AIDS education programs.

Table 1: Group Characteristics Possibly Relevant to AIDS Education[a] (cont'd)

Group	Characteristics possibly relevant to risk behaviors	Characteristics possibly relevant to access or acceptance
Youth	Unprotected sex	Low knowledge of contraception
	Use of needles for ear piercing, tattooing, and steroid injection	Greater use of peers as reference group for information and behavioral norms
	Exchange of "survival sex" for food, money, or shelter	Unsettled sexual self-concept
		Concrete thinking; short-term orientation
		Denial of mortality
		Greater interest in experimentation and risk-taking
		Alienation from family and public institutions
		Low sense of personal efficacy

[a]These characteristics have been cited by public-health experts as relevant to AIDS education for youth. GAO has not independently evaluated the relevance of these characteristics, and some characteristics may be more relevant to some individuals than to others. They are listed here as possibilities to be considered in designing AIDS education programs.

Table 2: City Programs for Minority Groups[a]

	Houston	Los Angeles	New York	San Francisco	Washington D.C.
Media					
Mass		X	X	X	X
Personal (peer)		X			
Personal (other)		X	X	X	X
Factual information					
Transmission and risk reduction		X	X	X	X
Nontransmission		X	X	X	X
Effect of risk reduction			X	X	X
Virus biology, AIDS symptoms		X	X	X	X
Skills					
Interpersonal				X	
Practical				X	X
Motivators					
Negative		X	X	X	X
Symbolic positive		X	X	X	X
Tangible positive					X

[a]Programs for which city currently serves as funding source or conduit. Data may not be complete; documentation was not always available, and respondents sometimes could not fully specify the message offered by personal outreach workers.

Table 3: City Programs for Intravenous Drug Users[a]

	Houston	Los Angeles	New York	San Francisco	Washington D.C.
Media					
Mass		X	X	X	X
Personal (peer)		X	X	X	X
Personal (other)		X	X	X	X
Factual information					
Transmission and risk reduction		X	X	X	X
Nontransmission		X	X	X	
Effect of risk reduction		X	X	X	X
Virus biology, AIDS symptoms		X	X	X	X
Skills					
Interpersonal					X
Practical			X	X	X
Motivators					
Negative		X	X	X	X
Symbolic positive			X	X	X
Tangible positive		X	X		

[a]Programs for which city currently serves as funding source or conduit. Data may not be complete; documentation was not always available, and respondents sometimes could not fully specify the message offered by personal outreach workers.

Table 4: City Programs for Youth[a]

	Houston	Los Angeles	New York	San Francisco	Washington D.C.
Media					
Mass	X	X	X	X	X
Personal (peer)					
Personal (other)[b]	X	X	X	X	X
Factual Information					
Transmission and risk reduction	X	X	X	X	X
Nontransmission	X	X	X	X	X
Effect of risk reduction	X	X			X
Virus biology, AIDS symptoms	X	X	X	X	X
Skills					
Interpersonal	X	X	X		
Practical		X			
Motivators					
Negative	X	X	X	X	X
Symbolic positive	X		X		X
Tangible positive	X	X	X		X

[a]Programs currently offered in city's largest public school district. Data may not be complete; documentation was not always available, and respondents sometimes could not fully specify the message offered by personal outreach workers.
[b]Classroom teachers.

Table 5: Exemplary Programs

Program and city	Target groups: Minority groups	Intravenous drug users	Youth
AIDS Foundation, San Francisco	X	X	X
Association for Drug Abuse Prevention and Treatment, New York		X	
Bayview-Hunter's Point Foundation, San Francisco	X	X	
East Los Angeles Rape Hotline, Los Angeles	X		X
El Centro Human Resources Corporation, Los Angeles	X	X	X
Health Watch, New York	X		X
Latino AIDS Project, San Francisco	X	X	X
Mid-City Consortium to Combat AIDS, San Francisco		X	X
Minority AIDS Project, Los Angeles	X	X	X
Project Return, New York		X	
Stepping Stone, Los Angeles			X
The Wedge, San Francisco			X

APPENDIX 1: EXPERT SOURCES[a]

Douglas Anglin
Neuropsychiatric Institute
University of California
Los Angeles, CA

Walter Batchelor
American Psychological Association
Washington, DC

Linda Beckman
California School of Professional Psychology
Los Angeles, CA

George Beschner
National Institute of Drug Abuse
Rockville, MD

Lydia Bond
Pan American Health Organization
World Health Organization
Washington, DC

John Bonnage
AIDS Task Force
American Psychiatric Association
Washington, DC

Jacqueline Bowles
Office of Minority Health
Department of Health and Human Services
Washington, DC

Ronald Bucknam
Department of Education
Washington, DC

Thomas J. Coates
University of California
San Francisco, CA

[a]These sources represent fields such as drug-use intervention, health- and sex-education, minority health care, marketing, and mass communications. For general background we contacted, or reviewed the published work of, other social scientists and representatives of AIDS-education projects, funding agencies, and advocacy groups.

Jane Delgado
National Coalition of Hispanic Health and Human Services Organizations
Washington, DC

Don C. Des Jarlais
Division of Substance Abuse Services
State of New York
New York, NY

Onke Ehrhardt
HIV Center for Clinical and Behavioral Studies
Columbia University
New York, NY

Brian Flay
University Of Illinois
Chicago, IL

Gilberto Gerald
National AIDS Network
Washington, DC

Michael Goodstadt
Addiction Research Foundation
Toronto, Canada

Debra Haffner
Center for Population Options
Washington, DC

Jill Joseph
University of Michigan
Ann Arbor, MI

Jeffrey A. Kelly
University of Mississippi
Jackson, MS

Douglas Kirby
Center for Population Studies
Washington, DC

Lloyd Kolbe
Office of School Health
Centers for Disease Control
Atlanta, GA

Vickie Mays
Department of Psychology
University of California
Los Angeles, CA

Stephen Margolis
Margolis and Associates
Atlanta, GA

Leon McKusick
University of California
San Francisco, CA

Sheila Namir
California School of Professional Psychology
Los Angeles, CA

John Neumeyer
Haight Asbury Health Clinic
San Francisco, CA

Kathy Reardon
Departments of Business and Preventive Medicine
University of Southern California
Los Angeles, CA

Ronald Rice
Annenberg School of Communications
University of Southern California
Los Angeles, CA

Oralee Wachter
ODN Productions
New York, NY

William Yarber
Indiana University
Bloomington, IN

Exhibit 1: "Free Dope," Bayview-Hunter's Point Foundation

FREE DOPE!

This dope may SAVE YOUR LIFE!
CLEAN YOUR WORKS!

Fast, easy and safe.

Step One

Step Two

Step Three

Horizons Unlimited

Asian American Residential Recovery Service

Bayview Hunters Point Methadone Program

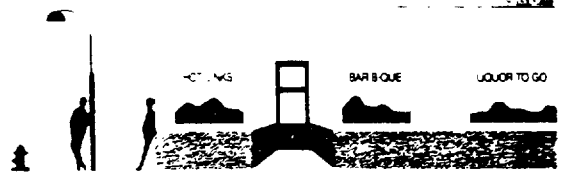
Multicultural Prevention Resource Center

Westside Methadone Program

San Francisco AIDS Hotline

(415) 861-2142
822-8200

Do YOU shoot up?

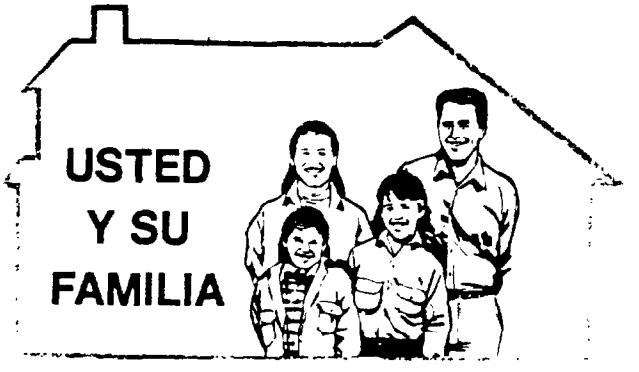


The best thing to do

The next best thing to do

Better than Nothing

Exhibit 2: "Usted Y Su Familia," Minority AIDS Project



Pueden protegerse del SIDA ¡Es facil!

SIDA es una enfermedad que hasta el momento no tiene curacion

SIDA es causado por un virus
El virus destruye la forma que el cuerpo tiene para protegernos de las enfermedades

Personas **LATINAS** han
agarrado **SIDA.**

Precauciones para ayudarnos a las personas
LATINAS a Protegernos del **SIDA.**

- [illegible]
- [illegible] E[illegible]e inyectarse drogas
- [illegible] E[illegible]e compartir jeringas
- [illegible]
- [illegible]
- [illegible]

Exhibit 3: "Break the Chain of Ignorance,"
Bayview-Hunter's Point Foundation

BREAK THE CHAIN OF IGNORANCE

M.A.P.A.

Multicultural Alliance for the Prevention of AIDS

YES We are an AIDS education and prevention program

Our focus is the ethnic and racial minority community

We are dedicated to stopping the spread of AIDS among

- Persons who share needles when shooting up
- Persons having unprotected sex
- And others who may be at risk for AIDS

If we do not make changes in our drug use and sexual behaviors, by 1991 more than 100 000 people of color will have contracted AIDS

FACTS

AIDS is a virus In the U S it has claimed the lives of more than 5 000 men, women and children in the Black Hispanic and Asian communities

In 1985, 5 minorities died of AIDS each day

This painful disease does not care if you are

- Male
- Female
- Gay or Straight
- Old or Young
- Doing drugs

Who can get AIDS?

YOU CAN get AIDS by having unprotected sex and by sharing needles when shooting up.

M.A.P.A. OFFERS

AIDS prevention workshops for

- IV drug users
- All persons at risk
  - gay straight and bisexuals

We want to halt the wave of this epidemic in our community

FACT

At this time, there is no cure for AIDS

— **IGNORANCE CAN KILL**

Education and prevention is our defense

- You can help break the chains of ignorance
- Our services are **FREE!!!**

Now is the time, tomorrow may be too late!!

CALL NOW

822-7500

This Call May Save A Life!

Exhibit 4: "Black People Do Get AIDS," Minority AIDS Project

BLACK PEOPLE DO GET AIDS

BUT NOT BY:

- Donating blood
- Sneezing, coughing or spitting
- Shaking hands with someone who has AIDS
- Hugging
- Using the same bathroom (toilet, sink, bathtubs) However, razors or toothbrushes could be contaminated with blood
- Furniture or doorknobs
- Being in the same room
- Living in the same house
- Writing with the same pen or pencil
- A kiss on the cheek
- Playing with a child who has AIDS
- Sleeping in the same room
- Utensils, dishes or linen used by a person with AIDS

No Cases of AIDS have ever been linked to Saliva, Tears or Sweat, nor by Eating Food prepared by someone who has AIDS

– REMEMBER –
AIDS IS NOT IN THE AIR

AIDS is spread through Blood or Sexual Contact ONLY

The AIDS Virus is sensitive and can be destroyed by
- Rubbing Alcohol
- Household Bleach
- Boiling Water
- Lysol
and other disinfectants

Our Black Brothers and Sisters need our Concern and Support

WANT TO KNOW MORE? ASK US:

MINORITY AIDS PROJECT

(213) 936-4949

Other Referrals 800/922-AIDS

Spanish Hotline 800/222-SIDA

Exhibit 5: "Straight Talk About Sex and AIDS," San Francisco AIDS Foundation

Exhibit 6: Bus Poster, San Francisco AIDS Foundation

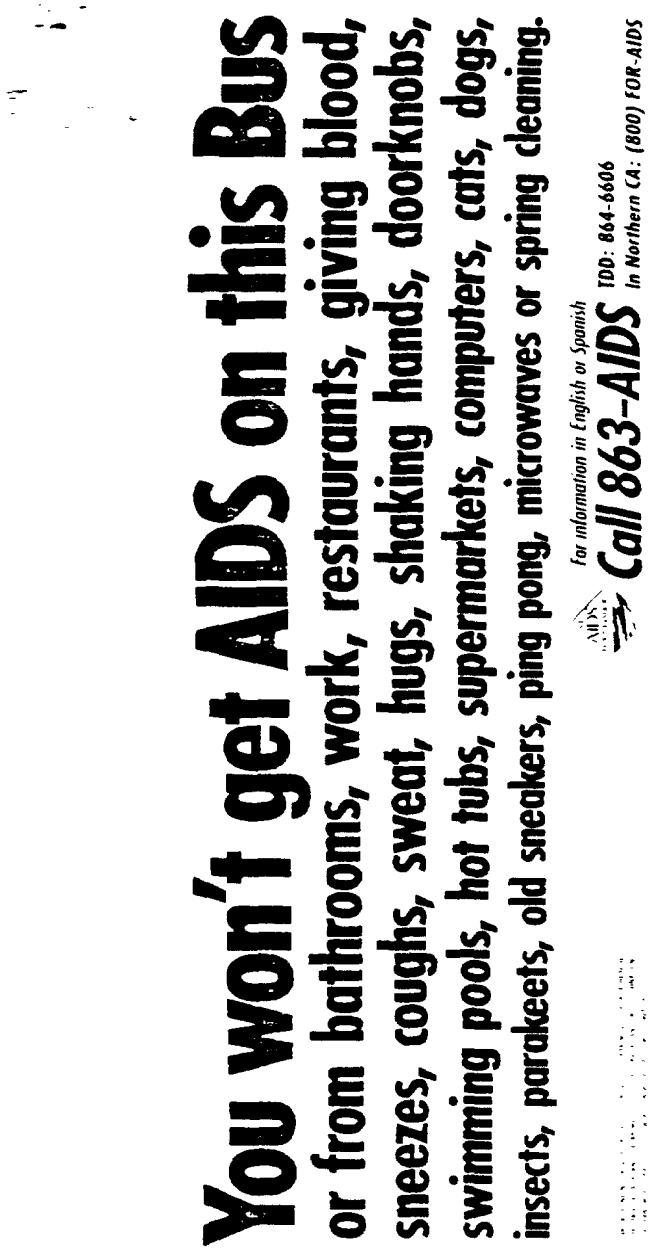


Exhibit 7: Two Pages From "The Works,"
San Francisco AIDS Foundation

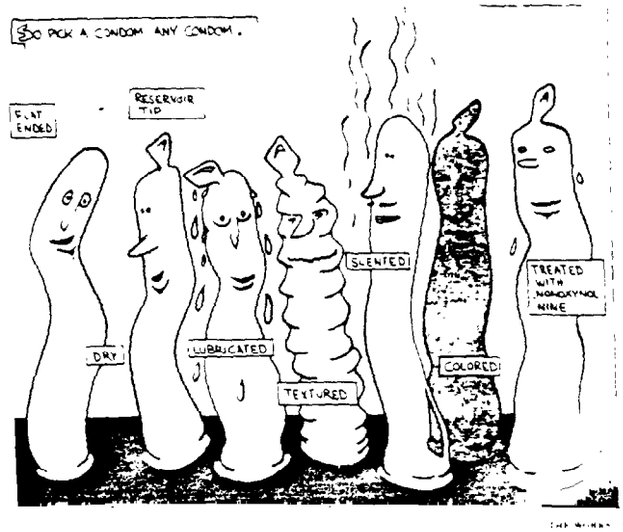
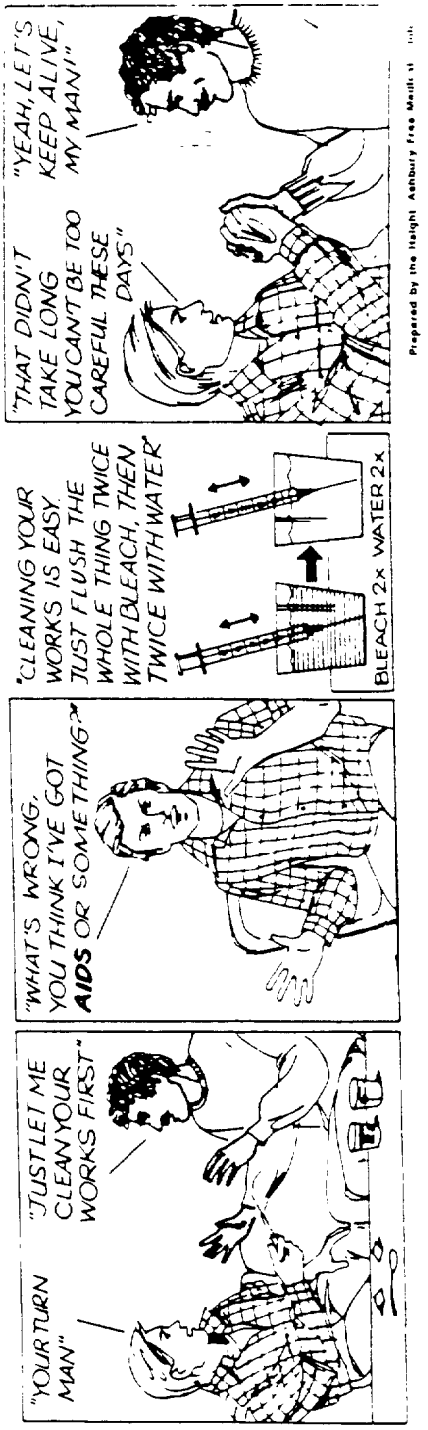


Exhibit 8: "The Adventures of Bleachman,"
San Francisco AIDS Foundation

Exhibit 9: Instructions for Cleaning Works,
Mid-City Consortium on AIDS



PEOPLE OF COLOR
"Because We Care"

Let's Talk

41% of ALL cases of AIDS are People of Color

DID YOU KNOW THAT

- 59% of all the **CHILDREN** with AIDS are **BLACK CHILDREN**
- 21% of all the **CHILDREN** with AIDS are **LATINO CHILDREN**
- 1% **ASIAN** or other

- 52% of **ALL WOMEN** with AIDS are **BLACK WOMEN**
- 25% of **ALL WOMEN** with AIDS are **LATINA WOMEN**

- **BLACK PEOPLE** are **11.7%** of the U.S. population, yet **25%** of the **AIDS cases**
- **LATINO PEOPLE** are **6.4%** of the U.S. population, yet **14%** of the **AIDS cases.**
- Of the men being inducted into the Armed Services **BLACK MEN** **are testing positive 4 to 1 over whites**

AIDS
IS
NOT!!

1. A WHITE Disease
2. A GAY Disease
3. A MALE Disease

AIDS
IS

1. FOUND IN WOMEN
2. FOUND IN CHILDREN
3. FOUND IN STRAIGHTS

WOMEN

If a woman is infected with theAIDS virus she can pass it to her unborn child. Think carefully if you plan on having a baby. It is possible that the AIDS virus may also be transmitted through breast milk.

AIDS IS AN EQUAL OPPORTUNITY DISEASE!!!

WHAT IS AIDS?

AIDS is a disease which attacks the body's ability to fight off some illnesses. It is caused by a virus (germ) spread by sexual contact or sharing needles when shooting drugs. Half of the people who have AIDS have died. There is no cure for AIDS. **PREVENTION IS THE ONLY WAY TO STOP THIS DISEASE.**

People can be infected with the AIDS virus and **LOOK HEALTHY**. However, they can pass the virus on to another without either person knowing it. It is difficult to know who is infected, we urge **EVERYONE** to take the simple precautions listed below to protect yourself always.

DO'S

Limit Sex to ONE Partner

USE RUBBERS

Social Kissing - on lips only

Take Good Care of Your Body

A. Plenty of rest

B. Good nutrition

C. Exercise

D. Reduce Stress or worry

E. Reduce Alcohol intake

DON'TS

No Exchange of Body Fluids (urine, semen (cum), blood)

No Oral, Rectal or Vaginal Sex (without rubbers)

No Drugs, but if you do DON'T SHARE NEEDLES

No Sex without Rubbers

Don't Take Chances

Exhibit 11: "Once You've Got It, You've Had It,"
Association for Drug Abuse Prevention and Treatment

85-Bergen Street, Brooklyn, NY 11231 718-834-9585

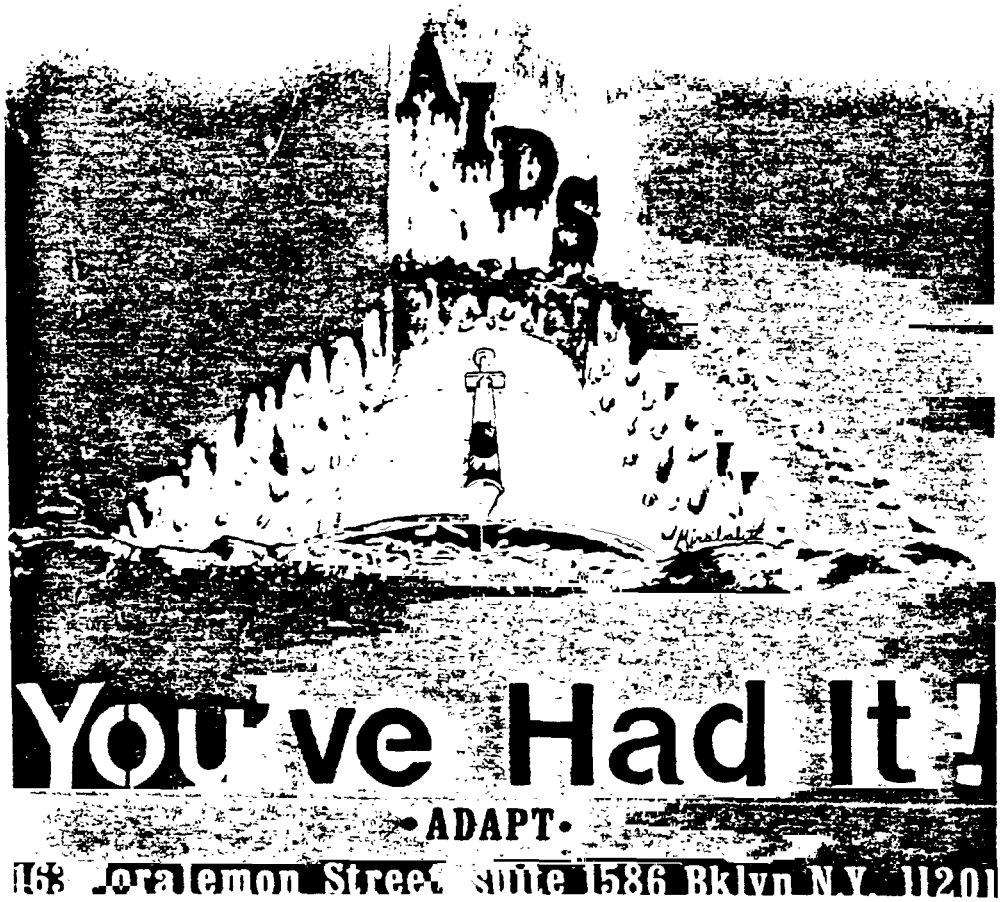


Exhibit 12: "Why Did My Daddy Die From AIDS?"

Bayview-Hunter's Point Foundation

WHY DID MY DADDY DIE FROM AIDS?

STOP THE SPREAD OF AIDS
IN THE BLACK COMMUNITY.
KNOW THE FACTS.

CALL MAPA 822-7500

Exhibit 13: "Drogas Y Sida," Latino AIDS Project