

Rethinking Prevention

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Received date: October 04, 2014, Accepted date: October 27, 2014, Published date: November 10, 2014

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Abstract

This paper questions the main trends that have developed in Aids prevention campaigns in Brazil over the recent past years and proposes alternatives to the established pattern of Aids and STD prevention in the country. The alternative model proposes a more involved participation of design professionals in every phase of campaign planning, in an effort to promote prevention strategies that may prove more humane, efficient and complete.

Keywords: Graphic design; AIDS prevention; HIV

Introduction

This paper has two goals. First, to present possible new paths for prevention in healthcare in Brazil based on models successfully implemented in other countries, as well as on the experience accumulated during the doctoral research entitled "Suposições: como você sabe o que sabe? Design, prevenção e sexualidade" (Assumptions: How Do You Know What You Know? Design, Prevention and Sexuality) held at the postgraduate program in design at PUC-Rio.

The second objective concerns the role of the design researcher in the conception of a new preventive model from its initial drafting to its definitive implementation. This kind of performance of the design professional raises some questions about the paths and possibilities of academic research in design, as well as the expansion of its boundaries, an aspect that should always be considered without losing sight of its practical aspects.

Why not invest in the expansion of the knowledge (theory) and the possibilities for action (practice) of the designer in developing campaigns to prevent HIV/Aids¹, in an attempt to obtain differentiated preventive campaign items that are merely a simple repetition of medical guidelines, but also take into account the subjective aspects related to the experience of a disease of the magnitude of HIV/Aids? The subjective experience in the resolution of the most diverse projects coupled with the humane and multidisciplinary formation of the designer could become a valuable tool to produce questions that lead to more effective prevention, not only concerning HIV/Aids care, but also health management in general.

The Reasons

"96% of Brazilians know that they can get Aids from sexual intercourse.

90% of Brazilians know that using a condom prevents Aids.

56% of Brazilians would not buy vegetables from a greengrocer known to be HIV+."

(Ministry of Health employee commenting on a questionnaire answered by three million Brazilians on Aids and education as shown on the television program Conexão Repórter on the SBT network on May 17, 2010.)

The quotation above was taken from a television program aired on SBT in 2010 in which an employee of the Ministry of Health was questioned about the awareness of the population about the forms of HIV contagion and condom use. According to the program's announcer, Brazilians were "well informed" about the virus and about the contamination, after all "96% of Brazilians know that they can get Aids from sexual intercourse", and "90% of Brazilians know that using a condom prevents Aids".

Meanwhile more than half of the interviewees would not buy vegetables from an HIV+ greengrocer for fearing contamination, which shows a huge misunderstanding about the actual forms of virus contamination.

This research shows a very interesting fact: knowing how the contamination happens or how to prevent it – at least sexually by the use of condoms – does not guarantee that the population is aware of the real risks of contamination, since 56% of interviewees fear becoming infected by the commercial contact with the greengrocer, which is known to be impossible if the relationship with the greengrocer is settled only when buying and selling vegetables.

The quotation shown above serves to illustrate how the Brazilian population in general has a very poor notion about Aids and prevention, which proves that information circulates, however in a limited way. It also shows how serious misconceptions – such as to associate the commercial contact with the greengrocer to a probable contamination – still happen, even after more than three decades into

¹ The spelling of the term Aids is used in this thesis with only the first letter capitalized. This option is due to the demand of the social movement of people living with the virus, who believe that the grammatical change shifts the focus from pathology to the person living with the syndrome. The new terminology was adopted also by the Ministry of Health.

the epidemic, as well as years and years of preventive campaigns being spread by the Ministry of Health.

Aspects of the limitation of the information flow related to the prevention of HIV/Aids appeared several times and in several ways during the doctorate research through the contact with informants, the survey of material published in the media, and even in everyday life, as that involvement with the research led researchers to all kinds of doubt – from the most trivial to the most complex – linked to the matter of prevention and sexual health.

This calls into question the theory of the "well-informed population." The information related to prevention, does not circulate on a regular and constant basis. Everything that is beyond the slogan "always use condoms" appears to be a very limited piece of knowledge almost unavailable to the public. People often do not know where or how to ask for help, for not knowing where to go, or for the fact that STDs are a cause for embarrassment, leading them not to discuss this type of question with the physician or health agent at the time of consultation.

The result is a reinterpretation of preventative information among the population, who inform themselves however or wherever they can. It is not rare to hear stories of people who have created their own "guidelines" for Aids prevention, based on their own "dogmas" or on being advised by friends and acquaintances who do not always have the correct answer to their questions. One example is the testimony of a taxi driver who considers himself immune to the virus because he only relates sexually to his neighbors. "I just hang out with neighbors." The reporter asks: "How do you know she is not contaminated?" And he answers: "Oh, we know our neighbors, we've known them forever, and they are always clean."

As it can be observed from the speech of the taxi driver, the reasons for non-prevention are the most diverse, and it can be noticed in other fairly consolidated discourses, for example the speech of "brother" Marcelo Dourado on the television program Big Brother Brazil in 2010, in which he claimed that heterosexual men would be immune, since the disease is restricted to the gay environment. On the other hand, some gay men who have had many sexual relations without condoms believe to be immune because they have not been contaminated yet. It is also not uncommon to find women who believe that most STDs are present only among "promiscuous people", thus their boyfriends/husbands cannot infect them, and therefore there is no reason to worry or take precautions, as they are in a monogamous relationship.

The misconceptions and lack of information regarding Aids undoubtedly point to a more general lack of knowledge about basic health care, which refers to a certain "reserve of knowledge" in our society, where medical knowledge detains the monopoly of this type of information. But in the case of Aids, this ignorance is increased by the mysteries and misconceptions that have always surrounded sexuality, even in our supposedly liberal society. This sexuality, in turn, escapes the control of the medical knowledge itself, scientific and rational.

"In Aids combat policies, medical discourse seems to consider organs and bodies as perfectly adjustable things. However, it faces an insurmountable resistance: desire. Medicine cannot cope with desire for it escapes the prescriptions according to an impulse that is not rational nor formalizable. (...) Not being able to regulate the avatars of desire, medicine excludes it – or else, it is outside the realm of the "real" – assuming that the existential pathways may be regulated

according to prophylactic conventions, to the detriment of passion, sexual arousal and intensity flows [1]."

The words of Perlongher offer a clue on one of the reasons why there is great difficulty on the part of medical knowledge in dealing with the threat of a disease in which one of the main routes of spread is the sexual act. Is it possible to conceive a prescription that can encompass such complex aspects as desire and the individual circumstances so present in sexual encounters?

Would it be feasible to actually take into account all these nuances and develop a medical prophylaxis, minimally able to consider the complexity of these issues, dodging the traditional sanitary postulates, which, in face of the threat posed by Aids to public health, prescribe a strict "sanitization" of sexual acts?

Apparently, this is less and less thought of, and the prescription of the maximum possible separation of the bodies remains – even through a thin layer of latex – making the use of condoms as such obvious and simple "doctor's orders", that it is clear that it should be followed by everyone.

Given the gaps present in the official prevention systems currently implemented in Brazil, we can begin to sketch different paths that lead to more effective preventive response by the population. Once the demand for more carefully detailed and complete preventive information becomes increasingly clear, why not provide in a timely and continuous manner this detailed information on the leaflets and prevention campaigns in general?

However, for the consolidation of a preventive model that more adequately meets the demands for information and clarification of possible misconceptions related to prevention, there must be developed a complex research from teamwork including professionals from various fields in a multidisciplinary effort. Moreover, the perspective of those living with the disease should be heard, seeking thereby to develop an inclusive prevention policy that takes into account the maximum possible aspects related to it.

For developing this proposal, we can think of a guideline used by the Ministry of Health in preventing the spread of HIV through the use of injectable drugs, the so-called "Damage Reduction" or DR. DR proposes bilateral and participative prevention that is little restrictive and open to new possibilities. However, this model is not widely used (or even entirely absent) in the care related to contamination through sex.

When using DR as a basic premise, the new proposal would be in line with an official policy of Brazilian public health, and would give the population a preventive alternative that would take into account other issues, beyond those that are currently raised in preventive policies such as the repetition of the safe sex discourse and the constant emphasis on condom use.

The Policy of Damage Reduction (DR) and HIV Prevention

Damage Reduction is a public policy that has as main objective to reduce the evils arising from practices considered harmful or that bring some health risk, such as the abuse of drugs and alcohol, and the practice of unprotected sex, among others.

Damage Reduction or (DR) in Brazil is a public policy authorized and used by the Ministry of Health, and is currently a political priority for the development of actions among drug users that are developed

by the three spheres of government and also by civil society organizations.

By the means of Ordinance No. 1028 of July 4, 2005, the Ministry of Health recommends establishing guidelines that conduct the implementation of DR actions and subsidizes municipalities and states in maintaining or implementing actions aimed at drug users. Moreover, the government has sought to establish partnerships between the Mental Health Programs, the Viral Hepatitis Program and the National STD and Aids Program aiming at promoting integrated care and visibility of DR as a public health policy.

"The concept of damage reduction exists for over 30 years. It began in the 1980s in England and the Netherlands, when there was the explosion of the HIV and hepatitis epidemics. Today it is all around the world. DR was a public health response to the spread of HIV (...). When the impossibility of some people to stop using drugs was realized, there was the advocacy for measures in order to avoid problems related to other areas of health – such as HIV infection, other sexually transmitted diseases or transmitted by sharing items employed in injecting drug use – from overlapping with the psychoactive substance consumption scenario."

DR can be thought of as a therapeutic counterpoint to the approach of abstinence that, as its own definition states, preaches abstinence as a form of treatment related to the abuse of narcotics, drugs and alcohol. The AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) are examples of institutions that employ the approach of abstinence through the twelve-step program in an attempt to promote the "recovery of alcoholics or addicts." The quotation below is an excerpt from the official Narcotics Anonymous website, which explains briefly how the recovery program of the two institutions work.

"The basis of the Narcotics Anonymous recovery program is a series of personal activities known as the Twelve Steps, adapted from Alcoholics Anonymous. These "steps" include admitting there is a problem, seeking help, self-examination, confidential self-disclosure, making amends for harm done, and working with other drug addicts who want to recover. Central to the program is its emphasis on what is called "spiritual awakening." (...) In Narcotics Anonymous, members are encouraged to comply with complete abstinence from all drugs including alcohol, even from substances that were not of that person's choice. The only requirement for membership is a desire to stop using drugs. NA members have discovered that complete and continuous abstinence provides the best foundation for recovery and personal growth."

However, with the emergence of HIV/Aids, there was a rapid spread of the virus among the injecting drug users, and face to the relapse of users trying the abstinence method as a therapeutic approach, DR proved to be an interesting alternative to combat damage to the health caused by injecting drug use, and to decrease the rate of HIV infection among these users.

The first DR works in Brazil were focused on injecting drug users, who initially were very affected by the HIV/Aids epidemic. The actions consisted in distributing disposable needles and syringes, bleach for cleaning syringes and distilled water for diluting the drug.

At that time, this practice was widely criticized by various sectors of society who believed that the supply of syringes and needles would encourage drug use and increase the number of "addicts". However,

what happened was a large reduction in the rate of contamination by the Aids virus through intravenous drug use.

"There are many ways to measure the efficiency and effectiveness of damage reduction. We can focus on the epidemiological data of HIV and hepatitis, for example. Communities where there are damage reduction programs have fewer cases of HIV and hepatitis among drug users, this is a fact."

The policy of damage reduction, or DR, is an interesting possibility to consider as an alternative to the current approach to Aids prevention, which is closer to policies related to the abstinence approach. If the use of DR policies for Aids and viral hepatitis prevention are already present in the Ministry of Health's actions related to the contamination by intravenous drug use, why not consider adapting this paradigm to prevent contamination by sexual intercourse?

Currently, Brazilian Ministry of Health uses preventive policies whose approach is diametrically opposed in the combat of one single epidemic. Another good reason to consider for thinking of an alternative paradigm to the one currently used in prevention campaign items, is the questioning concerning this kind of "method" as a means of control, treatment and/or prevention of diseases. It is known that the approaches related to abstinence in the control of the use of drugs and other narcotics are not much adhered to by users as those related to DR, which presents itself as a real endemic control problem related to Aids, because if the users do not definitively abandon the use of the substance, they remain subject to health problems resulting from this practice.

"The approaches that require abstinence as a criterion for inclusion have been questioned (...) it is noteworthy that there is a determination from ANVISA (Brazilian Health Surveillance Agency) – so that at least they expand their staff with the presence of graduated professionals."

On the other hand, the DR actions must recommend, if possible, the reduction of all damage to the health of individuals in any practice that may be detrimental or harmful to the organism. DR considers structural and cultural issues in their actions, developing programs that put into action protection, care and self-care strategies, in the search for a change of attitude towards situations of vulnerability, and not simply the introjection of an abstinence imperative.

The damage reducer builds a bridge and promotes the dialogue between the user and the healthcare professional, since they work directly with both, as a kind of "field messenger."

"It was me (ex-drug user and current damage reducer, emphasis added) and two psychologists (...) we visited all social, health and also religious facilities of the community (...) we entered the favela, it was not a tense atmosphere, at least not there at that time, but it was new and surprising. We went into a shack and I found out that what looked like a house was a brothel. (...) After entering through a door I realized that was what I wanted to do. The psychologist talked to the girls and left condoms, we talked to the regulars. They took a box full of used syringes and left another one with clean syringes."

Currently in Brazil, DR actions comprise an organized environment acting on several fronts: prevention and reduction of damage caused by drug use, such as STD infections, overdose, measures aimed at the abuse of alcohol and legalized drugs, prevention and control care of STDs in sexual practices such as BDSM and fistfucking²

² Sexual practice that consists in inserting one's hand and arm in the vaginal and/or anal orifice of their partner.

The role of DR in the matter of drugs is more evident and widespread, but it would be very interesting to extend this work to the control and prevention of diseases in general. Obviously, for this to be possible/feasible, this alternative would have to be part of prevention models conveyed by the main responsible agents for the dissemination of such resources.

It is undeniable that there is a contrast among public prevention policies related to DR (intravenous contamination), and those related to prevention focused on sex practices. There is a denial and possibly a reluctance to adapt some precepts of DR for Aids prevention focused on sex practices, and perhaps the difficulty for this "openness" derives from the process of stigmatization related to the social trajectory of the disease.

"The complex task of Public Health in a democratic and plural society is to bet on the realism of the proposals that reduce the most severe and most widespread damage to the integrity of citizens, according to the norms of the constitutional state and the protection of individual rights, not only because totalitarian measures clearly violate that state and those rights, as they have successively proved unsuccessful in controlling several epidemics the world has ever experienced."

This restriction probably owes much to the moral discussion surrounding some of the prevention campaigns spread by the official media.

Those Responsible for Prevention

The greatest responsible agent for health prevention in Brazil is currently the government, through its designated agency, the Ministry of Health. The implementation of the campaign items for these programs is done as follows: the government hires an advertising agency and they (the government) play the role of the client, creating a detailed briefing about what they want and how the campaign should be. The implementation is borne by the agency that responds only to the ideas of the representative of the government in question. There are also design studios that, by the force of demand or "tradition", specialize in the subject and depend on competition for funds allocated annually to health prevention in governments and local municipalities. In this case, creation is made and evaluated according to the studio owner, but always through the "sieve" of who provided the financial subsidy.

Finally, there are also agencies that have greater "freedom" of creation, the NGOs, which, in turn, also depend on funding, and work on demand. In the NGOs, the work is often done through a briefing, however the greatest difference is that in this case who usually discusses the contents is not the client (funder), but those responsible for the administration of the NGO, who might be militant and/or seropositive.

In general, preventive propaganda does not respond to the expectations/demands and needs of a directly "concerned" client, but to a funder instrument, and that apparently has been greatly limiting the messages contained in the preventive campaign items.

This arises as a double issue, primarily because many of the preventive actions take into account a derivation of a consolidated medical knowledge translated into short information at times provided by people who do not necessarily have some sort of familiarity with the matter of health prevention.

The second problem originates from the labor relations of the designer in any project situation, which is the negotiation of the formats and contents of a campaign item aimed at better solving design problems. Such negotiation typically occurs directly with the client and not with an "intermediate" agent.

Therefore, the planning of prevention campaigns presents even more restrictions than the clichés in the creative routine of designers, who usually work from the feedback of their clients, filling the gaps and needs that appear in each project. However, in the case of health prevention, such feedback can only be measured through surveys and epidemiological data related to the status before and after the implementation of the campaigns.

Then why not take advantage of the design professionals, who, thanks to their formation, are constantly placed before the search for the solution of problems and the filling of gaps, to think about new systems and models for health prevention and management? The paradigm of damage reduction can serve as an interesting reference in this regard, as it stresses the importance of information, built in interaction with the so-called risk populations and developed through multidisciplinary teams – which points to a possible more active role for the designer within this paradigm.

Other Possibilities beyond "Safer Sex"

For many years, various disciplines have been thinking about and studying the HIV virus and the Aids epidemic in different spheres. There is also an incessant struggle for finding a cure. Every year since the discovery of the virus, millions are invested in research funds and the creation of new drugs that are more effective and with fewer side effects. However, despite "intense" historical background related to the epidemic and the constant scientific discoveries related to the virus, its treatment and its forms of contamination, the campaigns to prevent and combat the virus have a key role in the epidemic. In the absence of effective medication, they were used as a first resort for preventing and combating the disease for nearly its entire trajectory. Currently they have an extremely important informative role for a number of reasons: the difficult routine of those living with the virus, the stigmatization related to seropositivity, the absence of a cure, and also the high care costs that an HIV+ individual demands.

The designers, in turn, have a very important role in this process as the creators of these campaign items, deciding the best graphic solution and creating new visual languages related to the virus. In some countries, there are design studios that are specialized and focused exclusively on the creation of prevention campaigns.

Here in Brazil, with regard specifically to "prevention design", little thought seems to be dedicated to the contents of these campaigns and the use of the same "formula", which is well known today, seeming to be constantly used in this sense. The slogan "always use condoms" is repeated while the images are modified exclusively to conform to the recipients of these campaigns.

However, much broader and complex preventive initiatives in other countries are already being propagated to the general public. The greatest difference among these campaigns and our governmental campaigns is the abundance of information available for consultation and the attempt to reach different strata of society. On the website of the British NGO "GMFA³, the gay man's health charity", a myriad of topics related to Aids and other STDs prevention are available for

consultation. In addition to the website, the NGO distributes booklets on various themes related to Aids/STDs.

as a page created especially to offer support and information for those living with HIV called "My HIV" (Figures 3 and 4), where the HIV positive individual can register, share information with other seropositives, physicians and volunteers, and also find many informative topics about the disease and its care.

Initiatives like this are carried out all over Europe and the United States, showing an interesting example of a possible new model for health care, where the NGO partially funded by the government plays the role of prevention, care and public health services agent. It is a public-private partnership that works in the treatment and counseling of people in a much more comprehensive manner. Moreover, most of these organizations have people performing some kind of fieldwork, be it preventive or "active" as condom distribution, and discussion groups about the disease.



Figure 1: Image of the GMFA website.



Figure 2: Details of the help topics on the GMFA website.

The amount of information is enormous, and the possibilities for counseling are not exclusively on the Internet. One can also visit the physical office of the NGO that provides testing, counseling and support.

There is a whole section dedicated to consultation called "Sex and Sexual Health" with topics such as HIV, Aids and safe sex, STDs, "How Risky Is...?", "Better Sex" and "Sexual Problems and Solutions." In addition to the pre-set items, there is also a space to ask a question. Each topic opens a subtopic, as can be seen in Figures 1 and 2, and when clicking on the subtopic themes the website user details the information they seek. In addition to this sexual health section the website has a variety of information related to the issue of living with HIV, testing facilities and health services.

Another British NGO does a similar job: the Terrence Higgins Trust or THT⁴. This NGO distributes print and downloadable magazines that offer a wide range of information on various topics related to male sexual health and prevention of Aids and STDs, as well

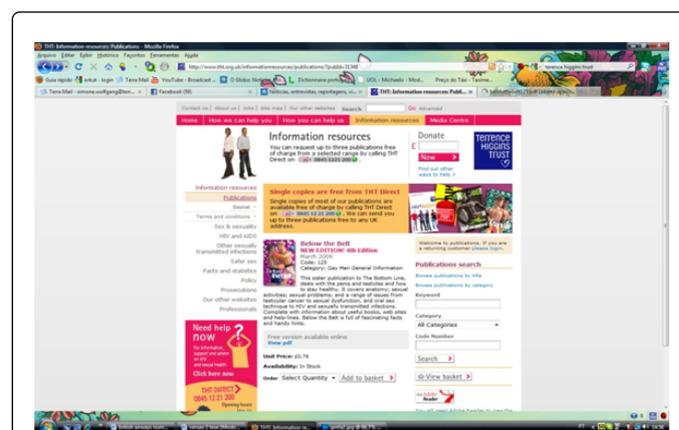


Figure 3: THT website "Information Resources" section.

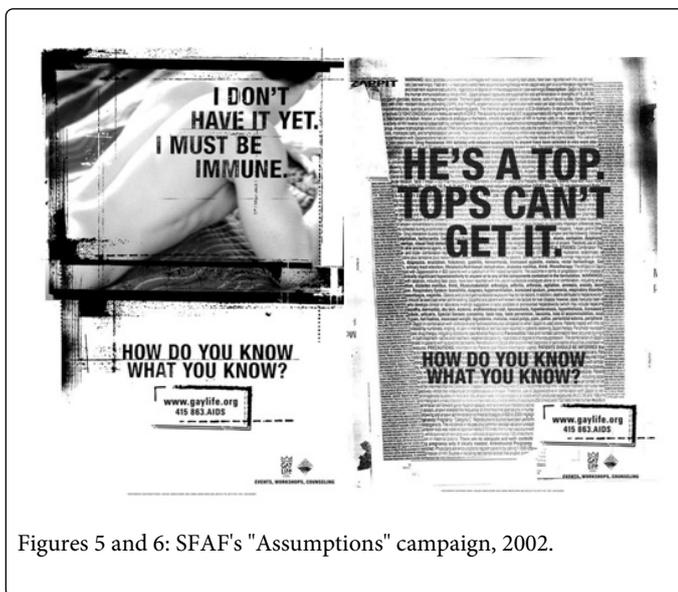


Figure 4: THT's "My HIV" webpage.

Another preventive alternative to the exclusive issue of "safer sex" is provided by U.S. NGO "San Francisco Aids Foundation", or SFAF, which illustrates this thesis with several of their prevention campaigns. This article shows a more recent project that is the campaign called "Assumptions" (phases 1 and 2) as can be seen in Figures 5 to 8. It is a

³ GMFA's website: www.gmfa.org.uk
⁴ Webpage address of the THT NGO: <http://www.tht.org.uk/>

series of posters that explored the issue of "people's beliefs" concerning the chances of contamination by the HIV virus.



Figures 5 and 6: SFAF's "Assumptions" campaign, 2002.



Figures 7 and 8: Second phase of the SFAF's "Assumptions" campaign, 2004.

The "Assumptions" campaign series always bore the slogan: "How do you know what you know?", and they explored the most common assumptions made by the male homosexual population concerning the possibility of contamination by the HIV virus. These campaign items were published between 2002 and 2004. In the first phase of the campaign the posters were always in black and white, and dealt with several issues that are still present today related to prevention, such as barebacking and the "beliefs" that many people have with respect to susceptibility to HIV infection. Figure 5, for example, bears the words: "I don't have it yet. I must be immune." Figure 6 says: "He's a top. Tops can't get it." The two posters address the "personal management of contagion risk" based solely on the beliefs of each person as mentioned earlier in this article on topic 2. This campaign sought to account for

the "truths" that many people create for themselves as a prevention tool, but that actually do not have any preventive effect. In fact, depending on the "mistake" in question, it can even increase the exposure of individuals to situations of risk. Examples like this can be seen in statements like the following made by a man in the community HIV-Br⁵: "With a seropositive boyfriend or strangers I only act as a top, because it is rare for tops to get it, the problem is when one comes inside you and the sperm stays there for many hours, that is what causes the contamination. That's why women get it a lot."

Pollak's quotation below also exemplifies the strategy of "personal management" of risk as a reassuring factor for the individual in relation to the epidemic, but with little or no prophylactic effect.

"(...) This strategy of "limited risk" reassures the individual mentally and prevents them from taking precautions they accept intellectually, but judge "unpleasant" and "frustrating". Needless to say, such a mental defense mechanism has no preventive effect [2,3]."

The second round of the "Assumptions" campaign presented posters with black and white photographs and words in color, still exploring the same theme. Figure 7 shows a picture of two men having sex and the text over the image of the first man, as if illustrating his thinking, says: "I came inside him. I must be positive." However, the text over the second man says: "He came inside me. He must be negative. How do you know what you know?" This SFAF campaign highlights another extremely important issue with respect to prevention, especially with regard to more sporadic sexual contacts: the lack of dialogue between partners promotes the spread of sexually transmitted diseases, since when one does not know well their partner, assumptions about him or her predominate. And these assumptions – regarding the care and prevention of sexually transmitted diseases – are closely related to the information that this individual carries with them because it is on this basis that they take the attitudes they deem necessary to protect themselves (Figure 8).

The "Assumptions" campaign was very important, because it brought up the issue of individual management of risk, which was not very thought about, much less spoken about. Currently the instruments of prevention in the United States and Europe encourage the dialogue between casual partners, and disseminate information of the same kind of the SFAF "Assumptions" campaign in an attempt both to promote better prevention of HIV infection, as well as a better health management on the part of those who are HIV positive.

The Possible Paths to the Proposal of a New Preventive System

During the doctoral research, several developments related to new possibilities regarding the conception of a "new kind of prevention" have emerged.

The first of these developments came from the observation of prevention campaigns that have been studied and/or analyzed. It is very common in the education and work environment of the designer, the conduction of graphical analysis of previously existing graphic elements for both the implementation of new work as well as the conduction of studies and research.

However, this type of analysis is usually limited to the observation of the graphical aspects of a campaign item such as: chromatic scale and number of colors used, typographic style, use or nonuse of

⁵ HIV-BR is an open discussion forum on Orkut: <http://www.orkut.com.br/Main # Community? Cmm = 95537>

photographic image, studies on forms – if they follow geometric lines or if they excel by organic forms, and the limitation to the assessment of graphical aspects contained in a preventive campaign item are aspects that do not meet the goals of this thesis due to its critical nature.

Therefore, the work described herein is not a graphical analysis on the common sense of the term, as described above. It is a critical analysis, which took into consideration the entire graphic piece as a whole, as an image indissoluble from speech. Actually, in most cases the discursive structure prevailed over the graphic aspects, however neither could have been studied separately, as the HIV/Aids prevention campaign benefits from the whole piece. It was from this observation of "the whole" that we could notice very clearly the verification of the repetition of a discourse present on virtually the entire history of Aids prevention: the discourse of risk. This discourse constitutes the construction of the notion of risk that permeated Aids prevention in general.

When spreading a series of prevention campaigns that merely repeat ready-made speeches such as "Aids kills", "The one who sees a pretty face does not see Aids", "If you do not take care of yourself Aids will get you", "Protect yourself, only practice safe sex" or "Always use condoms", a serious practical problem in preventive communication emerges: a huge number of people ignore the messages contained in prevention campaigns, and/or simply ignore their existence, not taking them seriously.

Why does this damping effect occur? Because the constant use of the "discourse of risk" disregards the subjective issues related to the existence of each individual, it disregards desire, endurance and individuality. Moreover, it leaves the door closed for any possibility other than condom use as maintenance of healthy sexuality, throwing all the responsibility of the preventive mechanism into the sphere of "moralized conduct."

Currently according to the Brazilian Ministry of Health, the highest numbers of HIV contamination cases occur within couples in stable relationships. This shows a serious problem in the management of information related to prevention, since most couples abandon condom use and make it a habit, which seems difficult to be "reversed" even out of the stable relationship. In fact, the very act of abandoning condom use among couples shows that condoms are not necessary, or provide some kind of discomfort or restriction that "may" be discarded out of risk situations. Below there are some statements related to both the discomfort associated with the use of condoms as well as a "need" to abolish it in stable relationships.

"I got it having anal sex with my girlfriend who I knew was positive. I stopped using a condom because with her it wasn't fun, and at one point what was worth was the pleasure I wasn't feeling and not the condom. There was also a great burden to get the condom, put the condom, be careful, all the fuss and everything else, you know? But if I knew that anal sex was more risky I would have continued to use it only in anal sex."

"It is normal to stop using condoms when I'm dating. For one, I get tested and I ask my boyfriend to get tested too. If the result is negative I stop using them. Condoms for anal sex are horrible, with the friction it gets hotter and hotter, and depending on the lubricant it has an astringent effect that really hurts and kills the pleasure."

"When I started dating X. I had never had sex without a condom in my life, but then we got engaged and she proposed. It was amazing, I

had never felt a wet woman on my p**, it makes all the difference when you have sex, when you're horny. I didn't know it before because I had never done it, but now it would be very difficult to start using them again."

Therefore, the current format of the campaigns leaves room for a number of practical questions, creating gaps that are filled by the assumptions of those involved, whether between people who are in a stable relationship and no longer use condoms with their partners or even those who are in a serodiscordant relationship and have no idea on how to proceed if the condom broke during intercourse.

Besides the context of stable relationships, we can also think about the people who usually practice casual sex and seek safer practices due to the sporadic nature of their encounters.

Taking into account the limitations present in prevention campaigns spread today, why not think of alternative ways to design a new preventive model?

And why not use some of the hypothesis of DR (Damage Reduction) as a possible alternative for the implementation of this model, since its precepts are already being used as an official policy of the Brazilian Ministry of Health to prevent STDs contamination through injecting drug use?

As the main intention of DR is to promote awareness on the possible effects of practices that are harmful or detrimental to health, DR seems to be an interesting starting point for prevention policies that seek, through the massive disclosure of information, a better preventive response by the population in general, as well as the possibility of interaction among the public prevention agencies and the population through the damage reduction agents who act directly on the field.

Unfortunately there is a limitation in the range of work of the designer with respect to their role in the conception of this type of work, once the designer is only called into the project at the time of the implementation of the briefing.

To allow for a more significant change in the format of prevention campaigns, the inclusion of the design professional in the project should occur since the beginning of the conception of the project, not only at the stage of finalization and implementation of the ideas pre-established by a health team.

Expanding Boundaries

What is the relationship that can be established between the conception and planning of HIV/Aids prevention campaigns and the role of the designer? In practical terms, this relationship may be minimal. The campaigns are elaborated in environments outside the reach of the designer (in advertising agencies, by demand of government agencies related to health policies), and the designer is only called to serve in the final materialization of the campaign items (graphic design, layout elaboration, etc.) – receiving for such job a "briefing" consisting of previously established concepts and decisions made beforehand. In short, their effective intervention in campaigns is restricted to the implementation of guidelines created by others.

If this is the limit and the end of all real possibilities of action for the designer in developing products and systems designed to intervene in any way in society, if the contribution of this professional is restricted to their technical expertise to materialize the demand of others, we should ask what the meaning of a college degree in design is, and

more, what the point of research and training in design at post-graduate studies is.

To think design as an isolated discipline is an extremely limiting attitude. First of all, it is necessary to highlight multidisciplinary as a vital aspect to how we think about design for several reasons: first because of how enriching the dialogue between design and other disciplines is. This dialogue provides the opportunity for the design professional to rethink issues of other disciplines from another point of view – in the case of this research, HIV prevention specifically –, and also because the "practical" projective activity of design is nothing more than a constant dialog and exchange with other kinds of knowledge, in other words, without exchange, there is no design.

Currently, some initiatives have already divorced from this "model", such as the development of a new prevention campaign against the damage caused by tobacco consumption in 2006/2007, through the creation of a study and research group for the elaboration of the campaign that featured some teachers of the Department of Arts & Design at PUC-Rio aimed at the study and creation of new imagery to appear on cigarette packs⁶ as a means of preventing the damage caused by the continuous use of tobacco-derived substances.

(...) With this goal, the INCA (National Cancer Institute), as mentioned earlier, created a study group formed by the National Cancer Institute itself, the National Health Surveillance Agency (ANVISA), the Neurobiology Laboratory at the Federal University of Rio de Janeiro (UFRJ), the Behavioral Neurophysiology Laboratory at Fluminense Federal University (UFF) and the Department of Arts & Design at the Pontifical Catholic University of Rio de Janeiro (PUC-Rio) [4]."

Another similar initiative is the creation of the online game "Foldit, Solve Puzzles for Science" (<http://fold.it/portal/>) in which – within an interface created by game designers and programmers – gamers solve scientific problems related to several issues unresolved by researchers for years. The game offers several alternatives of action for the player, who forms teams, chooses a challenge related to their skills and plays inside a system that scores new discoveries. The site currently offers alternative games related to electron density or the metabolization of allergenic proteins present in pollen. In the specific case of HIV, Foldit players resolved an issue related to the structure of RNA in the replication of the HIV virus and its combination with different proteins in three weeks, an issue that had long remained an unsolved problem among scientists and HIV/Aids researchers.

"Foldit allows people from different backgrounds around the world to collaborate in predicting the structure of protein molecules, key information for understanding their functions and uses. In this case, the mystery involved a type of enzyme that plays a key role in the proliferation of the Aids virus. However, the research for drugs to block that enzyme faced difficulties because its real appearance was unknown. (...) When the challenge was launched in "Foldit," users produced such good models of the structure of the enzyme that researchers could refine them quickly and in a few days they were able to determine it accurately. The structure is fundamental – sometimes more than chemical composition – because it highlights parts of the molecule that can serve as targets to deactivate the enzyme and contain the spread of the virus."

The above examples show how the insertion of professionals from various fields in both prevention and health care can be rich and advantageous. However, for this kind of integration to become constant and not just sporadic, it is essential to consider expanding the boundaries of the design research field, and/or also a possible permeabilization of this field, allowing for the exchange of knowledge between design and other fields of knowledge, and then think about the rich possibilities that a flexibilization of their choice of research subjects could bring to the theoretical field of design. "It can be argued that a design theory will not have a fixed field of knowledge, be it linear-vertical (disciplinary) or linear-horizontal (interdisciplinary), in other words, a design theory is unstable [5]."

Much is said in design schools about its "interdisciplinary" character, and the justification of the work proposed by many students is anchored in the "interdisciplinary" aspects of design, as well as the multiple projecting experiences which a designer faces throughout their professional career, and several times the solution of design problems is more successful and/or effective when there is a work partnership among people from other areas and when there is the exchange of experiences with the customer. This relationship with other disciplines occurs in different ways, varying according to the nature of the work and the understanding that the researcher/professional has of that in which consists the interdisciplinarity (how to relate to other disciplines) of their work.

"The interdisciplinary, of which much is said, does not consist on confronting disciplines that have been already constituted (none of them, in fact, consent to surrender). To practice the interdisciplinary, it is not enough to choose a "subject" (a theme) and call upon two or three sciences. The interdisciplinary consists in creating a new object that belongs to no one [6,7]."

"Interdisciplinarity is an expression endowed with different meanings and used to denote different situations of inter-relationship between two or more disciplines. As noted by Japiassu (1976)⁷, the term interdisciplinarity does not have a unique and stable epistemological sense. This is a new word whose meaning is not always understood in the same way by different people [8-12]."

However, despite this relationship is very clear in the practical sense, in research there is a constant resistance from some professionals and researchers to accept initiatives and research topics that do not sound so familiar at first glance, and that slightly transcend what has already been done and thought. This resistance is shown as a challenge not only for the growth and recognition of design theory, as well as initiatives akin to this research, which beyond cultural barriers (natural to those who venture across the field of medical care, and are not physicians) also encounter resistance from those who do not often recognize its legitimacy as design research.

It is necessary to expand the boundaries of the design field so that it is enriched, and so that the actions of designers can grow and be viewed without hostility by professionals from other areas. The research that introduces new objects and subjects is nothing more than a challenge that seeks to think its problems through design.

By introducing new questions, in the long run perhaps these issues could be shared at all levels of design study – undergraduate or graduate – and also the preparation of the design professional would

⁶ This action consists on the use of the packaging of tobacco-derived products to communicate the effects of tobacco use to the population.

⁷ JAPIASSU, H. Interdisciplinaridade e Patologia do Saber. Rio de Janeiro: Imago, 1976.

benefit from this. That is due to the fact that the more the field of study expands, the greater are the areas in which the professional might work, as well as greater are their abilities to deal with different requirements that may arise throughout their career.

Accordingly, DR could be an interesting approach for a more extensive field of work for the designer to create systems for prevention in health, since DR actions can only be made by the multidisciplinary point of view, with teams of professionals from diverse areas and by people who have some practical experience with that specific situation, working directly in the area.

Upon the insertion of the designer in all stages of the construction of the prevention campaign items, the information contained in the campaigns could be dealt with in a different way. First, because this "information" would be decentralized within a multidisciplinary team and would be revised by professionals from various areas. However, in addition to that, we should think that one of the major tasks of designers is to give the best possible treatment to information, presenting it in order to promote an interaction with the receiver/repeater.

If conceived in this way – as the design project that it is –, prevention would be much more focused on the propagation of information, aimed at the protagonists of the epidemic – and not as a static campaign item that "speaks" with no return – seeking to promote a dialogue among different fields of knowledge, health agencies of the state and the population. Even if the campaign item developed does not allow an immediate return on the part of the population – as may be the case with graphic pieces –, this return can be obtained by leading the reader to think about the subject and get more information about it or elucidation of doubts in other sources, always

understanding the preventive campaign item as part of a more extensive "network" of information and interactions.

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