Behaviour Change Communication for HIV Prevention in Barbados – A Proposal for a Strategy

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EXECUTIVE SUMMARY

The evidence is clear and compelling: While the Barbados HIV/AIDS programme has achieved high levels of awareness of HIV/AIDS, its transmission, prevention and treatment across all age and sexual behavior groups has been less successful in inducing and sustaining change in behaviours that would result in a control of the epidemic.

Like several of its Caribbean Community (CARICOM) partners, Barbados has a now recognizable 'KAP' (Knowledge, Attitudes and Practices) gap' – almost everyone has heard and are informed about HIV and the required prevention behaviours. Though many people are convinced that these behaviours are worthwhile, not all of them make the decision to adopt the sexual and other behaviours required to affect the control of the HIV epidemic. Even among those who decide to adopt one or more of the prevention behaviours, there are those who are not continuously practicing these behaviours. Reasons for discontinuing preventive practices vary depending on relationship status and fatigue, as examples.

The result, in terms of cases per population, is that the HIV prevalence for Barbados is increasing at a much higher rate as compared to the other countries in the Organization of Eastern Caribbean States (OECS[1]). These estimates are considered conservative and they represent only one-fifth of the infected population. An epidemic that in the early years was almost exclusively found in special groups with high-risk behaviour is now evident in the general population.

At present, increasing numbers of women and particularly female youth are becoming infected. In 2004, the male-to-female ratio of HIV cases was 1.49 to 1. By 2005, the ratio descended to 1.13 to 1. Females accounted for almost 47 percent of all HIV cases in 2005 as compared to just over 40 percent in 2004. The Health Ministry reports that despite a reduction in the overall number of HIV cases diagnosed from 2004 to 2005, there is an increase in the percentage of young people diagnosed in the 15-to-29 age group[2].

This situation is worrisome. If not addressed urgently, nationwide social and economic consequences could be disastrous. The following five-year behaviour change communication strategy proposes a plan to achieve a shift in behaviour adoption that is required if a change in the progress of the epidemics is to be achieved.

The plan proposes a deliberate and focused approach to behaviour-change intervention planning and implementation that:

i) Acknowledges that behaviour change (like behaviour development) is a process and that the process needs to be given time and enabled/ supported

[1] Camara, DeGroulard, Boyd-Scoby. 1998. A strategic framework for the prevention and control of AIDS epidemic in the OECS: 2001-2005.

[2] Ministry of Health Statistical Update. December 2006. Press Release for World AIDS Day 2006.

at every stage with appropriate communication elements (including the interpersonal) to produce the necessary results; and

ii) Recognizes that the behaviours (in this case, sexual, health seeking, partner selection, and others) of each individual are influenced as much by the individual's age, educational level, value system and other individual/ personal factors as by that individual's external environment – his home, school, church, workplace, the national policies and laws, social norms and values, etc.

iii) Ensures a coherent link between the components and communication elements of each intervention – whether advocacy, skill building, social mobilisation, programme communication, service delivery or policy change – so that each reinforces and is reinforced by the other.

The proposed approach focuses on the individual (to provide skills, attitudes and knowledge) while enabling that individual to adopt and maintain the desired behaviour(s) by providing supportive social (peer group, home, health system, church); policy (health care, human rights, access to quality sexual education); legal (access to services, protection of human rights); and work environments. In addition, because of the level of difficulty experienced in getting adults to adopt new behaviours, as well as the individual and societal health and other benefits of having young persons adopt the HIV prevention behaviours, a parallel focus of the strategy is on getting children and youth to adopt the desired behaviours.

The goals of the proposed strategy are to:

1. Positively affect the current epidemic by seeking to:
    a. Reduce HIV primary infection rates among persons who are sexually active through the use of HIV testing services, partner reduction, and the correct and consistent use of condoms until mutual monogamy is established for the couple;
    b. Reduce re-infection rates among PWHIV through the correct and consistent use of condoms and other safer sexual behaviours; and
    c. Increase survival rates for PWHIV through use of testing/diagnostic services, adherence to treatment regimes, healthy living, and the correct and consistent use of condoms and other safer sexual behaviours.

2. Influence disease (HIV/STI) trends by changing social norms about the timing of first sexual intercourse and gender norms associated with sexual partnering and condom use – two basic requirements for HIV/STI prevention.
    d. Increase the proportion of persons who choose to delay sexual debut or make a deliberate decision to adopt 'secondary abstinence'.

To achieve these goals, the strategy will be organized around sexual activity status and HIV status. The identified priorities are as follows:

- **Individuals who have never been sexually active**. The BCC priorities for this group are to enable and encourage delay of sexual debut while providing knowledge and skills about protective behaviours;
- **Individual who are no longer sexually active.** For this group, the focus is to encourage and support HIV testing to clarify status and once status is known either to adopt practices to maintain a negative status or to seek treatment and practice other healthful behaviours including good nutrition, psycho-social support, exercise/daily activity);
- **Individuals who are sexually active**. The BCC priorities for this group are similar to those of the group not currently sexually active – Testing to 'know your status', adoption of behaviours appropriate to the respective HIV status group. In addition, safe sexual behaviours will be included in the menu of behaviours promoted to PWHIV.

The proposed approach pushes the national programme to recognise the need to provide the support(s) and material needed by individuals at every stage in the behaviour adoption process. Such a comprehensive approach has implications for the type and content of specific behaviour change communication elements that are provided by the programme. This approach can help create an environment that is likely to support individuals maintaining the desired healthy behaviour.

The implementation period of the proposed strategy is 2007 to 2012. The focus of Year 1 will be on i) capacity building in BCC intervention planning at the NHAC as well as in partner agencies; ii) assessment of existing interventions using customized tools and the scaling up of at least one of the interventions that is successful or shows promise; iii) installing a manageable monitoring and evaluation framework to ensure accurate and timely data collection needed to monitor and evaluate the strategy as well as specific interventions introduced during the strategy period; iv) identifying research gaps and commissioning research studies; and v) developing a plan for sharing BCC experiences, throughout the life of the strategy, with colleagues in CARICOM partner countries through study tours and presentations in regional meetings and conferences.

In Year 2, the strategy would expand efforts started in the first year, specifically the identification and scaling up of existing, effective interventions. Additional capacity building may be needed in line ministries and the private sector. In Years 3 and 4, the strategy's focus would shift toward launching new interventions and evaluating the impact of ongoing efforts.

The proposed strategy includes a critical monitoring and evaluation component. Monitoring activities would be sustained throughout the implementation period. The NHAC would provide technical guidance to partner agencies to develop M&E plans including the development of necessary data collection tools. Information flowing from these efforts would be critical in guiding policy decisions; specifically, decisions about scaling up interventions (or intervention elements) that achieve their objectives.

The implementation of the proposed BCC strategy will require additional resources, Year 1 needing approximately BD$ 1 million. These resources and requirements include the establishment of additional positions in the NHAC Secretariat as well as in partner agencies. The multi-sector BCC team needs to be strengthened to support the specific communication and advocacy elements of the strategy. Ideally, the team would include in addition to the BCC specialist in the NHAC a Senior Behaviour Change Officer (Sn BCO), two Junior Behaviour Change Officers (Jn BCO), one with responsibility for advocacy and the other for edutainment, four Community Outreach Officers (COO), and a full time coordinator for the youth development portfolio. In the short-term, the BCC team should be increased by five positions (Sn. BCO, Jn. BCO (edutainment), 2 COO, and a coordinator for youth development).

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Attachments

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ACISS	Awareness Clubs In Secondary Schools
BCC	Behaviour Change Communication
BCO	Behaviour Change Officer
CARICOM	Caribbean Community
COO	Community Outreach Officer
HIV	Human Immunodeficiency Virus
KAP	Knowledge, Attitudes and Practices
MSM	Men who have sex with men
NAP	National AIDS Programme
NHAC	National HIV/AIDS Commission
NGOs	Non-Governmental Organisations
OECS	Organization of Eastern Caribbean States
PWHIV	Person (living) with HIV
SRH	Sexual and Reproductive Health
STI	Sexually transmitted infections
SW	Sex worker
UWI	University of the West Indies
UWI HARP	University of the West Indies HIV/AIDS Response Programme

I. INTRODUCTION

The epidemiological and social science data provide compelling evidence of the need for the Barbados National HIV/AIDS Commission to place a higher priority on behaviour change communication for HIV prevention, treatment and care and support. To that end, a consultancy was conducted in November 2006 to evaluate Barbados' current progress in prevention efforts, but more specifically to:

- Identify vulnerable and most-at-risk groups;
- Propose the key objectives and priorities of the BCC strategy; and
- Design a strategy for the development and implementation of the BCC strategy.

The information for the consultancy was obtained from two main sources:

1) Documentation providing information on the spread of the epidemics, and the main activities carried out and lessons learnt by the Commission;
2) Two sets of meetings and consultations with partners and key stakeholders engaged with the Commission in implementing the National AIDS Programme (NAP). Individuals and agencies participating in the consultations are listed in Attachment 1.

The consultations revealed the continued commitment and desire of the national programme (the Commission and its partners in the multi-sectoral response to HIV and AIDS) to stem the spread of the epidemics. In the 22 years since the first case of AIDS was identified in Barbados, the national programme has carried out a range of prevention activities. These have included:

- Mass media information campaigns targeting the general population;
- Targeted communication campaigns (e.g. Youth Against AIDS campaign);
- Targeted interventions implemented by partners (e.g. Ministry of Education, Youth Affairs and Sports);
- A prevention of mother to child transmission (pMTCT) programme;
- Promotions of correct and consistent condom use (for primary prevention); and more recently; and
- Voluntary counseling and testing (VCT) programmes.

The evidence is that prevention programmes implemented prior to 2001, when the multi-sectoral response to HIV and AIDS was implemented, were not sufficiently broad-based to address a range of social, cultural and behavioural aspects of the epidemic. The focus of current prevention programmes is different. They seek to:

- Maintain levels of awareness of HIV risk and protective measures;
- Promote safer sexual practices (especially among women and youth);
- Reduce high risk behaviours;
- Promote advocacy on human rights and non-discrimination.

There is no question that the current communication efforts, focused as they are on primary prevention, have created high levels of awareness of HIV, its transmission, treatment, and prevention across all age and sexual behavior groups. They have been less successful, however, in assuring and sustaining the changes in behaviour that would result in declines in the epidemics. What are some of the reasons proffered by programme partners?

1. Most of the communication programmes introduced to date have been very knowledge-focused. There is the realization among partners in the multi-sectoral response that knowledge (access to information) about HIV and related matters, although necessary, does not necessarily translate into behaviour change – resulting in the now recognizable 'KAP gap'. There is also growing acknowledgement that behaviour change (as is behaviour development) is a process and the process needs to be given time and supported to produce the necessary results.

2. Limited focus on evaluation: Interviews with key individuals and partners participating in the consultations identified another important perception, namely, that there has not been sufficient investment in evaluation. Further, there is the notion that where evaluation has been conducted, these have been premature – that is, they were conducted before the intervention of interest had the opportunity to effect any meaningful change in the attitudes and practices of the primary beneficiaries of the intervention.

3. Interventions not evidence-based: Another reason suggested for the lack of effective behaviour change interventions is that they are not sufficiently evidence-based. There are those who also suggest that there is an absence of sufficient basic social science research with which to identify needs, and the proximal determinants/ correlates of HIV prevention behaviours for sub-groups in the Barbados population. One result is that communication and other change interventions are not always based on real evidence.

The strategy framework outlined here will attempt to address several of these concerns. The goal is to install a system that, as needed, will enable the development, implementation and evaluation of meaningful, appropriate and effective targeted interventions, with the necessary policy and other environmental supports that, in time, will bring about the kind of behaviour development or change necessary to keep the HIV epidemics in check.

The final strategy for HIV behaviour change communication should include the following components:

- education and communication for sexual behaviour development and change – that is, education that provides opportunities for the development of skills (communication, condom use, negotiation, decision-making) and competencies as well as knowledge for several vulnerable groups including the pre-school child and the pre-adolescent;
- an increased reliance on interpersonal communication approaches, especially for adolescents and youth, that build self efficacy, self confidence and emotional intelligence;

- effective mass media elements and programmes;
- advocacy to effect changes in social norms related to gender, sex and sexuality;
- public education and advocacy to:
  - support the proper enforcement of laws that protect the sexual health and wellbeing of children;
  - assure modification of school-based sexual health education programmes to enable healthy discussions about sex and sexuality, sexual health and behaviours in ways that address need for changes in gender norms; and
- creation and/ or strengthening of support groups to enable: i) development of effective couple communication skills (as required by committed/married partners to protect each other from infection), ii) PWHIV and youth, especially, to access available health and social support services, iii) PWHIV, their families and significant others cope with stigma and discrimination; and iv) adolescents and youth who choose celibacy or to delay sexual initiation to cope with the associated stigma.

A rose, is a rose is a rose. Not really!!

As outlined above, this proposed BCC strategy may appear to be similar to what is currently being done by the NHAC and partners. This raises two questions: First, is there a difference between this proposed BCC strategy for HIV prevention and HIV prevention programmes of the past and second, what is the difference between what is being proposed and past prevention efforts?

The answer to the first question is YES, there is a difference. There are at least three fundamental differences between programming in the past and the proposed strategic focus of future HIV prevention behaviour change communication efforts.

- First, in the past, the programme relied almost entirely on one-off interventions that depended almost exclusively on mass media communication elements. This proposed BCC approach is grounded in behaviour theory and uses mass media strategically to support and reinforce the efforts of other more interpersonal communication elements.

- Second, the new strategy assumes that behaviour development and change is a process. It is theorized that an individual goes through five (or six, if there is relapse) main stages in the process of behaviour change[3],[4]. These are:
  - Step 1: Becomes aware

[3] Prochasta, JD, DiClementi, CG and Norcross, JC. 1992. In search of how people change: Applications to the addictive behaviours. *American Psychologist*. 47(9): 1102-1114.

[4] Everold Hosein's behaviour adoption model, HIC//DARM, includes seven stages. First we HEAR about the behaviour, then we become INFORMED about it and later CONVINCED it is worthwhile. In time we make a DECISION to do something about our conviction and later we take ACTION on the new behaviour. We await RE-CONFIRMATION that our action was a good one. If all s well we MAINTAIN the behaviour.

- Step 2: Contemplates change
- Step 3: Prepares to change/ Takes steps to change
- Step 4: Begins to make change
- Step 5: Maintains the new behaviour

- Step 6: Relapses (this may occur at any stage in the development/change process).

This new BCC approach pushes the national programme to recognise the need to provide the support(s) and material needed by individuals at every stage in the behaviour development/ change process. Such a segmented approach has implications for the type and content of specific behaviour change communication elements that are provided by the programme. Such a directed approach helps create an environment for the individual that is likely to support that individual to maintain the desired healthy behaviour.

- Third, this new approach to behaviour development and change will ensure that the components of every intervention – whether advocacy, information, service delivery, policy change, mass media communication for behaviour change – are linked in a coherent manner so that each component reinforces and is reinforced by the other.

II. HIV/AIDS SITUATION IN BARBADOS – WHO IS VULNERABLE?

The first case of HIV was reported in Barbados in 1984. At that time, like most other countries, HIV infection was prevalent among so-called high risk behaviour groups – namely men having sex with men (MSM) and sex workers (SW). During the last 20 years, the profile of the epidemic has changed. The trend is now for the general population to be infected. The 2005 data from the Ministry of Health surveillance system indicate that one in every three cases of HIV reported is a woman. This is up from 4:1 reported in 2000.

Data provided by the Ministry of Health indicate that in March 2005, about 73 percent of all reported cases of HIV were among persons 15-to-49 years of age. At that time, one in every three cases was a woman. One should note that although the proportion of persons 15-to-49 years of age with HIV declined between 2000 and 2005, the ratio of females reporting HIV infection in the same period has increased. As of December 2006, the major burden of HIV continued to be evident in the 20-54 age group, and despite the reduction in the number of new cases diagnosed between 2004 and 2005, there has been an increase in the percentage of youth 15-29 years diagnosed with HIV. As of December 1, 2006, an estimated 1827 persons were living with HIV (PWHIV)[5].

[5] These data were abstracted from Ministry of Health statistics released for World AIDS Day, 2006.

With respect to HIV and AIDS in Barbados, the situation in Barbados is not unique. Similar trends are reported for the wider Caribbean. However, in terms of cases per population, the rate for Barbados is increasing at a much higher rate compared to the other countries in the OECS[6]. These estimates are considered to be conservative and to represent only one-fifth of the infected population[7].

HIV is spreading in the Caribbean at a rate that is second only to that of sub-Saharan Africa. Levels of HIV infection in the region are highest among newly identified groups including women, adolescents and the poor.

The vulnerabilities that give rise to these new trends in the HIV epidemic derive from a dynamic conflation of prevailing social, economic and cultural factors. Important among these are social class differentials, a global culture of materialism that creates unrealistic economic needs and wants, entrenched gender norms associated with sexual partnering that place women at potentially high risk for infection by their committed male partners, and power dynamics that influence sexual outcomes, especially for adolescents and youth, but also for women. In the past five years, AIDS has become the leading cause of death in the Caribbean among adults 15-to-44 years of age and the epidemic is having the effect of reducing life expectancy at birth by as much as 9 years.[8]

Youth are especially vulnerable to early sexual initiation and HIV/STI infection due to their age, lack of power to negotiate in a sexual relationship, their poor economic status and the socially assigned tasks and responsibilities of child minding and household headship many of them must assume. The consultation revealed anecdotally that an increasing number of boys and girls are victims of incest and sexual abuse. Youth in secondary school – that is, persons in the age group 10-to-18 years of age - are vulnerable to the influence of and recruitment into gangs and other anti-social behaviours (alcohol and drug use) that help drive the epidemic among youth. It is estimated, for example, that 49 percent of youth in Barbados use alcohol. Use of Marijuana, tobacco and inhalants each is reported by 11 percent of youth in the same survey[9].

Other vulnerable groups identified during the consultation include individuals who are newly diagnosed with HIV. It appears that although the necessary care and support and treatment services are available, these individuals are often very tardy in accessing them. Further exploration is required to isolate reasons for this negative help-seeking behaviour.

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[6] Camara, B, DeGroulard, M and Boyd-Scoby, C. 1998. A strategic framework for the prevention and control of AIDS epidemic in the OECS: 2001-2005.
[7] Action Plan for a Comprehensive Programme on the Management, Prevention and Control of HIV/AIDS 2001-2006. Ministry of Health, Barbados. November 2000.
[8] AIDS Epidemic Update: December 2004.
[9] Minister Eastmond's presentation at launch of the Life Education Centre on October 26, 2006. www.barbados.gov.bb//ViewNews.asp/ID

Finally, the epidemiology data indicate that women, including married women, are also among the more vulnerable groups for HIV infection. The March 2005 data from the Ministry of Health indicate that men more so than women in all age groups except the 15-to-19 and 20-to-24 age groups are at higher risk of HIV. The infection rates for females 15-to-25 years are higher than for males in the same age group. The trend continues as the data from December 2006 shows that in 2005, females accounted for almost 47 percent of cases compared to just over 40 percent in 2004.

III. A SUGGESTED FRAMEWORK FOR CLARIFYING BCC PRIORITIES

Given the situation regarding HIV and AIDS and NHAC's ultimate goal of reducing the incidence of HIV in Barbados, how should the NHAC classify its BCC priorities?

Transmission of HIV in Barbados is primarily through unprotected sexual contact. One means of classifying the BCC priorities of the NHAC, therefore, is on the basis of sexual activity status. Three groups of individuals are identified when that classification is applied. They are: i) those who never have had sexual intercourse; ii) those who have had sexual intercourse but have chosen secondary abstinence; and iii) those who currently are sexually involved. If HIV status is superimposed on this classification, seven sub-groups emerge. A schematic of selected target behaviours and expected impacts for the priority groups is presented in Figure 1.

i) **Individuals who have never been sexually active.** The programme focus for this group should be to encourage delay of sexual activity by providing skills and a supportive environment (peer and parent support) to enable delay. In modern Barbados where the positive value formerly placed on virginity, especially for females, appears to be waning, the programme could focus on helping to remove the stigma associated with not being sexually involved by highlighting one's right to choose as well as the positive health benefits of delaying sexual involvement, especially for young adolescents. Public education and advocacy is required to remove the stigma associated with not being sexually active. Additionally, age- and gender-appropriate and specific education (information and skills) on safe behaviours (intimacy

alternatives[10], condom negotiation and use, and monogamy) should be part of the focus.[11].

ii) **Individuals who are not currently sexually active.** This group includes individuals who have chosen 'temporary celibacy'[12] (youth and adults). This group can be divided into three sub-groups – i) those who know their HIV status (not living with HIV), ii) those who do not know their status, and iii) those who know their HIV status (living with HIV).

- **Not currently sexually active and not living with HIV**: For this group, one focus should be on HIV testing in order to know one's status and the necessary skills and social supports to enable individuals to maintain that status.
- **Not currently sexually active and unaware of HIV status:** The focus for this group should be to promote use of HIV testing services and education/motivation to either appropriate help and health seeking (counseling, treatment, care and support or education for practice of protected sexual behaviours and intimacy alternatives as and when the individual chooses to become sexually active again).
- **Not currently sexually active and living with HIV**. The focus for this group should to encourage and enable health and help seeking – that includes access to and use of treatment services, education for healthy living, and use of social support mechanisms.

iii) **Individuals who are sexually active.** This group includes three subgroups – i) Persons who are not PWHIV, ii) persons who are unaware of their status, and iii) persons who are PWHIV.

- **Sexually active and not PWHIV** The programme focus for this group of individuals should be on promoting HIV testing as a means of 'knowing your status' and the using safe sexual practices

[10] Term was suggested by a participant in one of the consultations. It connotes alternative activities in which a couple may engage that will enable intimacy but will not expose either partner to risk of infection. Some of these 'alternatives' may include practices that have been defined in the literature as 'Outercourse'.

[11] The social science literature indicates that appropriate sexuality education does not hasten sexual debut but appears to enable the practice of safe behaviours (use of protection, etc.) when the young person chooses to initiate sexual activity.

[12] The term is used here to mean postponing sexual relations whether for religious reasons, because of dislike of the condom or fear of becoming infected with STI/ HIV. There is anecdotal evidence that a growing number of persons who were sexually active are choosing to postpone sexual relations for these reasons.

(fidelity, correct and consistent condom use, and safe intimacy alternatives) to safeguard one's health status;

- **Sexually active and unaware of HIV status:** The focus for this group should be on promoting use of HIV testing services and on education/motivation to either appropriate help or health seeking (counseling, treatment, care and support or education for practice of protected sexual behaviours and intimacy alternatives as and when the individual chooses to become sexually active again).
- **Sexually active and living with HIV:** The programme focus for this group should be to promote healthy living (diet and exercise, social interaction, and psycho-social support), ARV adherence, appropriate testing and practice of safer sexual behaviours including the adoption of safe intimacy alternatives.

Achievement of the expected outcomes proposed in Figure 1 for each priority group is dependent on the individual man, woman, or young person adopting a required set of behaviours. However, because of the dynamic relationship (some may argue 'reciprocity'[13]) between the individual and his/her environment, the adoption and subsequent maintenance of the desired behaviour(s) by that individual is dependent on a number of conditions being in place. It is clear that conditions required for successful behavioural outcomes will vary for each group of interest. However, the set of conditions should include:

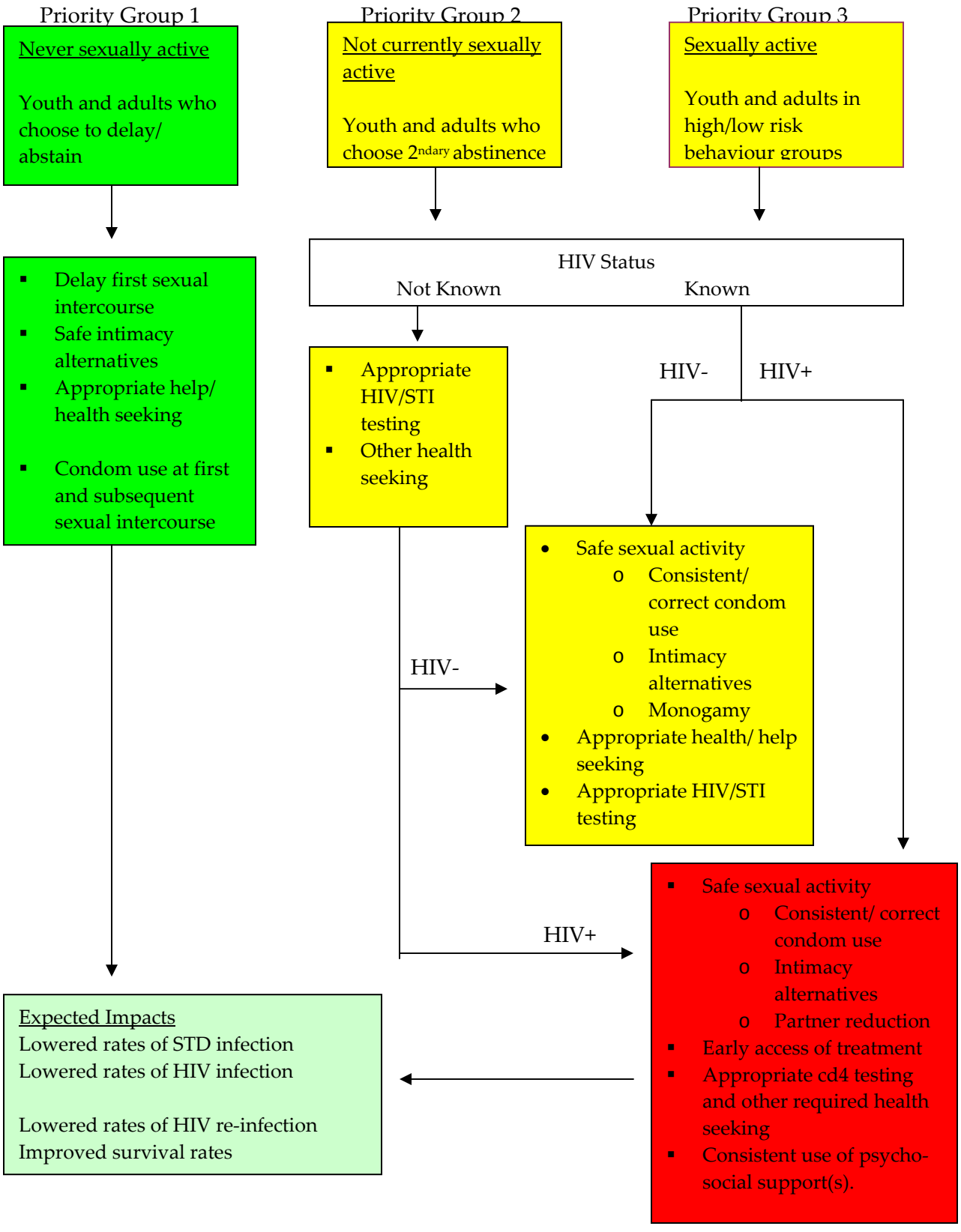
- access to safe, affordable, client friendly, confidential and age-appropriate education, counseling and clinical services;
- access to accurate age-appropriate sexuality education;
- access to accurate information about HIV and AIDS, HIV testing, and treatment and care;
- access to stigma-free and confidential psycho-social support services;
- a social environment (health facility, home, school, workplace) that is free from social stigma – whether directed to PWHIV, or persons who choose to delay/ postpone sexual debut, or to be monogamous, or to be in a same sex relationship; and
- a legislative and ethical framework at national and institutional levels that supports the provision of the conditions noted above and safeguards the rights of each individual.

In the name of equality, it should not be difficult for the NHAC to apply these conditions. These are delineated in several international conventions to which Barbados is a signatory. Notable among these conventions is the United Nations Convention on the Rights of the Child[14] and the International Conference on Population and Development (ICPD) Programme

[13] Bandura, A. 1986. Social Foundations of Thought and Action: A Social Cognitive Theory. Englewood Cliffs, NJ: Prentice Hall.

[14] http://www.unhchr/hurrican/html/men2/6/protoclchild.htm

Figure 1: Suggested Target Behaviours and Expected Impacts for BCC Strategy – National HIV/AIDS Commission, Barbados



of Action[15,16]. These conventions may indicate political will. Moving the rest of the population to accept them will require effective ongoing advocacy at several levels of society.

IV. CONTEXTUAL FACTORS AND CONSIDERATIONS THAT: -

A: Influence Sexual Behaviours

Sexual and other health behaviours that determine the spread, or not, of HIV are themselves derived from and supported by a series of socio-cultural and economic factors. One of these is gender – and more specifically, the perceived and real sexual roles and relations between men and women in society.

Gender Issues

Despite efforts in the past two decades to address gender and gender socialisation issues in Barbados and the rest of the region, gender norms that negatively influence the HIV transmission remain intact. It has been observed, for example, that men in the Caribbean are often rewarded within cultural contexts for the very risks that might increase exposure to and opportunity for HIV infection or transmission of HIV to others'[17] These risks contribute to what is now considered the 'feminisation' of the HIV/AIDS epidemic in Barbados and the rest of the region. In 2004, the Caribbean had one of the highest rates of new AIDS cases among women in the Americas with women 15-to-24 years of age being especially vulnerable.

The sexual double standard that persists allows men to have multiple sexual partners and families. Therefore, women who are married or in monogamous relationships are not guaranteed protection against HIV or other STI. Ironically, from the man's perspective, the characteristics that are considered masculine (being strong, having an intense sexual desire that demands immediate satisfaction and being audacious) are the ones that increase men's vulnerability for HIV infection. The challenge is to re-orient men's thinking to diminish vulnerability by being responsible, and a good financial, sexual and affective partner[18]. The NHAC must seek to get men to re-think masculinity and women to be so empowered as to not only have the 'condom conversation' but to insist on its use, and to recommend that both partners be tested for HIV.

Even as we observe the persistent double standard, there is anecdotal evidence from multiple sources that gender norms associated with sexual partnering are changing. Increasing numbers of young women see themselves as equal to men and, as such, entitled to engage in the same sexual partnering practices as men. While serial monogamy is generally the practice for young

[15] ICPD Programme of Action (1994). http://www.un.org/popin/icpd/conference/offeng/poa.html
[16] http://www.cepal.org/publicaciones/xml/9/1039/carg0557.pdf
[17] 'Strengthening the Caribbean Regional Response to the HIV Epidemic'. Report of the Caribbean Technical Expert group Meeting on HIV Prevention and Gender. October 28-29, 2004. Jamaica.
[18] Guerriero, ICZ. Gender and vulnerability to the HIV: how the concepts about masculinity influence heterosexual men's vulnerability. Global Forum for Health Research. Forum 8. Mexico City, November 2004.

women, increasingly multiple concurrent sexual partnering is being observed. These behaviours have important implications for the prevention programming content and approach that is adopted by the NAP.

Economic Considerations

Barbados' performance in the economic sphere has been described as impressive[19]. Between 1993 and 2000, the economy recorded eight consecutive years of growth that resumed in 2002 and continued through 2004. Unemployment rates have declined steadily from 24.3 percent in 1993 to 9.8 percent in 2004. In addition, poverty levels are low and the well-developed social security safety net is available to those who need assistance.

This healthy national economic situation belies the pressure, real or perceived, on adults and youth to acquire or own the latest 'brand' or 'in' item and look. The items may include the ubiquitous mobile telephone, a particular motor vehicle, designer clothes, sunshades and other accessories, or a house. This culture of materialism, diffused as it appears to be through the media (television and music videos) and travel, presents enormous challenges for social and behavioural change programmes as it has effectively changed traditional values and cultural norms. One effect of this trend is that it places already vulnerable individuals at even higher risk of physical and psychological abuse and more as they attempt to achieve the 'in' item or look.

In this context, programmes like the NAP are challenged in at least two ways. First, they need to make individuals conscious of potential risks associated with this culture of materialism. Second, they must attempt to create opportunities for the economic empowerment of individuals, including PWHIV. While it is not the role of a national HIV/AIDS programme to provide job skills training or to create jobs or employment opportunities, the NAP can be strategic in assisting individuals and groups to link to organizations and programmes that do. Further, the NAP can support, facilitate and encourage the placement of HIV prevention components in existing job skills training or employment programmes.

Legal and Regulatory Issues

The legal and regulatory framework and whether it contributes to sexual behaviours also should be considered in understanding the context in which sex and sexual practices and behaviours take place in Barbados. The state's protection of the young person from sexual abuse is enshrined in law and in the Constitution. Barbados also is a signatory of the Convention in the Rights of the Child which protects children from sexual harm and guarantees them access to accurate sexual and reproductive health information and services. Under the law, a young man or woman in Barbados can legally consent to participate in sexual relations if he or she is 16 years or older. Notwithstanding this legal requirement, several females younger than 16 years deliver babies at the Queen Elizabeth Hospital (QEH). The median age at first sexual intercourse reported from the recent Secondary School Behaviour Surveillance Survey (SSBSS)

[19] The National Strategic Plan of Barbados 2005-2025. June 2005, Draft. Research and Planning Unit , Economic Affairs Division. Ministry of Finance and Economic Affairs. Pp 11, 12.

is 13 years[20]. These two items of data provide evidence that the laws that protect the rights of children are not being enforced. The questions are whether youth and adults are aware of the law and its penalties and, if they are, to what extent are they compelled, or not, to recognize it. The programme is challenged to understand the social and cultural underpinnings, patterns and reasons for child sexual abuse and its role in controlling, or not, the incidence of HIV infection.

Under law, the young person at 16 years can legally consent to sexual activity but cannot access the services needed to prevent STI including HIV (testing, condoms), pregnancy or other health conditions without parental consent unless she has been emancipated. Giving birth to a child is one of the conditions that may emancipate the female minor. The anomalies in the age of consent to sexual relations and the age of majority (marriage, voting, medical procedures) need to be rationalized and addressed if the NAP is to provide or create an environment that enables and supports help and health seeking, among other positive preventative behaviours, among youth in particular.[21]

Parenting

Parenting practices and daily routines are known to be important factors in a child's social, physical and cognitive development[22]. There is also evidence of the value that having familiar patterns and rituals provide children, especially young children, with the security of knowing what to expect, and help build their sense of identity and responsibility[23]. In fact, there is compelling evidence that parents can positively influence the sexual and other health behavioural outcomes for adolescents and youth[24].

It has been observed, however, that:

> "Parents often assume the task of parenting without fully understanding and appreciating the significance of the role they must play in their children's lives …. A number of parents have had to assume this role before they are emotionally or psychologically ready, and many who believe they are ready are affected in the performance of their role by the many environmental factors which make the complex task of nurturing and caring extremely difficult"[25]

Given the importance of parents and effective parenting for values and attitudes formation, children's healthy development and healthy sexual and other health outcomes, the NAP should

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[20] Report on the Barbados Secondary School Behavioural Surveillance Survey, 2003/2004.

[21] The recent experience of Jamaica in approving guidelines for the provision of services, including contraceptives, to minors is worth noting and may provide important lessons.

[22] Young,KT, et al. 1998. Listening to parents. *Archives of Pediatric Adolescent Medicine 152:225-262.*

[23] Parenting practices that shape the lives of young children. May 2005. L.A.Health. County of Los Angeles, Department of Health Services. www.lapublichealth.org/

[24] Blum, Robert. Presentation to WHO Technical Consultation to Review Interventions to Support the Parents of Adolescents. Chevannes de Bogis, Geneva. October 2006.

[25] Elsa Leo-Rhynie. June 2006. Foreword. Parenting Pathways: A Caribbean Approach. Parenting Partners Caribbean.

continue to place emphasis on parenting. The programme for parents should be designed to encourage and enable effective parenting by providing skills, knowledge and social supports. Parents, role models and mentors might also be considered as a sub-component of a child/youth development intervention. Examples of effective parenting programmes in the region are available and should be studied carefully.

Music

The cultural and social norms in relation to sexuality and sexual expression, and interpersonal relationships of Barbadians, like many others globally, are constantly being influenced and re-shaped by the media, in particular television, music video and video games. Add the music DJ to the list of persons who influence youth culture in Barbados. The global electronic media is available and easily accessible to Barbadians. Although no specific data were available during the consultation on youth exposure to media, youth are reported to spend several hours each day watching cable television, surfing the internet and watching music videos of local, regional and international singers and entertainers. Besides this exposure, youth who attend popular night clubs and other entertainment venues are exposed to the influences of the music DJs.

The power of media influence has a number of immediate implications for the BCC efforts of the NHAC. First, the communication approaches and materials used by the NHAC in its BCC efforts must be as 'attractive' and 'appealing' to the designed audiences as those on the public media if the NHAC is to compete successfully with them. Second, the placement of the materials – for maximum reach and penetration, given cost – must be carefully thought out. Third, the power of the DJs as values influencers must be considered.

The importance and value of high-quality media research data is undeniable. Such data are currently collected by at least two private sector research consulting agencies in Barbados. The NHAC should avail itself of these reports and explore the possibility of using these surveys as omnibus opportunities, as well. It is essential to understanding the role of media as well as informing decisions about use of media and placement of communication material.

B: Influence Planning and Implementing Behaviour Change/ Development Interventions

1. Changing fertility norms - Lessons from the past:

Barbados has a rich history of successful social transformation in the area of sexual and reproductive health. In the period 1950-1990 Barbados was able to achieve replacement fertility levels though a broad-based pregnancy prevention programme that was modeled by several other countries. Through strong community outreach, education, increased access to services and government commitment to the benefits for the nation of fertility decline, the programme was able to move fertility rates from an average of 6 children per couple (in the 1940s) to 2 per couple (in the 1980s).

The success of the national family planning programme during that period can be attributed to a number of national, community, family and individual factors. First, Barbados is a small island state that, given its topography, allowed easy access to residents across the country.

Community outreach by committed educators and advocates thrived in this environment. The scope for inter-personal communication and interaction was therefore enormous. Second, Barbados had a very literate population for whom the rewards of fertility reduction were judged to be attractive. This was especially so for those woman who, by way of fewer children, could themselves transition from working class to middle class. Secondary education offered them, and their children, the real possibilities of lessening dependence on men for their economic and social survival. Third, the effective contraceptive methods available (notably the pill) could be discretely used by women without their partners' knowledge.

2. Proximate determinants – Delayed age of marriage (delayed sexual initiation):
The proximate determinants model of fertility reduction includes five factors[26] that, taken together, will help countries achieve their desired fertility goals. Each of the five factors has a differential contribution to the model. One of the most significant factors, however, is age of marriage – or in the Caribbean context where sex and marriage are mutually exclusive – age at sexual initiation.

The health and social advantages – for the individual and the community/ country respectively – of delaying first sexual intercourse (marriage) are enormous. The international literature provides clear evidence of the link between late age of sexual initiation (marriage) and reduced fertility, use of modern contraception at sexual initiation, and fewer lifetime sexual partners. By extension, there should be reduced rates of HPV and cervical cancer – a major advantage for the Caribbean region where cervical cancer rates are high and, in part, attributed to early sexual initiation and the related consequence on the number of sexual partners over a women's lifetime.

3. Principles of disease transmission and prevention:
In basic public health practice, the standard approach to reducing disease transmission is to eliminate the vector. In the case of HIV transmission in communities where transmission is via sexual activity, it is only individuals who have the virus who have the potential to transmit it. On this basis, effective ways to eliminate HIV infection would be to a) eliminate the infected person (an option that is neither ethically nor morally acceptable); b) restrict the infected persons' sexual contacts and ensure that he or she always uses prophylaxis during sexual intercourse (this option is likely to be seen as infringement on the rights of the individual), or c) to ensure that others do not come into intimate contact with the infected person (an option which would fuel the already high levels of stigmatisation of PWHIV.

Given the difficulty in implementing any of these options, the most effective approach to HIV prevention may be to attempt to delay sexual debut for young people and promote monogamy and fidelity. The advantages of such an approach are documented. The international social science literature indicates that delayed sexual initiation has positive health and social benefits for the individual and the society. Young persons who delay their sexual debut are more likely

[26] Bongaarts, J and Potter R. 1983. *Fertility, biology and behaviour: An analysis of the proximate determinants.* Academic Press.

than those who do not to use protection at first intercourse, to have fewer lifetime sexual partners, and have reduced risk of sexually transmitted infections.

For reasons associated with sex and sexuality and the related social, cultural, moral and religious values that govern them, managing the spread of HIV where it is sexually transmitted is not only different to general public health practice, it is difficult. Sexual delay until marriage or the attainment of the 'age of majority' is not always achievable. The option of consistent condom use, especially in relationships in which partners are not exclusive or are discordant, is required to control the spread of the virus. Mutual monogamy should also be actively promoted.

4. Promoting Healthy Living

Barbados' documented experiences with the healthy living and lifestyle initiatives in the private and public sectors[27] are relatively recent. Nonetheless, they provide important insights into the value Barbadians place on good health and longevity. These insights can be applied to HIV prevention efforts. If nothing else, they indicate the desire of a cross-section of the society to invest in healthy living – paying attention to healthy eating, exercise and the adoption of preventive practices.

Summary

A number of key lessons on how to approach BCC for HIV prevention can be learned from several contexts both local and international such as the proximate determinants literature, basic public health principles of disease transmission, Barbados' recent experiences with healthy living initiatives and her historic success with social transformation of the population structure in the 20th century. The lessons include:

- **The intrinsic positive value of interpersonal communication and outreach at the community level in effecting and sustaining behaviour change/development**. The role of well-trained, committed and credible community outreach workers, peer counselors and other behaviour change communicators could be significant in the HIV behaviour change effort.

- **The important, even central, roles of women to effect shifts in the epidemics**. These revolve around: women as mothers protecting children from sexual abuse and advocating for enforcement of child protection laws; mothers as partners who, uncompromisingly and collectively, demand monogamy or condom use; and women as mothers acting as positive role models and mentors for their children – male and female.

- **Promoting the physical and psychological health benefits (for the individual) of adopting desireable new behaviours. These measures are important,** whether they are

[27] These include the Health Lifestyle programme of the Nation [Keep Fit, Be Fit] which builds on their annual 'fun run' and 'walkathons'; Barbados National Bank's Wellness programme launched in September 2006; the Government of Barbados' Life Education Centre initiative launched in 2006; and the new thrust of the Ministry of Education to eliminate the sale of 'junk food' to primary school children.

having fewer sexual partners, consistently using condoms or testing to know one's HIV status. While considering the value that especially men place on sexual performance and prowess, additional measures are promoting safe sexual behaviours (monogamy) as a means of extending sexual lives, and safeguarding sexual performance by being a responsible, and a good financial, sexual and affective partner'[28]).

- **Easy access to services.** Enabling access to service (whether reducing physical distance to services, making services user friendly and providers competent, creating stigma-free service and education environments, or establishing efficient referral systems) should increase use of services and assist individuals to adopt and continue newly-adopted positive behaviours.

- **The perceived personal benefit (economic, psychological, emotional) in the short and long term of using the new technologies/ services**. This lesson is consistent with the health belief conceptual model of health behaviour[29]. It has been referred to as the Exchange Theory[30] and it should be used to identify incentives for motivating adoption of the preventive behaviours.

- **Accepting that sexual abstinence is the only true means to reduce the spread of HIV** and enabling those men, women or youth who choose to delay sexual debut or to practice temporary celibacy/abstinence to do so effectively and unashamedly.

- **Delaying the age of sexual debut has important positive implications** for use of protection at first sexual intercourse, reduced likelihood of STI/HIV infection, fewer lifetime sexual partners, and reduced likelihood of cervical cancer.

V. THE STRATEGY

A. Suggested Overall Strategic Focus of the BCC Programme

Given that unprotected sexual intercourse is the predominant route of HIV transmission in Barbados, the goals of BCC efforts should be two-fold: a shorter-term goal to:

1: Positively affect the current epidemics by seeking to:
   - Reduce HIV primary infection rates among persons who are sexually active through use of HIV testing, partner reduction, the correct and consistent use of condoms until the couple's mutual monogamy is established, and promotion of safe intimacy alternatives;
   - Reduce re-infection rates among PWHIV through the correct and consistent use of condoms and other safer sexual behaviours; and

[28] Guerriero. Nov 2004. op cit.
[29] Strecher, VJ and Rosenstock, IM. The health belief model. In: Glanz K, Lewis, FM and Rimer BK. Health Behaviour and Health Education: Theory, Research and Practice. Jossey-Bass. 2000.
[30] Russell-Brown, PA. Conceptual framework for

- Increase survival rates for PWHIV through use of testing/diagnostic services, adherence to treatment regimes, healthy living, and the correct and consistent use of condoms and other safer sexual behaviours, including intimacy alternatives.

And a longer term goal to:
2: Influence future disease (HIV/STI) trends by changing social norms about the timing of first sexual intercourse and gender norms associated with sexual partnering and condom use – two basic requirements for HIV/STI prevention.

- Increase the proportion of persons who choose to delay sexual debut or make a deliberate decision to adopt 'secondary abstinence'.

Persons with special needs – the hearing impaired, blind, and persons with mental and physical disabilities are often a 'hidden group' – not necessarily reached by broad-based HIV prevention programmes. They are as much, or more, in need of attention as any other group. One very common perception is that persons with disabilities, whether physical, sensory (deafness and blindness) or intellectual, are sexually inactive (Russo, 2000; Fine & Asch, 1988). Available research does not support this perception, however. Studies of youth in Vietnam showed that youth with disabilities are as sexually active as their non-disabled peers (Hang, 2003). In addition, a recent global survey of 57 countries established that HIV/AIDS represents a significant threat to disabled people around the world, at rates often significantly higher than found in the general public (Groce, 2004). But, individuals with disabilities are often not included in most AIDS outreach efforts.

Barbados is an exception. The disabilities sector is well organized and the NHAC is a step ahead on the matter of support for the National Disabilities Unit to carry out HIV prevention work[31]. Therefore, it should be relatively easy for the sector to be included in this new BCC strategy. In that way, persons with special needs and disabilities and their representatives would benefit from capacity building initiatives and related technical assistance offered by the NHAC. They and their representatives also would be involved in the planning and targeting of BCC interventions and initiatives using the approach agreed on by the NHAC.

B. Conceptual Framework

Several conceptual approaches have been applied to HIV prevention work in the region and internationally. While they may differ in the specifics, they generally are similar in asserting that sexual behaviours of the individual are influenced by individual factors as well as external social and cultural factors. External factors (determinants) may vary depending on the age of the individual, his/her social class, physical development, need for attention or love, desire for money, educational attainment, sexual attitudes and values, and locus of control. As an example, for adolescents and youth who are not sexually active, the international resilience literature indicates that connectedness to caring and loving adults (parents or surrogate parents) who articulate clear goals and expectations, communicate with the young person, value education and who provide the young person with responsibilities and structure (boundaries

[31] World Bank Report. Draft 2006.

for conduct are well defined) are factors that contribute to the young person delaying sexual debut, not using drugs and not engaging in violent behaviours[32],[33]. As previously indicated, compelling evidence demonstrates that parents can positively influence the sexual and other health behavioural outcomes for adolescents and youth[34].

Individuals (youth or adults) who are sexually active are motivated by a number of factors – personal and external - to engage in sexual activity. Included among the important external factors are peer influence, societal norms and definitions of masculinity and femininity and gender relationships, partners' desire for children, partners' attitudes to condom and condom use, and desire to please one's partner. These factors may also influence whether the individual has protected or unprotected sexual relations, or has multiple concurrent sexual relationships. Given that the factors influencing sexual behaviour (and by extension health outcomes) may be different for each group to be targeted by NHAC for BCC intervention, the NHAC needs to adopt a process that enables it to identify the problem to be addressed for the specific target/vulnerable group, the behaviour(s) of interest for each problem identified and the related and important determinants. At the end of the process, NHAC will be able to identify interventions, including essential communication components, which will assure achievement of the goal of reduced incidence of HIV.

The suggested conceptual framework, Figure 2, provides the following guidance for the NHAC in implementing the BCC strategy. The national programme using appropriate communication methods (mass media, interpersonal) will aim to achieve two objectives simultaneously - change the knowledge, skills, attitudes and perceptions of individual Barbadians related to HIV prevention and create supportive social, cultural, service and policy environments for the respective individual. Much of the work of the NAP to date has been to achieve those objectives.

Even as the programme consolidates achievements in these areas, it must seek to move the individual who knows and is informed about HIV and related issues to become convinced of the value of the new prevention behaviours. The individual who is informed and convinced of the value of the desired behaviour(s) will, in the context of a supportive social, cultural and policy environment, and appropriate communication inputs, be motivated to adopt the behaviours. In time, as that individual can be convinced of the personal short and long term benefits of the new behaviour(s) and supported by the service and policy as well as social and cultural environments, that individual will maintain the behaviours. In the long term, the programme will achieve the four goals: i) reduction of HIV primary infection rates among

[32] Scott-Fisher, K and Campbell-Forrester, S. 2000. Resiliency factors in Jamaican adolescents. Pan American Health Organization (PAHO): Caribbean Sub-region.
[33] Benard, B and Marshall, K. 2001. Protective factors in individuals, families and schools: national longitudinal study on adolescent health findings. National Resilience Resource Center, University of Minnesota, Minneapolis and the Center for the Application of Prevention Technologies.
[34] Blum, Robert. Presentation to WHO Technical Consultation to Review Interventions to Support the Parents of Adolescents. Chevannes de Bogis, Geneva. October 2006.

persons who are sexually active; ii) reduction of re-infection rates among PWHIV through the correct and consistent use of condoms and other safer sexual behaviours; and iii) increase in survival rates for PWHIV; and iv) increase in proportion of persons who choose to delay sexual debut or make a deliberate decision to adopt 'secondary abstinence'.

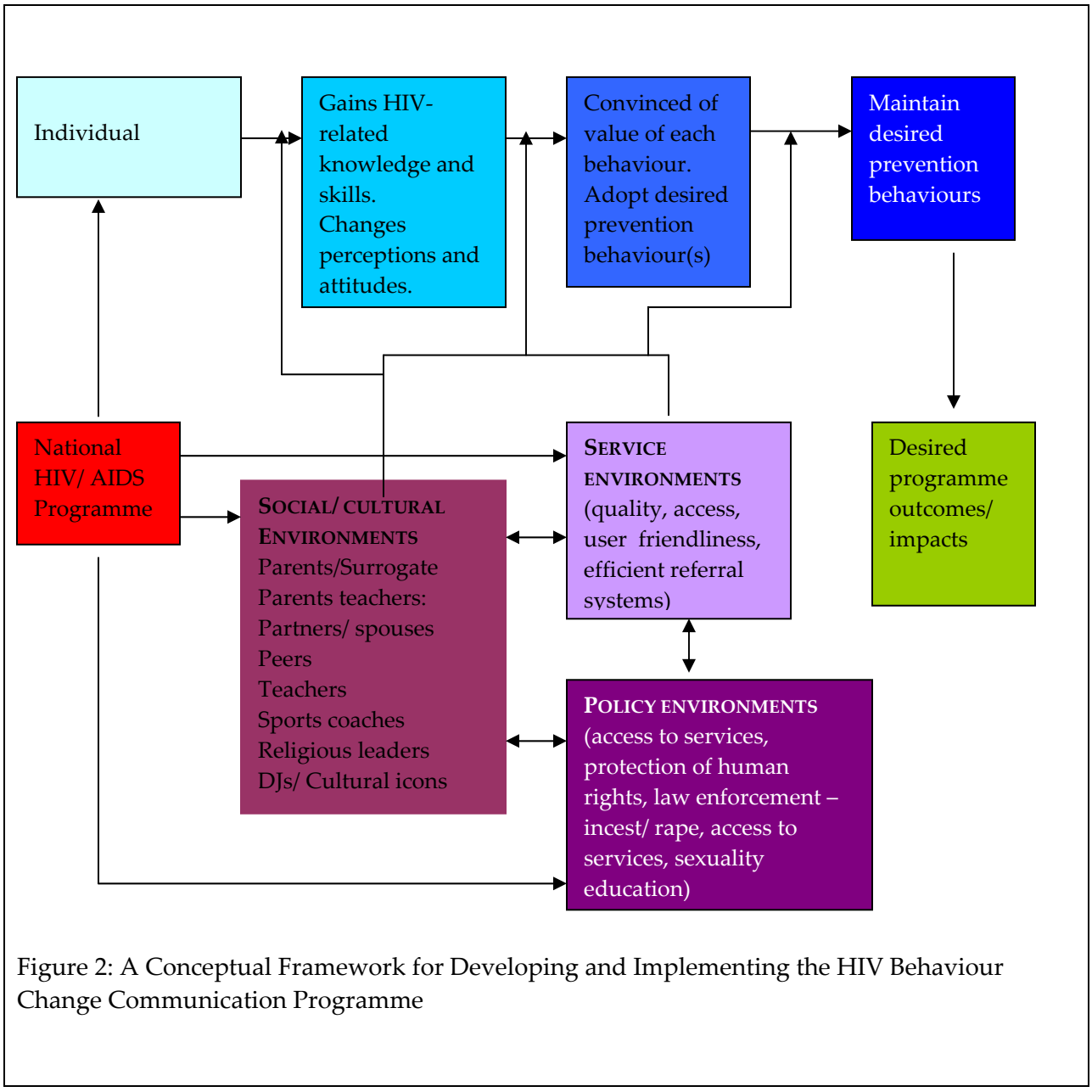

Figure 2: A Conceptual Framework for Developing and Implementing the HIV Behaviour Change Communication Programme

C. Guiding Principles of the Strategy

Based on theoretical frameworks developed and what is known about behaviour and behaviour development and change, the BCC strategy should allow for:

1. The introduction of interventions that are:
   - Multi-level – i.e. interventions directed to influence the individual while ensuring an 'environment' that enables and supports the individual to maintain the new behaviour. 'Environment' will vary depending on the vulnerable group of interest and may include the policy, programme and personal environments.
   - Theory-based – use behaviour and other theory to help to inform the design and evaluation of BCC interventions.
   - Culturally sensitive - take account of the social norms in relation to sexual behaviour (timing of first sex, sexual partnering, serial monogamy, etc.) issues, social relationships, health beliefs, information sharing and communication, and others that are unique to Barbados, in identifying intervention approaches and activities. Use communication approaches and methods that are culturally appropriate.
   - Focussed on 'protective factors' (rather than only on 'risk factors').
   - Gender sensitive and gender specific language, content and planning approach.

2 Analysis and strengthening of existing BCC interventions based on criteria listed above. A specific example is the Project ACISS. (See Attachment 2).

3 Application of an intervention planning approach that starts with the goal and follows a step-wise process that allows for the identification and prioritisation of the behaviours of interest, determinants of the behaviour(s) of interest, and the selection of intervention approaches and activities that are culturally, socially, politically and economically and technically feasible[35].

4 Training of all partners in the multi-sectoral HIV/AIDS response in the use of the agreed behaviour change intervention planning approach and involving them in the process to develop and implement BCC interventions.

5 Selection and use of communication approaches and elements that are culturally appropriate, targeted and shown to be effective – for example interpersonal methods for youth and adults, mobile telephone technology to reach youth, puppets for pre adolescents, etc.

6 Coordination mechanism: Implementation of a mechanism to coordinate BCC plans and communication contents. Lack of coordination between partners can lead to contradiction in communication messages.

7 Inclusion of strong monitoring and evaluation components into each intervention or programme.

[35] Russell-Brown, P. 2003. Behaviour Change Interventions for Sexual Health Promotion: A Manual. CAREC.

8 Basic research [decision-making - youth, condom use dynamics (age groups and relationships), health beliefs re testing, etc.].

9 The participation and involvement of individuals from the respective community and communities of interest in planning, designing, implementation, monitoring and evaluation.

10 Mechanisms that help to create links and assure continuity of intervention themes across the lifecycle. that target individuals at different stages of the lifecycle.

D. Applying the conceptual framework

The following are examples of how the proposed conceptual framework might be operationalised for four priority groups identified in Figure 1. A fifth example of an intervention – one that specifically targets young men - is added. Conceptually, each of these examples may be applied to persons with disabilities. In any event, the suggested content and material in each example should be modified, based on data, evidence and needs, for the specific group.

Example 1: Pre adolescents (School-based intervention for basic and primary school students)[36]

Suggested Intervention: An intervention that targets the child to build self esteem as it targets the teachers to develop skills to develop and use new methods of teaching and the parents to improve knowledge and skills in child development and parenting.

Goal: Age of sexual debut delayed
Indicator: Age of sexual debut delayed by six months. /Proportion of youth who delay sexual debut increased.

Objectives:
1. build self esteem and resilience as a means of delaying the timing of sexual debut;
2. increase knowledge and skills to make healthy decisions about relationships, sex, drugs, etc.

Theoretical bases: Constructs drawn from Social Learning Theory, Health Belief Model and Diffusion of Innovation Theory. The latter is focused on getting buy-in from all schools by Year 3 of the strategy.

Communication elements: Interpersonal communication (teachers and students; parents and children). Media (material developed by teachers; workbooks for students; music, games, songs, puppets, etc.)

Evaluation: Requires longitudinal research (annual measurements) to track skills, attitudes and behaviours of students exposed to the interventions.

Influencers	Suggested Content	Method(s)	Indicators of Success
Teachers	Enable instructors to use interactive, culturally relevant methods to teach the existing curriculum and the HFLE curriculum	Seminar/ workshop training/ re-orientation for teachers Technical assistance to develop culturally- and age-appropriate communication – games, songs, puppets, and other teaching tools and materials	Teacher uses the methods appropriately Teacher motivated to develop new material
Parents	Parenting education: boundary setting/ discipline/ sexuality/ child & adolescent dev/ incest/ gender socialization/parents as models/ advocacy.	Seminars/ workshops using participatory and interactive methods. Ensuring that themes in parent education are linked to the content of students' programme.	Self reported change in parenting knowledge, attitudes and practices. Parent attendance at parent teacher conferences increase.

[36] Similar intervention implemented in Jamaica (2001-2004), Youth.now project (Futures Group/USAID)

Example 2: Married persons/ persons in committed relationships (Faith-based intervention)

Suggested Intervention: Intervention for heterosexual 'couples' that empower women and men (separately and together) through seminars, and same- and mixed-gender support groups.

Objective: Develop/improve couple communication generally and specifically about sex and sexual expression as a means of assuring the practice of safe sex (monogamy or condom use) – include alternatives to penetrative sex, intimacy alternatives, value of foreplay, etc.

Theoretical bases: Constructs drawn from Stages of Change Theory and Social Learning Theory.

Communication elements: Interpersonal communication (counselors and couples/individual partners; partner to partner); diaries; media (educational material developed for couples; games couples can play together; public education campaign); marketing support group.

Evaluation: Surveys and self/ couple evaluation using targets set by couples.

Influencers	Suggested Content	Methods	Indicators of Success
Partner and Peers	▪ Communication in a relationship (Communicating sexual feelings and needs) ▪ Masculinity/ femininity ▪ Sexual fidelity ▪ Trust ▪ Setting boundaries in your relationship ▪ Sexuality and marriage ▪ Sexuality across the life span ▪ Intimacy alternatives ▪ HIV Testing – 'Know your status' ▪ Remaining healthy after the test	o Seminar series o Guided self reflection o Support groups for men and women o Support groups for couples o Provision of individual and group counseling (marriage/ pre and post HIV testing) Public education campaign on couple communication/ about sex and sexual relations (using edutainment/ process drama)	Increased number of couples who register/ complete the programme Proportion of couples who achieve xx percent (to be determined) of their targets in the required time Proportion of couples who remain (do not regress) after x year/ month
Counselors	Communication in marriage	▪ Seminar (refresher course) ▪ Self reflection	

Example 3: Project ACISS (High school-based intervention) – See Attachment 2

Example 4: Persons newly diagnosed HIV+ (Community-based/ NGO agency-based)

Suggested Approach: Empowerment of persons newly diagnosed as HIV+ to seek care, support and treatment in a timely manner, to accept family and partner support, and to deal with community rejection/acceptance.

Objective: To reduce the interval between HIV diagnosis and arrival for counseling and treatment services for men and women newly diagnosed with HIV.

Theoretical bases: Constructs drawn from Stages of Change Theory, Social Learning Theory and Natural Helper Model (self-help/ support group).

Communication elements: Interpersonal communication (professional counselors and PWHIV; peer educators and PWHIV; community outreach); mass media (TV/ radio – stigma and discrimination campaign; educational material on recommended post-HIV test behaviours and actions developed for public and PWHIV)

Evaluation: Data from logs of professional counselors, peer counselors & outreach workers.

Influencers	Suggested Content	Methods	Indicators of Success
Partner	Providing social support to PWHIV (treatment compliance/adherence, social acceptance, etc.) Safer sexual practices	One-on-one education and counseling Role play Support group (Partners of PWHIV)	Qualitative measures – partners' valuing of group support and counseling
Parent/ family member	▪ As indicated ▪ Providing social support to PWHIV (treatment compliance/adherence, social acceptance, etc.) ▪ Living with a PWHIV	Outreach to home. One-on-one education and counseling Role play Edutainment/drama Support group (Parents of PWHIV)	Qualitative measures
PWHIV	HIV infection/reinfection Safer sexual practices Testing (cd4, etc.) Healthy living as a PWHIV (good nutrition, exercise, social interaction, etc.) Treatment (drugs, side effects, adherence and compliance, etc.) Coping with stigma	Counseling One on one education Print material Support group	Testing as recommended (Yes/No) Accept ARV treatment (Yes/No) Consistently meets adherence standards (Yes/No)

Example 5: Young men 15-17 years (School-based or community club-based) [37]

Suggested Approach: Use physical education teachers and sports coaches to educate and influence for safe sexual behaviour adoption.

Objectives:

- Increase awareness of HIV status
- Increase ability/skill to successfully negotiate safe sex behaviours (no sex/intimacy alternatives, condom use)
- Assure correct and consistent use of condom

Theoretical bases: Constructs drawn from Social Learning Theory, Stages of Change Theory and the Natural Helpers Model. Diffusion of Innovation theory (to support scaling up of the intervention).

Communication elements: Interpersonal communication (sports coaches, physical education teachers with youth; youth to youth; parent to youth/ youth to parent); mass media (TV/ radio - men's campaign); educational material

Evaluation:

Influencers	Suggested Content	Methods	Indicators of Success
Physical education teacher/sports coach	Training for PE teachers/coaches to include: ▪ Law and sex/sexual abuse ▪ SRH incl HIV and AIDS	Seminars Role play Video/ process drama	Number of sessions conducted Number of referrals for testing
Parents	Parenting the male child Special needs (physical, emotional, psychological, spiritual) of the boy child at adolescence, early adulthood. Gender socialisation Building self esteem/resilience	▪ Special seminar series ▪ Edutainment/ process drama ▪ One activity per term to encourage healthy parent/ child relationship ▪ Joint parent/child workshops	Qualitative pre and post self assessments Quality of communication between child and parent(s). Number of joint activities initiated by parent/ child completed
Peers	▪ Nutrition and sports; Drugs and sports; Sex and sports ▪ On being a man/Masculinity ▪ Saying no to sex/drugs ▪ Peer support – what is it? How to provide it!	Create triads/support networks Skill sharing in peer groups	HIV knowledge Condom use skill (demonstrated)

[37] Intervention model draws on experiences from Jamaica (Implemented by Whole Life Ministries with support from Futures Group/USAID) and Trinidad and Tobago (Implemented by Family Planning Association of Trinidad and Tobago – FPATT)

VI. IMPLEMENTING THE BCC STRATEGY

A. Implementation approach

The assumption is that NHAC and partners will continue to adopt a multi-sectoral and multi-disciplinary approach as they implement this BCC strategy. NHAC should take the lead to:

- Outline the BCC planning approach to be used and how that approach will become institutionalised.
- Train partners/partner agencies to use the BCC planning approach.
- Guide development of BCC intervention plans ensuring a good fit with the BCC strategy and agreed BCC planning approach
- Develop tools for reviewing existing interventions to decide on their potential to be scaled up.
- Guide partner agencies in developing M&E plans ensuring that they are in synch with national M&E plan.
- Mobilise and engage the support needed to strengthen the interpersonal communication components of BCC interventions (NGOs, PTAs, other government divisions and agencies) and monitor their capacity to deliver the desired quality.
- Monitor and evaluate the overall strategy. In this regard, the BCC Specialist will develop annual work plans that include clearly defined M&E targets (and indicators) for the strategy.

B. Critical Human Resource Needs

The proposed strategy will be implemented by the NHAC and partners. In February 2007 the technical resources of the NHAC were strengthened with the confirmation of the BCC Specialist in the position. This confirmation should significantly enhance the NHAC's ability to provide technical guidance and direction in BCC to partners and the programme in general.

Given the scope of the strategy and the extent of the epidemics, the NHAC needs to set this BCC strategy in process in as timely a manner as possible. Ideally, the NHAC would need a BCC team that includes the BCC Specialist, and three others - a Senior Behaviour Change Officer (Communication Specialist); and two junior Behaviour Change Officers, one to be responsible for edutainment/drama specialist and the other for advocacy. If resources are limited, the recommendation would be to forego one of the junior Behaviour Change Officers (advocacy). Some of the advocacy tasks could be assumed by the current BCC Specialist.

To strengthen community outreach and interpersonal activities, every effort should be made to hire community outreach officers (in partner organizations) or to build their capacity to effectively deliver HIV prevention communication. It is strongly recommended that a full-time coordinator is hired to manage Project ACISS and other school-based initiatives. The strategic mobilization of partners in the NGO and private sectors will assist the NHAC and partners to strengthen the human resource base required to deliver interventions that have strong

interpersonal communication components. Draft Position Descriptions for the proposed positions are attached.

It is anticipated that periodically the NHAC may need to hire technical assistance from outside of the NHAC to strengthen the BCC efforts. Scope of work/Terms of Reference would be developed by the BCC Specialist and her team as needed.

C. Time Line

The proposed strategy will be run for five years – from 2007 to 2012. As shown in Table 1, the proposed focus of the first year of the strategy would be on three areas: i) capacity building at the NHAC as well as in partner organisations and agencies; ii) developing and implementing targeted BCC interventions; and iii) review and strengthen existing interventions that show promise and meet criteria to be developed by the NHAC.

The objective of the capacity building at the NHAC would be to ensure that the NHAC has the capacity to guide and direct the BCC efforts of the programme. The objective of capacity building in partner agencies should be to enable each agency to identify needs, and to plan BCC interventions using the format to be approved by the NHAC.

Capacity building efforts in partner agencies is expected to generate ideas and proposals for new BCC interventions as well as plans to strengthen or expand existing interventions. In collaboration with the partner agency, the NHAC would review the proposed BCC intervention plans, and support revisions of the plan and its implementation. The NHAC may be best served if it worked first with agencies that have a demonstrated capacity to do the work and leave other less able agencies for later when they can receive more focused attention and inputs. The advantage of such an approach is that implementation of new BCC interventions could begin in Year 1 of the strategy period.

Programme effort in Year 1 also should focus on identifying (and scaling up) existing interventions (or intervention elements) that seem promising. An appropriate assessment/evaluation tool should be developed by the BCC Specialist for use in this process. Interventions (intervention elements) identified in this process as successful, or potentially so, should be scaled up and provided with the appropriate support to enhance their survivability.

During the November 2006 consultations, stakeholders identified the need for research that provides empirical evidence for future intervention planning. During Year 1, the NHAC should consider convening a task force or working group to identify research needs and gaps. Possible approaches to completing the research agenda could be to (i) commission research studies, including media use and effect research (through local consultants); (ii) provide incentives/support to master-level student research at Cave Hill or other campus of the UWI; and buy time/ space in on-going research (Omnibus surveys).

Finally, a Monitoring and Evaluation (M&E) plan for each BCC intervention that is consistent with the targets of the M&E plan for the strategy and the national programme should be developed and implemented in Year 1. Putting this plan in place should enable the generation and availability of accurate data on the progress of each BCC intervention during strategy Year 1 and beyond.

In Year 2 of the strategy, the NHAC should continue its capacity-building efforts as well as the intervention development and implementation. The suggestion is that Year 3 should be devoted to implementing new interventions (if necessary) and to monitoring/evaluating each of the interventions implemented up to that time. As new issues emerge, new intervention may be required. Those new interventions could be introduced in Year 4.

Monitoring of specific interventions would be continuous/on-going activities across the life of the strategy. Evaluation of specific interventions would be scheduled as necessary. The NHAC would provide technical guidance to partner agencies to develop M&E plans for their interventions and the necessary tools for completing the M&E. This M&E data will be crucial in guiding decisions about scaling up the interventions (or intervention elements) that are successful. Scaling up of the new interventions implemented under this strategy may start as early as Year 3.

The plan for monitoring and evaluating the BCC strategy, with specific targets and data sources, will be developed by the BCC Specialist. This plan must be consistent with the M&E plan for the national programme.

Table 1: Suggested Schedule of Activities (2007-2012)

Activity	Year				
	1	2	3	4	5
Review and approve BCC strategy	x				
Recruit new BCC staff	x				
Capacity Building					
Build capacity in BCC in partner agencies	X	x	X		
Partner organizations develop targeted BCC intervention(s)	x	x		x	
Implementation					
Implement new targeted intervention(s)	X	x	X	x	
Strengthen existing intervention(s)	X				
Scale up existing interventions	X				
Scale up/roll out successful interventions			X	x	x
Research					
Identify specific research needs/gaps	X				
Commission anthropologic and other social science research	x	x			
Research dissemination meetings		x		x	
Monitoring and Evaluation					
Develop M&E plan (indicators, data sources, etc.)	X				
Put M&E plan in place	X	x	X	x	x
Evaluation		x	X		
Dissemination					
Arrange study tours to observe/ share	x	x		x	
NHAC staff participate in regional/ international conferences	x	x	X	x	x

D. Cost

The cost of implementing the first year of this proposed strategy is estimated at BDS $916,000. Costs were estimated on the assumption that eight new staff positions would be supported (one Senior BC Officer, two Junior BC Officers (Edutainment/Advocacy), four Community Outreach Officers (based in partner agencies), one full-time Coordinator (Project ACISS and other school-based interventions). A budget summary for Year 1 is provided in Table 2.

Table 2
Estimated Cost for Year 1 Behaviour Change Communication Strategy

Particulars	Personnel	Other Costs
A. Personnel	277,100	
B. Capacity Building Workshops		41, 276
C. Strengthening Existing Interventions		110,000
▪ Project ACISS		70,000
▪ Abstinence Programme		40,000
D. Develop new interventions		5,000
E. Advocacy		7,784
F. Communication Material Development/ Placement		330,000
G. Research, Evaluation and Dissemination		107,484
H. Communication Costs		5,000
I. Supplies, Furniture and Equipment		32,390
TOTAL	277,100	638,934
	BDS $916,034	

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Attachment 1

Individuals and Agencies Participating in BCC Consultation (Nov 29-Dec 1, 2006)

N=30

Consultations

- Care Barbados (1)
- Entertainment Champions x 3
- Faith-based Community (2)
- Ministry of Health (Team of 5)
- NHAC Youth Committee (1)
- UGLAAB (2)
- UWI HARP (1)
- Youth Development Programme (youth 14-30+)
- Strategic Plan Consultants (4)

Individuals and Groups not Available for November/ December Consultation

N=3

NAP Abstinence Committee (Dr. Vijava Thani and Mrs. Edgehill)

Ministry of Education, Youth and Sports (Mr. Richard Carter, Director, Youth Affairs)

Individuals and Agencies Participating in Second BCC Consultation (January31, 2007)

N=14

- Care Barbados (Ms. Patricia Phillips)
- Ministry of Community Development (Mr. Derek Odle)
- Ministry of Health (Ms. Alexis Nurse).
- NHAC Secretariat (Director Alies Jordan and 4 members of technical team)
- NHAC Youth Committee (Mr. Corey Lane)
- Public Investment Unit of the Ministry of Economic Affairs & Development (Ms. Dale Foster)
- Strategic Plan Consultants (Ms. Jeanette Belle, Ms. Christine Oladimeji, Dr. Beverly Miller)
- UGLAAB (Mr. Robert Best)

Attachment 2

Suggestions for Strengthening the Project ACISS

Description of the Programme:
The programme's mandate is to: reduce HIV and AIDS among youth through influencing policy and activities and developing programmes for youth.

Programme is linked to the school-based awareness clubs – Adolescent Fighting Against AIDS (AFAA). AFAA operates in 30 schools - 23 public schools and seven private secondary schools. The programme targets students in Forms 3-6. Membership tends to include the 'better' students – students most likely to succeed. The group meets weekly.

The programme is modeled on the standard peer education programme in which a group of self-motivated individuals is trained and engaged in education and outreach in their school and other communities. The programme theory of action is that students who are members of AFAA will be able to do HIV/AIDS education and outreach to their peers in and out of school. Members will also influence their peers through their actions as role models.

The programme is coordinated by the Chairman of the Youth Committee of the National HIV/AIDS Commission. Direct support is provided by the Ministry of Education, Youth Affairs and Sports through the Chief Education Officer.

Programme Strengthening:

- Select schools that show promise.
- Work with schools to improve the aspect of their programme that need strengthening.
- Recruit large numbers of students. The new evidence is that the larger the number of students recruited and trained the greater the chance that they will be effective in carrying out their tasks[38].
- Encourage schools to conduct membership drives (once per term). Offer an incentive to members who bring the largest number of new recruits and who remain active for one year.
- Establish links to other clubs in the school. Choose clubs that will enable the communication process for the AFAA and expand AFAA influence in the school (drama club, dance, etc.).
- Include information on VCT in members' prevention education package. Use members to promote VCT – Slogan: 'Know your status'.
- Build in simple M&E components with indicators and targets.
- Add training in basics of VCT, advocacy and fundraising for club members. Train school-leaders in VCT for the workplace.

Resources needed:
- Non-monetary incentives for membership drives

[38] Gayle, H. 2004. Evaluation of peer programme. Youth.now. Futures Group.

- Criteria for recruitment
- Non-monetary incentives for Guidance Counselors (plaques, book tokens, etc. presented at annual event)
- Travel advance for field officer(s)
- Funds to hire 4-5 local consultants (training, motivational talks, selling the programme to principals and guidance counselors, etc.)
- One additional field officer/ community outreach officer (part time)
- Full time coordinator.

Synopsis of ACISS[39]

Emanating from the 1st Caribbean Children's Submit on HIV/AIDS held in Barbados in 2004, a decision was taken and a declaration signed by policy makers and students from across the Caribbean to form HIV/AIDS clubs in schools. Subsequent discussions have led to the decision to form Awareness Clubs In Secondary School (ACISS) to broaden the focus.

The project is now in the pilot phase starting with five schools, Garrison Secondary, Harrison College, Grantley Adams Memorial, Lodge School and St. James Secondary. The pilot phase will focus on:

- Development of students as spokespersons about dangerous activities
- Looking at the pleasures and dangers of music and popular culture
- Establishment of Ambassadors for healthy and positive lifestyles
- Behaviour change communication and realisation
- Other similar programs as approved by the relevant authorities.

It is understood that persons may be brought in for discussions and that information will be disseminated and displayed with the permission of the schools' management (i.e. the principals).

Continuing on from the groundwork that was laid in the five schools that were identified (Garrison Secondary, Harrison College, Grantley Adams Memorial, Lodge School and St. James Secondary) the next step will be to work with the students who have expressed a continuedI interest. A special feature of the mode of operation for this phase will be the introduction of creative projects to attract those influential students and get them on board in a serious way. One of the proposed ideas to do this is through the very popular group dancing. It is my firm belief that this small feature could be very effective.

Some of the proposed activities are as follows:

[39] Summary prepared by Corey Lane of the NHAC Youth Committee

- Learning about the experiences of PLWHA
- Awareness entertainment segments – Drama, Poems, Songs etc
- Interaction with the NHAC and NCSA Champions
- Trips, Tours and visits with other clubs
- Video of effects
- Research
- Parenting, Teachers and Student seminar
- **Other In school awareness projects**

Mode of Operation

Using the time slots allotted to the project by the schools, there will be some visits to fine tune plans. Execution of project items will then take place on a systematic basis. Each school is expected to put on an average total of 10 items before exam period to be monitored and evaluated. Therefore, this phase will be:

- Implementation of projects
- Clubs working fully as clubs
- Monitoring
- Evaluation

By the end of this phase a final report should be drawn up, as should be a final proposal for implementation across the secondary school system. That final proposal would include a proposed framework, structure and an implementation plan.

- Phase 1, Phase 2 and the input of these meetings helped to shape the type of projects the schools would adapt in accordance to the culture and atmosphere of the school environment.
- The project was aimed at reaching the core of the problems identified in previous phases as it related to behaviours. To go deeper toward the core, there was a project designed for parents but unfortunately it was not implemented this time around. Interestingly enough, analysis of the information gathered in the two previous phases highlighted the fact that reaching parents would have been an effective approach but this was the only one of the 15 proposed projects not to be selected in the final selection process. This speaks to the need for and lack of cooperation between our school's stake holders.
- Attached – List of projects by school

Note: The final report will encompass all phases. It will examine the variables, indicators and results and a final proposal for implementation across the secondary school system. That final proposal would include a proposed framework, structure and an implementation plan.

Chart of Progress thus far:

Objectives	**Progress Status**
Development of students as spokespersons about dangerous activities	Ongoing
A look at the pleasures and dangers of music and popular culture	Ongoing
Establishment of Ambassadors for a healthy lifestyle	Ongoing
Behaviour change communication and realization	Ongoing
Learning about the experiences of PLWHA	Ongoing
Awareness entertainment segments – Drama, Poems, Songs etc	Satisfactory
Interaction with the NHAC and NCSA Champions	Incomplete
Trips, tours and visits with other clubs	Ongoing
Video of effects	Ongoing
Research	Ongoing
Parenting, Teachers and Student seminars	Incomplete
Implementation of projects	Satisfactory
Clubs working fully as clubs	Completed
Monitoring	Ongoing
Evaluation	Ongoing
Distribution of packages	Incomplete
Training and sensitization of students	Ongoing

Attachment 3

Draft
Terms of Reference
Senior Behaviour Change Officer

Job Function
Under the supervision of the BCC Specialist, provide guidance on the content, design and production of all communication material and elements (interpersonal, print, electronic, etc.) that support the targeted HIV/AIDS BCC interventions to be implemented by the NAP and its strategic partners in the effort to reduce the spread of HIV in Barbados.

Duties and Responsibilities

- Work with the BCC team to assist in creating and facilitating the production of the communication components of all BCC interventions of the NAP and its strategic partners.

- Support the BCC specialist in developing evidence- and theory-based BCC interventions and direct their implementation, and monitoring and evaluation.

- Conduct the formative required with specific target groups to help identify issues, concepts and content of the respective communication programmes and material.

- Design and conduct research to pre-test communication material developed by the NAP and partners.

- Assist in the creation and production of BC communication material suitable for use in interpersonal settings, as well as for print and electronic media.

- Assist the BCC Specialist to identify the BCC training needs of partners in the NAP.

- Plan and conduct training in the theory and concepts of effective communication for behaviour change and other communication issues for partners of the NAP.

- Identify local and regional communication development and production resources.

- Contribute to the creation of the electronic database of technical (human) and other resources needed for effective BCC intervention planning, implementation, and monitoring and evaluation.

- Work with the PRO to establish a document centre that houses all communication material produced by the NHAC.

- Perform all other related duties as assigned.

Attachment 4

Draft

Terms of Reference
Junior Behaviour Change Officer (Advocacy)

Job Function
Under the supervision of the BCC Specialist, develop and implement a plan to use drama and edutainment as a BC strategy that supports the targeted HIV/AIDS behaviour change and communication BCC interventions to be implemented by the NAP and its strategic partners in the effort to reduce the spread of HIV in Barbados.

Duties and Responsibilities

- Work with the BCC team to assure the appropriate integration of drama and related communication methodologies into targeted BCC interventions and programmes.

- Assist in creating (writing scripts) and facilitating the production of drama and related communication components.

- Plan and conduct training for partners, especially youth, in the writing of scripts and the use of edutainment and drama (street theatre and process drama) as effective BCC tools.

- Supervise process drama, street theatre and other events at which drama is used as a BCC tool.

- Liaise with the Monitoring and Evaluation Specialist to design and develop simple tools for monitoring and evaluating the effectiveness of drama in achieving the objectives.

- Identify local and regional human and other resources in edutainment and process drama that could benefit the NAP in Barbados.

- Contribute to the creation of the electronic database of technical (human) and other resources needed for effective BCC intervention planning, implementation, and monitoring and evaluation.

- Work with the PRO to establish a document centre that houses all communication material and products of BCC efforts of the NHAC and NAP.

- Perform all other related duties as assigned.

Attachment 5

Draft

Terms of Reference
Junior Behaviour Change Officer (Drama/Edutainment)

Job Function
Under the supervision of the BCC Specialist, develop and implement a plan that promotes the use of drama, edutainment and related methodologies as strategies that support the targeted HIV/AIDS behaviour change and communication intervention to be implemented by the NAP and its strategic partners in the effort to reduce the spread of HIV in Barbados.

Duties and Responsibilities

- Work with the BCC team to assure the appropriate integration of drama and related communication methodologies into targeted BCC interventions and programmes.

- Assist in creating (writing scripts) and facilitating the production of drama and related communication components.

- Plan and conduct training for partners, especially youth, in the writing of scripts and the use of edutainment and drama (street theatre and process drama) as effective BCC tools.

- Supervise process drama, street theatre and other events at which drama is used as a BCC tool.

- Liaise with the Monitoring and Evaluation Specialist to design and develop simple tools for monitoring and evaluating the effectiveness of drama in achieving the objectives.

- Identify local and regional human and other resources in edutainment and process drama that could benefit the NAP in Barbados.

- Contribute to the creation of the electronic database of technical (human) and other resources needed for effective BCC intervention planning, implementation, and monitoring and evaluation.

- Work with the PRO to establish a document centre that houses all communication material and products of BCC efforts of the NHAC and NAP.

- Perform all other related duties as assigned.