The Australian Aid Program
Guide to HIV/AIDS and Development

Australia’s health aid seeks to improve the health of the poor in developing countries by providing primary health care.

One of the highest priorities for Australia’s health aid is to prevent the advance of HIV/AIDS, mitigate its impact on people and communities, and respond to the social and economic needs created by the disease.

The Guide to HIV/AIDS and Development seeks to ensure that Australia’s aid program delivers high quality health projects in the area of HIV/AIDS.

It presents policy principles, documents lessons learned and poses guiding questions for the design and implementation of HIV/AIDS activities in developing countries.

The Guide reflects the experience of many Australians working with development NGOs, HIV/AIDS community organisations, public health institutes and government departments.

Whilst it is primarily intended for use on Australian Government HIV/AIDS projects in developing countries, the Guide may also prove to be a useful reference for policy makers and health professionals in developing countries as well as other international aid donors.

For more copies of this publication contact:
Bibliotech
GPO Box 4
Canberra ACT 2601
Tel: 02 6249 2479  Fax: 02 6249 5677
Email: books@bibliotech.com.au

For further information contact:
Director, Health Group
AusAID
GPO Box 887
Canberra ACT 2601
Tel: 02 6206 4660  Fax: 02 6206 4870
Internet: www.ausaid.gov.au
©Commonwealth of Australia 1999

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgment of the source and no commercial usage or sale. Reproduction for purposes other than those indicated above require the prior written permission from the Commonwealth available from AusInfo. Requests and inquiries concerning reproduction and rights should be addressed to the Manager, Legislative Services, Ausinfo, GPO Box 1920, Canberra ACT 2601.

ISBN: 0 642 41483 1

Published by the Australian Agency for International Development (AusAID), Canberra.

October 1999

For further information contact:
Director, Health Group
AusAID
GPO Box 887
Canberra ACT 2601

Phone (02) 6206 4660
Fax (02) 6206 4870
Internet www.ausaid.gov.au

Designed by Spectrum Graphics, Canberra
Set in Rotis
Printed in Australia by National Capital Printing
## Contents

**Ministerial foreword** 1

**Preface** 2

**Introduction** 3
- What is the guide 3
- Who should use the guide 3
- How to use the guide 4
- Who to consult for advice 4
- HIV/AIDS and development 5

**Objectives and principles of Australia's overseas HIV/AIDS activities** 7
- Objectives 7
- Guiding principles 7

**Country programming** 11
- Addressing the impact of HIV/AIDS on social and economic development 11
- Surveillance 11
- Considering HIV/AIDS in all activities 12

**Cross-cutting issues** 13
- Coordination 13
- Partner country priorities 14
- Capacity building 14
- Partnerships: approaches 16
- Partnerships with those most affected 17
- Community action 18
- Multisectoral approaches 20
- Decentralisation: district primary health care services 22
- Social and economic analysis 23
- Human rights 25
- Vulnerability of women and girls 26
- Youth 27
- Australian expertise 29
## Activities promoting behavioural change

<table>
<thead>
<tr>
<th>Strategies and options</th>
<th>30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospects of changing sexual behaviour</td>
<td>31</td>
</tr>
<tr>
<td>Removing obstacles to the adoption of lower risk behaviours</td>
<td>32</td>
</tr>
<tr>
<td>Power to change behaviour</td>
<td>33</td>
</tr>
<tr>
<td>Opposition and support</td>
<td>34</td>
</tr>
<tr>
<td>Empowering women and girls</td>
<td>34</td>
</tr>
<tr>
<td>Involving men</td>
<td>35</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>36</td>
</tr>
<tr>
<td>IEC materials and activities</td>
<td>37</td>
</tr>
<tr>
<td>Positive and negative messages</td>
<td>39</td>
</tr>
<tr>
<td>Community workers, counsellors and peer educators</td>
<td>40</td>
</tr>
</tbody>
</table>

## Other prevention activities

<table>
<thead>
<tr>
<th>Strategies and options</th>
<th>43</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion and provision of condoms</td>
<td>44</td>
</tr>
<tr>
<td>STD management</td>
<td>45</td>
</tr>
<tr>
<td>Improving blood products and medical practices</td>
<td>46</td>
</tr>
<tr>
<td>HIV testing</td>
<td>47</td>
</tr>
<tr>
<td>Mother-to-child transmission</td>
<td>48</td>
</tr>
<tr>
<td>Sex workers</td>
<td>49</td>
</tr>
<tr>
<td>Injecting drug users</td>
<td>50</td>
</tr>
<tr>
<td>Other high risk groups</td>
<td>51</td>
</tr>
</tbody>
</table>

## Mitigating the impact on individuals and on society

<table>
<thead>
<tr>
<th>Strategies and options</th>
<th>53</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and home based care</td>
<td>54</td>
</tr>
<tr>
<td>Social and economic support</td>
<td>56</td>
</tr>
<tr>
<td>Income generating activities</td>
<td>57</td>
</tr>
<tr>
<td>Orphans and HIV positive children</td>
<td>58</td>
</tr>
<tr>
<td>Combining prevention and care</td>
<td>59</td>
</tr>
</tbody>
</table>

## Design and implementation

<table>
<thead>
<tr>
<th>Basic design issues</th>
<th>61</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale of activities and delivery mechanisms</td>
<td>62</td>
</tr>
<tr>
<td>Sustainability</td>
<td>63</td>
</tr>
<tr>
<td>Monitoring mechanisms</td>
<td>64</td>
</tr>
<tr>
<td>Performance indicators</td>
<td>66</td>
</tr>
<tr>
<td>Administration and management</td>
<td>67</td>
</tr>
</tbody>
</table>

## Charts

<p>| Chart 1: structure of the guide                             | 6  |</p>
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFAO</td>
<td>Australian Federation of AIDS Organisations</td>
</tr>
<tr>
<td>ATSP</td>
<td>AIDS Technical Support Program, USAID</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APCASO</td>
<td>Asia Pacific Council of AIDS Service Organisations</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>AZT</td>
<td>Azidothymidine, an anti viral drug</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>HIDNA</td>
<td>The HIV/AIDS International Development Network of Australia</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug Users</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication materials and activities</td>
</tr>
<tr>
<td>IGA</td>
<td>Income Generating Activities</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NAPAC</td>
<td>North Thailand HIV/AIDS Prevention and Care Program</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
</tr>
<tr>
<td>SANASO</td>
<td>Southern African Network of AIDS Service Organisations</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>TASO</td>
<td>The AIDS Support Organisation, Uganda</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>USAID</td>
<td>US Agency for International Development</td>
</tr>
</tbody>
</table>
MINISTERIAL FOREWORD

I am pleased to release the Guide to HIV/AIDS and Development. The Guide seeks to ensure that the Australian Government’s overseas aid program delivers high quality health projects in the area of HIV/AIDS.

More than 35 million people around the world are living with HIV, with ninety-five per cent of them from developing countries. HIV is now the fastest growing threat to economic, social and human development in Africa. Life expectancy, which had improved significantly, has been cut by as much as thirty years in some affected countries. Alarmingly, HIV/AIDS is starting to spread through the vast populations of Asia. In India about 5 million people are now infected, with a high percentage of cases in large cities. Pacific Island countries are also reporting an increase in infections.

The epidemic strikes people in their most productive years and leaves millions of orphaned children. It also disrupts key sectors such as mining, agriculture, education and transport. For this reason, political leaders need to commit themselves to making HIV/AIDS a priority in all development programs and to make more resources available to combat the spread as well as to address the dire effects of this disease.

Australia will continue to play an important role in arresting the spread of the disease in the Asia-Pacific region. For example, under the aid program Australia has helped prepare a strategy for the Mekong region and funds the Mekong Region HIV/AIDS Initiative. Australia is also committing substantial resources to Papua New Guinea where a proposed National AIDS Support Project will assist the work of the government in implementing a national HIV strategy.

Australia’s response to the epidemic is informed by our own national experience. We have benefited from a productive partnership between affected communities, and medical professionals and from strong cooperation among all levels of government. Australia’s Fourth National HIV/AIDS Strategy provides the overarching framework under which our international efforts in HIV/AIDS can be focused to arrest the advance of the epidemic, provide appropriate treatment and care for those afflicted.

The HIV/AIDS guidelines draw on lessons learned in the planning and implementation of Australian aid funded HIV/AIDS activities as well as the experiences of other donor countries and international aid organisations. They have been prepared with the help and guidance of a large number of Australians from NGOs, academic institutions, HIV/AIDS support organisations and medical and community health specialists. The Guide to HIV/AIDS and Development will not only help to ensure that Australia’s international response to the HIV/AIDS epidemic is of a high quality, it will also provide practical benefits to partner governments and the international donor community in developing their responses to this growing international crisis in developing countries.

ALEXANDER DOWNER
Minister for Foreign Affairs
PREFACE

This document seeks to guide the HIV/AIDS activities carried out through the Australian Government’s overseas aid program. It presents guiding principles, documents lessons learned and poses guiding questions for the development and implementation of overseas HIV/AIDS activities. It represents the second phase of a project that started with the Review of HIV/AIDS Policy and Programming in AusAID in 1998. The Guide replaces the 1993 HIV/AIDS Policy Guidelines for Australia’s Development Cooperation Program in the light of:

- Australia’s policy: Health in Australia’s Aid Program
- AusAID’s research paper Issues and Trends in International Health and
- the formation of UNAIDS.

The Guide was written by Bernard Broughton of Project Design & Management Pty Ltd. A reference group that included AusAID, the former Department of Health and Family Services and the HIV/AIDS International Development Network of Australia (HIDNA) was formed to contribute ideas and guidance. Officers within AusAID provided program and policy advice as required. A draft of the Guide was reviewed by Dr Peter Deutschmann of the Macfarlane Burnet Centre for Medical Research.
Introduction

WHAT IS THE GUIDE

Aim of the Guide
The aim of the Guide is to improve the quality of Australia's overseas HIV/AIDS projects by helping AusAID activity managers and contractors understand the complexity of these activities and apply guidelines and lessons learned to their design, implementation and appraisal.

What the Guide does not do
The Guide is designed for use where HIV/AIDS is the main focus or significant component of an aid activity. It is not designed to deal with HIV/AIDS as a cross-cutting issue in non-HIV/AIDS specific activities.

Why use the Guide
There are many lessons from Australia's highly successful public health response to HIV/AIDS that can help improve the quality of Australia's overseas aid activities. This Guide provides a tool for AusAID project managers, health advisers and contractors to work through particular issues. Guiding and auxiliary questions help clarify ways to prevent the spread of HIV, minimise its impact and address accompanying needs.

WHO SHOULD USE THE GUIDE

The Guide is intended primarily for use by:
- AusAID desk officers
- AusAID Health Group
- AusAID engaged consultants and NGOs designing, implementing and reviewing HIV/AIDS projects within Australia's aid program.

The Guide may also be of use to:
- Australian health institutions and community organisations working on HIV/AIDS
- developing country policy makers and practitioners working on HIV/AIDS
- other international donors.
HOW TO USE THE GUIDE

The Guide is designed as a reference document rather than a text to be read from start to finish. The Guide has a table of contents to help you find information quickly and follows an easy format of questions, lessons and examples (See Chart 1).

Start with the key guiding question relevant to your inquiry. Then ask auxiliary guiding questions. Last, look at the lessons and think through the implications. Case studies have been included to help illustrate the lessons.

The Guide asks you questions as if you were assessing or appraising a project. This is the primary use for which the Guide was designed. You may also, however, use the Guide to monitor and evaluate HIV/AIDS activities by changing the tense of the question.

The Guide includes:

- a statement of Australia's international HIV/AIDS objectives and principles for aid activities
- a discussion of how to consider HIV/AIDS within the design of country programs
- a look at cross-cutting themes relevant to all HIV/AIDS activities
- questions posed by the prevention and care activities that may be encountered
- design and implementation issues, including monitoring and evaluation.

WHO TO CONSULT FOR ADVICE

Health Group (HLG) is available for assistance when using the Guide. HLG comprises health policy officers and technical advisers. You can contact these people if you require further advice on HIV/AIDS policy and project design.

In-country experts who can provide country-specific advice may be identified by AusAID posted officers, AusAID activity managers, and NGOs.

A Peer Group may be appointed to advise and support the activity manager through activity preparation and implementation. Peer groups may include specialists from outside AusAID.

HIV/AIDS and Development

HIV/AIDS is a significant problem in many developing countries - placing enormous stress on national health systems. However HIV/AIDS is not just a public health concern - the epidemic poses serious social, economic and other development challenges.

The social impact of HIV/AIDS is already significant in many countries and will worsen in coming years. The consequences include falls in life expectancy, a loss of skilled labour, weaker agricultural sectors and the sickness and death of family income earners. Developing countries need to counter the HIV/AIDS epidemic if they are to succeed in improving living standards.

The HIV/AIDS epidemic interacts with sustainable human development in three ways:

- HIV/AIDS can negate the gains from development
- patterns of development can contribute to the spread of HIV/AIDS and exacerbate its consequences
- lessons from what works in sustainable human development can inform responses to the epidemic.

Basic Facts about HIV and AIDS

HIV stands for Human Immunodeficiency Virus, the virus that causes AIDS. AIDS stands for Acquired Immune Deficiency Syndrome. This condition is present when the immune system has become seriously weakened by the virus and the infected person can no longer fight off certain infections.

Following infection, the virus replicates rapidly leading to a strong immune response and the development of antibodies. These antibodies can usually be measured by a blood test within a few weeks of infection. If they are detected the person is said to be HIV positive.

For a varying period of time the immune system keeps HIV infection in check and the person only gradually develops serious immune deficiency. She or he appears healthy with little sign of infection although the virus can be transmitted to others through semen, vaginal and cervical secretions and blood. During this period, provided the conditions are right, people living with HIV can have long and productive lives.

Gradually HIV overwhelms the immune system causing susceptibility to infections that healthy people successfully fight off. These opportunistic infections include certain kinds of pneumonia, tuberculosis, some fungal infections and many other diseases. This end stage of HIV disease is called AIDS.

**CHART 1: STRUCTURE OF THE GUIDE**

Five main themes are each broken into key issues specific to that theme. The following example demonstrates the flow of the Guide using the theme of Other Prevention Activities and the key issue, Mother-to-Child transmission.

**Cross cutting issues**
- Promotion and provision of condoms
- Activities focusing on STD management
- Improving blood products and medical practices
- HIV testing

**Other prevention activities**
- Mitigating the impact on individuals and society
- Design and implementation

**Key Guiding Question**
- Does the activity address mother-to-child HIV transmission?
- If it does, has a viable strategy been adopted?

**Auxiliary Guiding Question**
- Will testing be part of the activity?
- Will HIV/AIDS inhibiting drugs be used?
- How will the use of these drugs be ‘contained’?
- Will mothers be advised not to breastfeed? How will this impact on other health messages?
- What assistance will be provided to mothers to access substitute milk/food and maintain the hygiene of feeding equipment?

**LESSONS LEARNED**

HIV inhibiting drugs - AZT reduces mother-to-child HIV transmission and combination therapy involving additional drugs can produce more rapid and greater reductions, even with only 2-3 weeks of pre-partum therapy. This raises the problem of translating an expensive and perhaps prolonged intervention, successful in a controlled trial, into an efficient and cost-effective therapeutic field intervention. Even if HIV inhibiting drugs can be successfully used to reduce mother-to-child transmission we are left with the ethical dilemma of justifying not treating the mother in her own right. This also involves a practical consideration because the infant’s chances of survival will be greatly reduced if the mother becomes ill and/or dies.

Additional materials:
- Mother-to-child transmission of HIV. UNAIDS Technical Update, UNAIDS Best Practice Collection, November 1997

**CASE STUDY**

**Zimbabwe**

In Zimbabwe the prevalence of HIV in the general population, and therefore among women of child bearing age, is extremely high. A project has now been initiated in the light of recent studies that have demonstrated the protective value to the unborn child of maternal AZT therapy in the last four weeks of pregnancy (provided that the mother does not subsequently breastfeed). The community-based initiative will investigate issues concerning the impact of confidential HIV testing and counselling on decisions that face HIV pregnant women in relation to anti-viral drug therapy and breastfeeding. (Funded by the Australian Government)
Objectives and principles of Australia's overseas HIV/AIDS activities

OBJECTIVES
The objectives of Australia's aid program in the area of HIV/AIDS are to help:

- prevent the spread of HIV
- mitigate the impact of HIV/AIDS on the individual and on society
- address the social and economic needs created by the impact of HIV/AIDS.

Targeting Poverty with a Primary Health Care Focus
Experience has shown that strengthening primary health care is the most effective way to improve the health of the poor. Because poor people are also very vulnerable to HIV/AIDS, all Australian HIV/AIDS activities should seek to have a primary health care focus.

GUIDING PRINCIPLES
The principles guiding Australia's aid program in HIV/AIDS are:

(i) Coordination
Australia should help develop and implement international policy and contribute to better coordination of international efforts at the global, regional, national and community levels.

Australia should support the efforts of UNAIDS. Australia's activities should be consistent with the policies of UNAIDS. Australia should maintain regional partnerships to improve coordination and collaboration in addressing the epidemic. In each partner country Australia should coordinate its activities with other bilateral and multilateral donors and promote the development of networks of indigenous NGOs and CBOs.

(ii) Partner country priorities
Australia should respond to the specific needs and priorities of each partner country in a way that supports national plans, strategies and services for the prevention and control of HIV/AIDS.

(iii) Capacity Building
Australia should help partner countries develop their own capacity to respond to the epidemic. Where Australia is a leading donor in these countries it should work to develop national policy and coordinate prevention and care programs. Australia should consider helping indigenous NGOs and CBOs to improve their managerial and technical capability in the areas of advocacy, prevention and care. Seed funding for NGOs, CBOs and support networks should be considered.
(iv) Partnership
An effective response to the epidemic requires high level political will and partnerships between government, the medical and scientific establishments, the non government sector, religious groups, the media and the public. Australia should foster these partnerships, and promote the exchange of information, strategies and experiences between developing countries.

It is important to collaborate closely with those most affected by the epidemic including PLWHA, their carers, sex workers, injecting drug users, men who have sex with men and communities with a high incidence of infection. Those directly concerned have a right to be involved because it is their health that is affected. They also help to ensure activities are more effective and sustainable when fully involved in project design, implementation and review. Australia should encourage partner governments to involve PLWHA and the communities most affected by the epidemic.

Australia should develop partnerships with appropriate intermediaries including community leaders, representative bodies, indigenous NGOs and CBOs, to achieve a collaboration with those most directly affected.

(v) Community action
Community based, self-help initiatives are highly effective in HIV/AIDS prevention and care. Australian activities should seek to complement and strengthen community or group initiatives and mobilise affected communities not yet able to articulate their needs.
Australia should encourage partner governments to work with community leaders, representatives of those affected and other local interested parties to determine the type of activities that are most relevant and sustainable.

(vi) Multisectoral Approach
HIV/AIDS is not just a health problem. Australia should consider how projects in the areas of governance, infrastructure, education and rural development may contribute to a multisector strategy. Strategies must be adopted to counter any potential increase in risk of HIV transmission to some groups resulting from the economic and social changes as a result of aid activities.

(vii) Decentralisation: District Primary Health Care Services
Australia supports moves in developing countries to adopt more decentralised health services focused on primary health care at the district level. HIV/AIDS activities should increasingly be integrated into district level health services.

(viii) Social and economic analysis
Programmers should examine the wider social and economic structure of targeted communities to ensure project designs take into account the effect of HIV/AIDS on personal, social and economic development. This requires social and economic analysis before and during project design. Aid activities need to be sensitive to the religious, cultural and social values that influence individual behaviour and provide a supportive environment that will facilitate community and individual behaviour change.

(ix) Enabling environments
If high risk behaviours are to be reduced supportive environments need to be established. These might include an official acknowledgment that HIV/AIDS is present in a community, supportive legal and social policies, public discussion of HIV/AIDS, equity between men and women and the development of alternative livelihoods. Activities that remove impediments to the adoption of low risk behaviours should be supported.

(x) Human rights
The human rights of PLWHA must be respected including their right to confidentiality concerning their status. Aid activities should promote respect for PLWHA and guard against the marginalisation and discrimination that they may experience. Discrimination undermines public health campaigns because it forces those who would benefit from counselling and medical care underground. This deprives PLWHA of help and denies the community credible bearers of HIV prevention messages.

Australia should support the provision of basic information, as its importance is often underestimated. People have a right to information about HIV transmission and risk behaviours so they can protect themselves and avoid endangering others.

(xi) Vulnerability of Women and Girls
Projects need to take into account the different needs of men and women for HIV/AIDS prevention and care. Women are more susceptible to infection, have less control over high risk behaviours, and bear the risk of transmitting the disease to their babies. Women tend to be the main carers for other family members with HIV/AIDS. Men are often socialised to behave in ways that endanger themselves and their partners.

Strategies should be adapted for different gender needs but should also complement and reinforce each other. Failing to emphasise the role of men for example, could convey the message that HIV prevention is women’s responsibility.

Australia’s HIV/AIDS activities should be consistent with the Australian aid program’s gender policy. Social and gender analysis is essential to the design of effective HIV/AIDS programs.

(xii) Youth
Australia’s HIV/AIDS activities should include a focus on youth in developing countries because their attitudes and actions will have a profound effect on future prevention and control of the epidemic. All activities should be subject to a youth analysis in the same way that gender analysis is used. More youth specific strategies and activities are required in future programming.

(xiii) Australian expertise
Australia should provide expertise and products in areas where it has particular strengths and which are suited to the needs of developing countries. AusAID should work closely with other Australian government agencies, NGOs and the health and research communities to develop effective strategies and activities, particularly for application in our region. These consultations should take place primarily during AusAID’s country programming.
Country Programming

ADDRESSING THE IMPACT OF HIV/AIDS ON SOCIAL AND ECONOMIC DEVELOPMENT

All programs and sectors of Australia’s development cooperation program should address the potential impact of HIV/AIDS on social and economic development. In most cases the preparation of AusAID Country Strategy Papers should include an assessment of the impact of HIV/AIDS on the country concerned. Possible areas of analysis include the impact on:

- regions (urban and rural)
- social groups
- women and adolescents
- national and regional economies.

Various development issues affect and will be affected by HIV/AIDS. As HIV/AIDS spreads further into rural areas for example, existing problems with infrastructure, institutional capacity and human resources will be exacerbated. In areas of high HIV incidence ongoing aid activities may need to be modified in order to take the impact of the epidemic into account. Development programs aimed at improving self sufficiency will be needed in order to reduce vulnerability to HIV/AIDS, particularly for women and socially marginalised groups.

These broad issues should be addressed during the preparation of Country Strategy Papers and be informed by up to date social and economic analysis concerning the impact of HIV/AIDS and emerging trends.

It should also be recognised that economic and social development itself brings about changes that may increase the risk of HIV transmission for some groups. Strategies should be adopted to address this.

Australia’s international HIV/AIDS activities should support partner governments’ capacity for long-term planning to address the social and economic impact of the epidemic.

There is a clear need to strengthen the ability of individuals and communities to deal with HIV/AIDS. Not all Country Programs have to include specific HIV/AIDS activities. Even those populations hardest hit by the epidemic are facing other health, social and economic challenges. Activities that improve health services, employment and food security will help to lessen the impact of HIV/AIDS on society and on those most affected.

SURVEILLANCE

Surveillance is important in order to monitor the epidemic and assist with future programming. Surveillance activities include monitoring HIV prevalence among the most vulnerable groups (injecting drug users and sex workers) and among other groups in the community (antenatal women, blood donors and recruits to the defence forces). It also involves monitoring behavioural change (eg condom use) and social and economic impacts (eg death rates of working men and women).

If provision for surveillance is not included in a Country Program links should be established with other donors, international organisations or partner government departments that have taken on these responsibilities.
CONSIDERING HIV/AIDS IN ALL ACTIVITIES

HIV/AIDS should be considered as a potential issue for all projects in all sectors. Care should be taken to ensure that proposed and existing activities do not exacerbate the spread or consequences of the epidemic. In some cases mitigating measures will be clearly required (see ‘Bridges and Condoms’ below). Emergency and humanitarian programs will also need to address HIV/AIDS as refugees and displaced persons are particularly vulnerable to infection. Attention should also be paid to the impact of HIV/AIDS on the sustainability of development activities.

Partner governments may require advice and support to avert developments or crises that could exacerbate the spread of HIV/AIDS within their borders, such as drug trafficking. Government recognition of potential risks will foster the political will to formulate strategies and allocate resources accordingly.

Bridges and Condoms

During the construction of the Friendship Bridge, AusAID, John Holland, Maunsell and the Australian Red Cross collaborated to ensure HIV/AIDS issues were addressed. With the cooperation of the local government the Red Cross undertook a needs and impact analysis that led to HIV/AIDS education for workers and communities at the bridge site in Laos. John Holland made the supply of condoms camp policy in order to avoid any hesitation or embarrassment on the part of the workers. Condoms were distributed to everyone on the camp payroll and the Red Cross provided education sessions at the end of the working day. While this was a good start, it does not address the long-term impact of the bridge on HIV/AIDS through increased transport, trade, migrant workers and sex work.

Australian HIV/AIDS organisations

The HIV/AIDS International Development Network of Australia (HIDNA) provides a forum for information exchange and communication between Australian NGOs working on HIV/AIDS and development. The Australian Federation of AIDS Organisations (AFAO) is focused on Australia but has played an important role in establishing and strengthening networks overseas, including the Asia Pacific Council of AIDS Service Organisations (APCASO).
Cross-cutting issues

COORDINATION

Key Guiding Question
Will the activity contribute to better management and coordination of the response to the epidemic?

Auxiliary Guiding Questions
- What discussions have taken place with the recipient government, other donors and NGOs with overlapping interests?
- Is the proposed activity consistent with the policies of UNAIDS?
- Will the activity complement what others are doing? Is coordination built in to the design of the activity?
- Will the activity contribute to improved coordination between the recipient government and the non-government sector?
- Will the activity contribute to networking amongst indigenous NGOs and CBOs?

Lessons learned
Duplication - Many HIV/AIDS projects funded by donors have involved duplication and competition. More effort should be made to foster coordination to achieve complementarity.

Networking - An HIV/AIDS client has so many needs that they cannot be met by one department or one organisation. For this reason there needs to be close collaboration and referral amongst government services, NGOs and CBOs. Professional exchanges at the regional level can result in a strengthening of coordination.

Role of AusAID - Organisations funded by the Australian Government should be encouraged to share materials, resources and technical expertise and to network with government and other organisations to achieve common objectives. The risk of duplication and the potential for complementarity should be addressed during assessment and appraisal.

In India - AusAID has found that support of government and networking with government programs is crucial to ensure that long-term benefits are realised from HIV/AIDS activities provided through NGOs.
North Thailand HIV/AIDS Prevention and Care Program (NAPAC)

This project provides support for community initiatives primarily through small NGOs working in HIV/AIDS. The project facilitates networking, technical, financial and managerial support, implementation of prevention and care and cooperative initiatives with provincial government involvement. Recognised as a successful model and originally funded by the Australian Government, the European Union has now adopted the project for ongoing support. (HIDNA 1998)

PARTNER COUNTRY PRIORITIES

Key Guiding Question
Does the activity respond to the specific needs and priorities of the country concerned?

Auxiliary Guiding Questions
- What consultations have taken place with the recipient government? If the government is not involved, why not, and how viable is the alternative?
- Will the activity be compatible with national HIV/AIDS plans and service structures, including in health?

CAPACITY BUILDING

Key Guiding Questions
What capacity does the partner country have to respond effectively to the epidemic?

Auxiliary Guiding Questions
- Is there a coherent national strategy to address the epidemic?
- Are there weaknesses in the implementation of, or the capacity to implement, this strategy?
- Does planning and implementation make adequate provision for collaboration with PLWHA and the communities most affected?

Lessons learned
Early intervention - In countries where HIV/AIDS is not yet prevalent, early technical support and advice are critical. Intervening at the early stages of the epidemic's development has a greater impact and higher cost-benefit ratio than intervening at a later stage.

Denial - Official denial of the existence of HIV infection in a country and complacency about its current and expected magnitudes are common obstacles to HIV prevention programs.

What technical and managerial capacity will be required for the successful implementation of the particular activity?

- Will the necessary technical and managerial capacity be available or be developed for the implementation of the activity?
- What technical and managerial capacities do the indigenous NGOs involved have?
- What capacities do PLWHA and the communities most affected have to be involved in planning and implementation of the activity?
Lessons learned

Need for capacity building - In most settings funding, without longer-term technical skills building and managerial assistance, has been unsuccessful. Technical and managerial capacities are equally important and should be addressed simultaneously.

Long-term perspective - Capacity building should not be approached as a short-term investment. A commitment should be made for a longer-term investment in capacity building, conducted as a phased activity.

Training - Too much training has been done as a one off event in the name of capacity building. A 'training of trainers' model without continued support that allows for an ongoing process of planning, training, and evaluation is likely to have limited long-term effects.

Capacity building and sustainability - When a project is located within a government institution, government ownership of the project has to be promoted. This sense of ownership helps develop a commitment to institutionalising the project activities. Attention has to be paid to building the capacity for government implementation from the outset, not towards the end of the project.

Strategic Plans - To assist in achieving sustainability, institutional strengthening projects should include a long-term strategic plan and mission statement that outline what the organisation intends to achieve beyond the life of the project.

Partnership with more experienced organisations - In the Southern Africa Network of AIDS Service Organisations (SANASO) Project, partnership with a more experienced organisation was recommended to assist with institutional development.

Networking for change - Helping develop networks amongst NGOs can lead to effective advocacy aimed at changing legislation and negative attitudes to PLWHA and increasing support services.

In India - AusAID has found that training and capacity building are key areas and need special attention in HIV/AIDS work.

National planning, Philippines

In cooperation with the National AIDS Council of the Philippines, the Macfarlane Burnet Centre for Medical Research helped facilitate the development of a new national HIV/AIDS strategy for the Philippines through a process based upon the principles of sustainable human development. The process involved an analysis of principles other countries had used in responding to the epidemic and the development and dissemination of a discussion document. This was followed by workshops throughout the country, a rewriting of the plan and national consensus building around a final plan. The final document was launched by the President in 1995. (Australian Government funded project)

Provincial level planning, Indonesia

The Indonesian HIV/AIDS bilateral project adopts a provincial level planning and implementation approach, seeking to strengthen planning and implementation capacity through cooperative government and NGO programs. It provides mutually supporting roles for provincial government and NGOs. (Australian Government funded project)

Community based annual review and planning, India

A community group responding to HIV/AIDS and injecting drug use in Manipur, India, was helped by an Australian NGO in annual reviews of its programs, the introduction of the first needle exchange program in India and subsequent program planning. This project now provides the same assistance to similar community based responses in other regions of the same state, the adjacent state of Mizoram and neighbouring country of Myanmar. (Australian Government funded project)
PARTNERSHIPS: APPROACHES

Key Guiding Question
Will the proposed activity promote partnerships between stakeholders?

Auxiliary Guiding Questions
- Who are the key stakeholders and how will they be involved? If some stakeholders are not to be involved, why not?
- What would be required to ensure equity in the relationships between stakeholders? Has this been addressed?
- How are information, strategies and lessons to be exchanged? Is it designed into the activity?
- Are the most vulnerable involved, including PLWHA?

Lessons learned
Success of partnership model in Australia - The relative success of responses to the epidemic in Australia would not have been achieved without the partnerships that were established between organisations representing vulnerable groups, government, medical and scientific bodies, the media and the broader community. The success of the partnership model in Australia underscores the need to involve representative bodies, community leaders, and indigenous NGOs and CBOs in partner countries to ensure the views and perspective of those most affected are respected.

Replication - The partnership established in Australia between the government and non-government sector is not easily replicated in developing countries. The advocacy and active involvement of the urban gay community were a critical factor in Australia. Marginalised groups in developing countries do not have this negotiating power and the general population is not easily organised around HIV/AIDS as a public health issue. Moreover, the governments concerned often lack the political will, resources or capacity to respond effectively.

Different contexts - The biggest challenge for Australian NGOs is the different context and epidemiological profile of HIV/AIDS in developing countries. Different strategies and approaches are required because the populations affected are far bigger and far poorer, national budgets far smaller, fatalism and complacency higher, the epidemic much more advanced and the ability to do something about it much more limited.

Cultural differences - There is evidence that cross-cultural differences in communication styles and language between Australians and overseas partners have constrained responses. To be effective in policy and program development, it is necessary to reconstruct much of what has been learned from Australia’s domestic success into tools that are recognised as indigenous.

Obstacles - In some countries, such as in Burma, it may not be appropriate to establish partnerships at the government level and there are obstacles to establishing partnerships with indigenous NGOs and CBOs.

Capacity building strategies and options:
- Help partner governments strengthen their policy setting, planning and implementation capacity;
- Help establish a broad institutional capacity to respond to HIV/AIDS with attention to coordination mechanisms integrating all levels and all stakeholders;
- Help establish an increased community capacity to cope with HIV/AIDS;
- Incorporate technical and managerial assistance into funded activities.
PARTNERSHIPS WITH THOSE MOST AFFECTED

Key Guiding Questions
What level of collaboration will be achieved with those most affected, including PLWHA?
What will be done to ensure that those most affected have the capacity to be involved?

Auxiliary Guiding Questions

- Which affected groups are to be targeted?
- Have they been or will they be involved in project design, development, implementation or review?
- Do PLWHA actively support the activity?
- What intermediary organisations/individuals will be involved to ensure collaboration with those affected?
- What assistance has been or will be given to those targeted by the activity to identify and articulate their priorities and turn them into projects?
- What will be done to help indigenous HIV/AIDS organisations improve their managerial and technical competence in prevention, care and advocacy?

Lessons learned
Building trust - Relationships break down when organisations or individuals are seen not to be listening to the people directly affected by the epidemic.

Collaboration with those most affected - HIV/AIDS activities are most effective and sustainable when those most affected by the epidemic are fully involved in project design, implementation, review and evaluation. It is thus important to work with PLWHA, their families and carers, sex workers, injecting drug users and communities with a high incidence of infection.

Support and involvement of HIV positive people - The direct experience of healthy looking HIV positive people is one of the most effective means of promoting IEC as well as sensitising communities to their responsibility for care.

Disclosure - Programs that assist people to publicly identify themselves as HIV positive have good demonstration effects. Social awareness increases and discrimination decreases as more people publicly identify themselves. However, because it is recognised that PLWHA are an effective channel for conveying HIV/AIDS messages, pressure is sometimes put on them to identify themselves and share their experiences.

Support must be carefully planned for both the individual and his or her family, clan and in some instances, wider network of acquaintances.

Encouraging partner governments - Partner governments may be reluctant to forge partnerships with the groups that are affected. Australia should work with partner governments in this regard, encouraging them to lead by example by demonstrating a commitment to collaborate with those most affected.

Communication and policy input - In most countries there is a need to work on better relationships between stakeholders - notably between government policy makers, project workers, and PLWHA.

PLWHA networks - In some countries, including in the Pacific, the number of people who identify as PLWHA is quite small. They need regular contact with people in other countries to boost their morale and develop a greater understanding of their advocacy role.

Linkages with government - NGOs have learned that it is vital for PLWHA to maintain communication with officials. NGOs in Thailand network at various levels with provincial, district and village authorities.

Myanmar HIV/AIDS Project
World Vision found that while gaining the support of local authorities was vital, it was also important to make clear to local authorities that the communities involved should participate out of choice. In this project the authorities forced people to attend classes. Local authorities were very supportive once they understood the aims and objectives of the project. (Australian Government funded project)
# COMMUNITY ACTION

## Key Guiding Questions

Will the proposed activity complement and strengthen existing community or group initiatives, or mobilise affected communities and groups?

Is community action sustainable?

## Auxiliary Guiding Questions

- Does the activity build on a community or group initiative? Could it have? Are any CBOs involved?
- Is the community or targeted group likely to mobilise around the proposed activity?
- Have local intermediaries been used eg. indigenous NGOs? What support and experience do they have at the community level?
- What material assistance will be provided, to whom and for how long? What will happen after project completion?
- What up-front commitment is the community or target group expected to make?

## Lessons learned

### Effectiveness

Community self-help initiatives offer the most effective approach to HIV/AIDS prevention and care. Whether in the United States, Uganda or Thailand, community action is at the centre of many innovative and successful responses to HIV/AIDS. The largely untapped community capacity to take forward HIV/AIDS prevention and care is pertinent given the lack of resources available to governments and agencies to reach people.

### Community based organisations

Given the complex socio-economic and cultural context of HIV transmission, CBOs are often best able to initiate appropriate and innovative responses to the epidemic, as well as to work with vulnerable and marginal populations. Where CBOs are not present the challenge is to develop effective models of community action. The best approach is to identify what the community can do and build slowly on that. A key activity is helping communities establish a strategy using participatory needs assessment and participatory planning techniques.

### People's priorities

Health promotion that works and is sustained begins by asking people about their own priorities for living. People are then supported to meet those goals through community and group mobilisation. HIV/AIDS prevention and care should build the skills that give people the collective capacity to deal effectively with issues that affect their lives, as they themselves perceive them.

### Capacity building

Much is expected of CBOs and community groups without appreciating how much assistance they need.

Special emphasis needs to be placed on enabling them to improve their managerial and technical competence.

### Empowerment

Community action is ultimately about empowerment. Strengthening community action therefore should not just be a project component but a project objective that must inform everything that is done. One way of expressing the objective is to state that the activity should enable people to increase control over their lives. Empowerment may include progressive interventions with marginalised people including PLWHA, sex workers, injecting drug users, gay men and men who have sex with men.

### Steps

Community mobilisation begins by defining local needs and priorities and identifying CBOs with appropriate mandates and linkages. Subsequent steps include local needs assessments, proposal development and implementation. All stages require technical assistance.

### Overburdening indigenous organisations

Donors tend to look to local NGOs or CBOs to implement activities, but their capacity is limited and this has to be recognised. The capable ones end up being flooded with funds and their staff are quickly stretched, working on multiple programs and projects. Further capacity building is required but this is a long-term process. In the short term it may be preferable to tailor activities to community abilities rather than designing activities assuming there are well developed organisational structures to implement them.

Continues....
Churches - In the Pacific, PNG and the Philippines the churches are a powerful force in society in terms of attitudes to sex, sexual roles and HIV/AIDS. HIV/AIDS is sometimes regarded as a punishment for sinful behaviour. This view impacts very negatively on PLWHA. The churches are one of the foundations of social organisation and youth and women's groups are often church based. Consequently the churches offer an alternative avenue for IEC where NGOs and CBOs are not well developed.

Self Direction - It has been found that PLWHA groups and organisations cannot be sustained simply by providing external assistance. PLWHA need to be able to organise themselves and run their own affairs. Government and other assistance should be decentralised to PLWHA groups or organisations.

Sustainability - Community responsibility is the basis of sustainability. Effective mobilisation should lead to communities articulating their own priorities and solutions. HIV/AIDS initiatives are more likely to be embraced and sustained if project identification engages individuals and groups in a genuine dialogue and lays the foundations for local ownership. However, while these approaches give communities responsibility for program planning, decision making and implementation, they will still require technical assistance and support.

Additional materials

NGO Package of Information AusAID


Uganda

In trying quickly to meet village medical needs, The AIDS Support Organisation (TASO) learned that the rapid introduction of drugs with a commercial value unrealistically raises community expectations and can lead to resources vanishing with nothing to show for it. TASO learned not to rush communities with medical and other support until the community demonstrated its readiness to assume responsibility. (Supported by Quaker Service Australia/Australian Government)

India

In response to an epidemic of injecting drug use, communities in Manipur, India, established rehabilitation services, based on abstinence. The emergence of an associated epidemic of HIV/AIDS left the community overwhelmed. AusAID recognised and funded an emerging community initiative, the SHALOM project. SHALOM harnessed an established community response and provided a new way forward with the introduction of programs based on harm reduction principles (needle exchange and condom promotion) and community based care and counselling.
MULTISECTORAL APPROACHES

Key Guiding Question
Is prevention and care well integrated and being approached on a broad front?

Auxiliary Guiding Questions
- Is there a narrow focus on just one measure or strategy? What is the potential for developing a more multisectoral strategy?
- Will the proposed activity be complemented or reinforced by other activities, including what other donors are doing?
- Does the activity adopt an integrated approach to treatment and care, education and prevention?

Lessons learned

Broad front - Effective HIV prevention depends on a comprehensive combination of successful behavioural, bio-medical, social and economic approaches.

National integration - Breaking linkages by focusing on single components tends to increase problems because societies and individuals no longer perceive themselves to be either part of the problem, at risk, or part of the solution. The establishment of a greater sense of responsibility from national governments through to village communities has to be an essential strategic component.

District level networks - Successful attempts have been made to link all forms of HIV/AIDS responses within communities (home care, education, income generating activities, etc). This includes having PLWHA visit other villages and districts to encourage them to form groups. Networking results in greater cooperation and reduces overlap, making community work more effective and efficient. Networks can put healers, helpers and carers in contact with each other.

Overlap - The multisectoral approach needs to be clearly defined to avoid one sector competing with or repeating what another is doing rather than focusing on what it can do best. The correct course is to utilise the strength and expertise of each sector, in a coordinated and integrated manner.

Linkages with development activities - It may be extremely valuable to link HIV/AIDS activities with development, working to change the social, cultural, and economic context of people’s lives (eg. education programs for girls, income generation activities for women).

Supporting activities - HIV prevention strategies need to address issues in the areas of poverty, violence against women and the exploitation of women and children and emphasise the human rights of ethnic minorities, refugees, migrants, drug users, sex workers and the poor.

Dissipation of impact - The team leader of an Australian Government funded HIV/AIDS project in Indonesia, covering four provinces and including four components, concluded that impact was being dissipated by the breadth of coverage and that it would be better in future to concentrate resources within a specific geographical area and focus on a particular issue. This was reflected in the development of IEC materials. The development of targeted campaigns across several provinces called for a research and marketing base that did not exist. A concentration on one province or city would have consolidated efforts, concentrated resources, decreased the number of cultural and behavioural variables to be considered, better utilised local expertise and increased the potential for sustainability.
**Integrated prevention strategies**

Programs to prevent the spread of HIV work best as a package, with each initiative reinforcing the others. The best prevention campaigns work simultaneously on many levels:

- increasing knowledge of HIV/AIDS and how to avoid it
- creating an environment where safer sexual or drug-taking behaviour can be discussed and acted upon
- changing laws, employment practices and even economic policy to create an environment in which people can more easily reduce or control their exposure to HIV
- providing services such as HIV testing, treatment for other STDs (which if left untreated greatly magnify the risk of HIV transmission) and access to cheap condoms and clean injection equipment
- helping people to acquire the skills they need to protect themselves and their partners
- supporting community level action.


**USAID’s experience**

A 1996 evaluation of USAID’s major global program, the AIDS Technical Support Project, concluded that the three technical strategies of condom promotion, reduction of STDs and behaviour change communication are appropriate and important components of any comprehensive HIV/AIDS program, particularly if they are combined in a mutually reinforcing way. However, the evaluation noted that although the three technical strategies are essential, they are not sufficient to make a sustainable impact on HIV transmission. It was recommended that a broader response include more attention to:

- developing ‘contextual interventions’ for HIV prevention
- supporting a more ‘community-organising’ approach to HIV/AIDS
- reaching beyond traditional risk groups to reduce women and girls’ vulnerability to HIV/AIDS
- linking HIV/AIDS prevention and care.

**Thailand and Nepal**

Evidence from Thailand suggests prevention can work even if the epidemic is in a phase of rapid growth. This was achieved by the adoption of a 100% condom use policy in brothels, offering better educational and vocational opportunities to young women, keeping them out of the sex industry, and mass media campaigns encouraging respect for women and discouraging men from commercial sex. The disadvantage was that HIV/AIDS became seen as a sex worker’s disease and condom use outside brothels remained low.

In Nepal a vigorous campaign to inform truck drivers and sex workers of the risk of unprotected sex, plus the provision of condoms at convenient points along truck routes, successfully reduced the risk behaviour of sex workers and the transport workers who make up the bulk of their clientele.

DECENTRALISATION: DISTRICT PRIMARY HEALTH CARE SERVICES

Key Guiding Questions
Will the proposed HIV/AIDS activities be integrated with PHC, including reproductive health programs?
Are the activities consistent with a decentralised health service model, focused at the district level?
Will the clinical aspects of the activity be backed up by any preventive strategies?

Auxiliary Guiding Questions
- What is the reason for combining or not combining activities?
- Will the costs of integrating HIV/AIDS activities into PHC including reproductive health programs, justify the benefits?
- Are the proposed activities located at the national level? Is the focus on a vertical program justified? Could the focus be shifted to the district level?
- Will the activities be integrated with district level health initiatives/services?
- Are any counselling and education activities to promote behavioural change proposed?
- Will health staff be provided with any training in HIV prevention?

Lessons learned
Entry point for IEC - Integrating HIV/AIDS prevention and care with other health services (primary health care, reproductive health/maternal and child health, STD management) offers an entry point for HIV/AIDS information, education and communication and for training and sensitising health staff.
Entry point for screening - HIV prevention programs should be integrated with other HIV services such as testing, counselling and surveillance. Efforts to prevent and control HIV must be coordinated with efforts to control other STDs and other communicable diseases with some similar modes of transmission such as Hepatitis B or C.
Institutional support - Activities like condom promotion/distribution and strategies to deal with drug use need to be linked to health and social services.

Reaching more women - Integrating maternal and child health, family planning services and HIV prevention offers an obvious mechanism for reaching women who may only use health services at key points in their reproductive cycles. However, this approach does not achieve greater coverage of men.

Attracting funding for STD management - Integrating STD services and HIV prevention offers a way of securing additional funds to support and improve STD services. Targeting STDs has been shown to be an effective strategy for reducing HIV transmission but STD services are generally poorly resourced.
Compatibility of programs/services - HIV/AIDS prevention and care will not always be compatible with other services. An assessment needs to be made. PHC programs for example, are not well suited to dealing with the particular needs of PLWHA. Moreover, there may be conflicting approaches between HIV/AIDS prevention and care and the particular program or service with which it is proposed it be integrated.

Costs of integration - It remains to be determined if the greater cost of staff, training, drugs, and clinical equipment that is likely to be involved in an integrated reproductive health care approach will be outweighed by the money saved from reducing STDs and the ensuing complications requiring treatment. There is also a need to ensure that integration of reproductive health services does not create a broader range of services resulting in a significant loss of focus and possible decrease in the quality of services.

Continues ...
Vertical programs - Large-scale bilateral projects targeting specific diseases may tend to reinforce a vertical, poorly integrated approach to the delivery of health services both at the peripheral and national level. Moreover, centralised national programs tend not to reach remote rural communities. The competing benefits of a vertical HIV/AIDS focus and the decentralisation and integration of health services have to be weighed.

Confidentiality - Integrating HIV/AIDS prevention and care into other health services raises issues of confidentiality. On the one hand health staff would need to be trained to respect confidentiality and procedures would have to be put in place to ensure records were coded to ensure confidentiality. On the other hand, people may be more willing to attend a non-HIV/AIDS specific service because they would be far less likely to be identified publicly as HIV positive or suffering from AIDS.

**SOCIAL AND ECONOMIC ANALYSIS**

**Key Guiding Question**
What social and economic research has been conducted?

**Auxiliary Guiding Questions**
- What is the quality of the research and analysis that has been conducted?
- Has it examined the broader social and economic structure of the community and the way HIV/AIDS affects personal, social and economic development?
- Has it included gender analysis?
- Are the activities sensitive to the cultural, social, peer group and religious values that influence individual behaviour?

**Lessons learned**
Social research - Social research is essential to the design of effective programs and the use of qualitative and quantitative social research is a highly effective tool in improving program implementation. Participatory social research linked to program action greatly enhances prevention and care programs. Efforts to link and strengthen collaboration between field program staff, academic researchers and policy leaders are vital. Research also needs to be pragmatic and immediately useful to program monitoring and evaluation. In this context research tools that are simple, relevant and easily adapted to the country context are highly valued.

Context of behaviour - Although it is now well established that social, economic, and cultural factors affecting behaviour have to be addressed to initiate and sustain behavioural change, interventions still pay inadequate attention to the context in which high risk behaviour occurs. One reason for the deficiency in HIV prevention programs for women is the lack of reliable data on women's sexual lives and the ways in which socio-economic and cultural factors act as determinants of their sexual experiences. Effective programs must include gender analysis and social research.

Early warning - Behaviour precedes infection therefore information about behaviour and the social, cultural and economic factors that influence it can act as an early warning system, helping to define the likely path of the epidemic. Behavioural data can indicate how exposed a community may be to HIV/AIDS. The information can identify groups who are especially vulnerable and can pinpoint particular behaviours that threaten to drive the spread of the virus. When collected over time it can also indicate trends in risk behaviour and vulnerability, validating existing prevention approaches or suggesting what changes need to be made for greater impact.

Behavioural data can be especially crucial in the early stages of the epidemic, when the virus may be spreading largely among people with well-defined behaviours such as drug injecting or commercial sex. Only behavioural information can identify the links that may, if identified early enough, suggest practical ways of preventing spread among the general population.

Continues...
Support for research - Assistance with epidemiological and social behavioural research and with seroprevalence surveys improves knowledge of the epidemic in specific settings and therefore improves the impact and effectiveness of programs. Such research also plays an important role in helping increase awareness about the nature, likely scale and costs of the epidemic among policy makers and program planners in recipient countries. This is a useful way to overcome denial and complacency about the current and expected magnitude of HIV infection - one of the most common obstacles to HIV/AIDS control programs.

Justification - Research should demonstrate clear, practical or programmable outcomes and complement practical programs, rather than be an end in itself. Proposals for research funding should clearly demonstrate that the research is needed and that it will not duplicate what others are doing (unless justified by the need to verify important findings).

Innovation - A valid consideration in choosing activities to be funded is the piloting of new and innovative approaches that might help develop more relevant policies and programs.

Research ethics - Australian Government assisted research activities should take account of the HIV/AIDS research ethics that apply in Australia and in the recipient country.

Research in support of disease control programs
Effective mechanisms for Australian support to particular disease control programs, including HIV/AIDS include:

- support for multilateral agency programs and research (disease control programs of UNAIDS)
- selected national level research (support for national governments to improve their capacity to collect information; centres of excellence)
- pilot community based projects aimed at adapting proven strategies to the needs of specific populations and geographic areas (supporting community based projects implemented by indigenous and Australian NGOs aimed at developing and improving approaches to specific disease problems, such as HIV/AIDS that require adaptation to specific population groups and geographic areas).

Adapted from Issues and Trends in International Health, Drs Michael Toole and Maxine Whittaker for AusAID, 1997, pp 142, 151

Papua New Guinea
Research into sexual practices by the Institute for Medical Research led to the development of community based peer education and intervention programs in Port Moresby and Lae. These programs target vulnerable groups including sex workers, transport workers, seamen and police. This behavioural research provided an early warning of the potential for rapid transmission of HIV where STD rates were very high.
HUMAN RIGHTS

Key Guiding Questions
Will the activity incorporate the provision of clear and accurate information about HIV transmission, risk behaviours and protection?

Will the activity discriminate against or stigmatise PLWHA, an identified high risk group, or anyone else?

Auxiliary Guiding Questions

■ What is assumed about the target group's knowledge about transmission, risk behaviours and protection? Have these assumptions been tested?

■ Will the activity address the information needs of leaders, parents and educators?

■ Will the right to confidentiality concerning status be compromised in any way?

■ Is any minority or disadvantaged group marginalised by national plans or supported activities?

■ Will there be any restrictions on the access to health services by at risk groups?

Lessons learned
HIV/AIDS is a human rights issue - Women, poor people and marginalised groups are generally more vulnerable to infection, less able to protect themselves or cope with illness. Stigmatisation and discrimination against PLWHA have a critical impact, not only on their self esteem but on their physical well-being and longevity. The stigma of being HIV positive or having AIDS prevents many people coming forward for assistance or information. Employment is difficult for PLWHA and job protection is rarely, if ever, provided by law.

Right to information - Everybody has a right to information about HIV/AIDS, including how HIV is and is not transmitted and how one can protect oneself and others from infection. This information should be clear and accurate. Unfortunately, many mass campaigns have provided very inaccurate information about the threat of HIV/AIDS, in some cases overstating the risks, leading people to adopt a fatalistic attitude and forego protection. The need to provide basic information is easily underestimated.

Rights of the non-infected - Hospital staff, parents with children at school and carers all have a right to information about HIV/AIDS and the risks of infection. Providing information about how HIV is transmitted can directly benefit PLWHA because the community learn that the risk of infection as a result of every day social interaction is extremely low.

Youth - Young people need access to information about HIV/AIDS and access to youth-friendly sexual and reproductive health services. These services should safeguard the rights of young people to privacy, confidentiality and informed consent with respect to cultures and traditions.

Parents - Parents also need information about HIV/AIDS. It is easy to assume parents know more about HIV transmission, risk behaviours and protection than they actually do. Parents often feel powerless because they don't know what is happening to their children or what they can do to advise and protect them.

Infringements - Mandatory testing, quarantine, restrictions on movements and social ostracism are infringements of the human rights of PLWHA and create unnecessary hardship for people suffering from a life threatening disease.

Stigmatisation and violence - Fear based campaigns to promote behavioural change can lead to stigmatisation and violence against PLWHA or other high risk groups. Consider all IEC materials and activities from the point of view of PLWHA.
VULNERABILITY OF WOMEN AND GIRLS

Key Guiding Question
Has the vulnerability of women and girls been adequately addressed?

Auxiliary Guiding Questions
- What gender and social analysis have been conducted?
- What specific measures have been taken to address the vulnerability of women and girls?
- Do these activities address the underlying causes of vulnerability?
- How are men to be encouraged to take responsibility for preventing HIV?

Lessons learned
Different needs - Men and women have different needs in relation to HIV/AIDS prevention and care and this should be reflected in programming. While different strategies are needed to address different problems, they should be complementary and mutually reinforcing. However, the attention to women’s needs should not imply that HIV prevention is solely women’s responsibility.

Women and girls more at risk - Women and girls are more vulnerable because they are more readily infected and have far less control over the circumstances that give rise to risk. For example, the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2-4 times higher for women than men (UNAIDS). It has been reported from Uganda that among 15 to 19-year-olds, six young women are infected for every young man. Women’s subordinate status makes it very difficult for them to take measures to protect themselves. Men still feel they own their wives, particularly where bride price has been paid. Communities may respond to the needs created by the epidemic but do not take gender issues sufficiently into account. Women also bear the risk of transmitting the disease to their babies and play a key role as carers of other family members with HIV-related illnesses.

Reaching the majority of women - The HIV/AIDS epidemic has not stayed confined to ‘risk groups’ in most developing countries. The increasing prevalence of heterosexual transmission is affecting women who may have regarded themselves as low risk. Prevention programs will not reach the majority of women if they target only sex workers or other groups perceived as high risk. Special attention needs to be given to preventing the sexual exploitation of women and girls.

Underlying causes - Underlying the progression into the general population are many factors that make women and girls vulnerable to HIV/AIDS, including the power imbalances between men and women and the social construction of gender roles. There is a need for activities that address the basic inequities underlying women’s vulnerability to HIV/AIDS.

Additional materials
Guide to Gender and Development, AusAID
Women and AIDS: UNAIDS Point of View, UNAIDS
Best Practice Collection, Oct. 1997

India
In Mumbai, India, increasing numbers of women and children are being rendered homeless and blamed for their husband’s HIV-related illness or death. In Indian culture once ostracised or widowed under such circumstances women are unable to return to their ancestral homes. They are homeless and economically vulnerable. A project Jacob’s Well, initiated by an Indian NGO, OASIS, has responded to this need with the establishment of vocational training units. Market research was so effectively done that a seed grant of $10,000 from the Australian Government was all that was required for the project to be sustained through subsequent manufacture and sales of garments and goods produced by the women.
Prevention activities for women

AIDS in the World II, 1996, makes the following recommendations for HIV prevention for women:

- Focus resources on structural changes to improve the status of women by increasing women's access to education, credit, skills training, and employment.
- Support biomedical research for development of female-controlled preventive technology that women can use without the knowledge of their partner.
- Make STD services more available and accessible to women by integrating them with family planning and maternal health services.
- Help empower adolescent girls and women by increasing their knowledge about sexuality, HIV/AIDS and other STDs and improving their skills in using condoms and negotiating safe sexual behaviours with their partners. Such efforts can facilitate individual behaviour change as well as possibly lead to collective action to change socio-cultural norms in the community.
- Design programs for adolescent boys and men that promote sexual and family responsibility.
- Fund participatory action research that examines the cultural, economic, and social factors related to sexuality and gender relations and that ensures a strong focus on the realities of women's lives. In many countries, data is limited regarding the sexual attitudes of men and women, the cultural and socio-economic factors that put women at risk, and the options available to women for HIV prevention.

YOUTH

Key Guiding Questions

Does the activity address HIV prevention for young people?

If young people are included or targeted, has a viable proven strategy been adopted?

Auxiliary Guiding Questions

- What age groups are IEC messages or activities being pitched at? Will school students receive appropriate education on sexual and reproductive health at all levels?
- Are the needs of out of school children addressed?
- Homeless youth are especially vulnerable. Are their needs considered?
- What assumptions have been made about the sexual activity of young people?
- What problems have been anticipated in reaching them? Will appropriate intermediaries be used?
- What strategies have been adopted for gaining the support of parents, teachers, education authorities, health authorities, religious leaders, NGOs and CBOs?
- Will young people be involved in the development of strategies?
Lessons learned

Conditions for young people to avoid risk behaviours - Young people need an enabling environment of peers, parents and other adults as well as a community that supports open communication among youth on their sexual health.

Focus on youth critical - Teenagers are a highly active sexual group and making information and services available to them is increasingly important in arresting the spread of HIV. Their attitudes and actions will have a profound effect on the prevention and control of the epidemic. Accordingly, HIV/AIDS activities should have a special focus on youth.

Window of opportunity - Young people are in the early stages of developing attitudes, communication patterns, and behaviour related to sex and relationships. This provides an opportunity to influence the behaviour of young people who are sexually active from the start of their sexual lives, thereby potentially slowing the course of the HIV/AIDS epidemic.

Activities - Every opportunity must be used to help young people acquire the information and practical skills they will need to negotiate a safer path through life in the HIV/AIDS era. Successful activities have included anti-AIDS clubs providing sex education and information on HIV/AIDS and additions to school curricula.

Young people more likely to act - Young people are reported to be more responsive to prevention messages concerning HIV transmission than adults. This is partly because those who are not yet sexually active can be fairly confident that they are uninfected whereas those who are sexually active are unsure (testing is rare in most developing countries) and prone to fatalism. (See the box below on Uganda and Tanzania.)

However, the view that young people are more likely to respond to IEC is not unanimous. World Vision has reported that in Masaka, Uganda changes in sexual risk behaviour are more evident among adults and least evident among youth. They attribute this to a number of socio-economic factors including poverty, lack of education on sexuality, redundancy (and lack of appropriate entertainment during free time) and cultural changes that contribute to the high rate of sexual partners.

Safeguarding girls - Interventions designed to safeguard young women’s sexual and reproductive health must involve adolescent boys as well as adult women and men.

Additional materials
Learning and Teaching about AIDS at School: UNAIDS Technical Update, UNAIDS Best Practice Collection, October 1997

Uganda and Tanzania

In Uganda prevention programs brought into schools focused on delaying sexual relations and negotiating safe behaviour. Infection rates in younger age groups are now falling, which in part can be attributed to this intervention. Behavioural studies in Uganda show that young people are now adopting safer sexual behaviour - later sexual initiation, fewer partners, more condom use - than was common a decade ago. First signs of falling infection rates in young people are also being seen in neighbouring Tanzania, in areas with active prevention programs (Report on the Global HIV/AIDS epidemic, June 1998, p12)
AUSTRALIAN EXPERTISE

Key Guiding Question
Do the activities focus on areas in which Australia has particular expertise and capacity?

Auxiliary Guiding Questions
- Does the proposed activity build on a successful strategy developed in Australia or with Australian funding overseas?
- Does the proponent or proposed contractor have a demonstrated capacity in the area concerned? Is the proponent/proposed contractor able to build on experience in the country concerned?
- Are the strategies, activities, experts, products or services suited, or have they been adequately adapted to the needs of the country concerned?

Lessons learned
Australia’s experience - Australia's domestic HIV/AIDS response offers a credible example of how to reduce the transmission of HIV and the impact of the epidemic within vulnerable communities. These domestic successes were based upon early decisive action, an adequate investment in resources and a commitment to comprehensive partnerships.

Expansion and modelling - Programming should emphasise Australian expertise and offer assistance in the expansion and modelling of approaches developed in Australia and through Australian Government funded activities overseas.

Planning and integration - Australia has expertise in assisting national governments with strategic planning and in the integration of HIV/AIDS programming into NGO/community based efforts in cooperation with local government.

Marginalised groups - Australia has significant international experience in harm reduction programs and community focused education and development, especially with marginalised populations. Through the non government sector, Australia has a capacity to work in partnership and offer critical analysis and information exchange.

NGOs - Networking and cooperation by Australian NGOs is an asset that can result in the sharing of lessons, resources and technical assistance across regions.

Experience of NGO/contractor - Organisations tendering for work in HIV/AIDS and development should have previous experience in both development and HIV/AIDS programming. Long standing experience in a country greatly enhances HIV/AIDS programming and NGOs with roots in the community are likely to be more responsive to community needs.

Care and support - Australian assistance has been effective in supporting community based care models.

Australian Red Cross Greater Mekong Sub Regional HIV/AIDS Program

The program provides financial, technical and managerial support to the Australian Red Cross country programs in Laos, Vietnam, Cambodia and Yunnan Province in China. This has strengthened Red Cross societies across the region with skills in HIV/AIDS program facilitation, monitoring and evaluation.

(Consultative Review, HIDNA, 1998)
STRATEGIES AND OPTIONS

A critical factor in countering the spread of HIV/AIDS is the need to change behaviours, particularly sexual and injecting drug practices. Despite difficulties, the priority among donors is still to reduce risk behaviours and this should continue to feature prominently in Australian aid activities.

The main strategies for reducing risk behaviours are to:

- research vulnerability and risk, particularly in relation to sexual and injecting drug behaviours;
- develop information, education and communication (IEC) materials and activities, with the participation of target audiences;
- ensure that the means to change behaviour are available to the target audience - services for example that provide condoms or clean needles;
- create environments more supportive of behavioural change by helping to bring about fundamental social, economic and political change.

IEC is central to most efforts to reduce risk behaviour. Many people associate IEC with materials such as posters developed for schools. IEC activities are however equally if not more important. These may include:

- peer education and counselling, counselling with home visits or counselling at drop-in centres
- outreach programs; formation of AIDS committees and anti-AIDS clubs
- workshops, seminars and dramas
- HIV testing and free clinics
- building community support for behavioural change.
PROSPECTS OF CHANGING SEXUAL BEHAVIOUR

Key Guiding Questions
What is assumed about how to change sexual behaviour by those designing the proposed activity? How well are the impediments to change understood?

Auxiliary Guiding Questions
- What risk behaviour and what community or group is to be targeted? Has the highest risk group and type of behaviour been targeted?
- What is the quality of the available information? What assumptions underlie the approach adopted to reduce risk behaviours?
- What will be done to support behavioural change by ensuring that necessary services are available such as condoms and clean needles.
- What will be done to create an enabling environment for change?
- How will change be monitored? Will trend data be collected? Has allowance been made for ongoing modifications to IEC materials and activities?

Lessons learned
Limitations of IEC - On their own, IEC campaigns have had limited success because increased awareness of high risk behaviour does not automatically lead to changes in behaviour. The impact of such campaigns is particularly limited in areas where the epidemic is yet to emerge, when HIV positive people are unwilling to make their status public or where people with HIV/AIDS are not visible. Nevertheless people have a right to public health information about HIV/AIDS. IEC campaigns are essential components within wider behaviour change strategies.

Being realistic - It is unrealistic to expect people to alter dramatically their behaviour solely on the strength of a public health message (as in a ‘Just Say No’ campaign). There are considerable socio-cultural barriers involved. One must be realistic about prevailing norms and how big a change is required to significantly reduce risk. A realistic objective for behavioural change for example might be to reduce the rate of HIV transmission.

It can be done - Many donors have concluded that well designed HIV prevention activities can reduce high risk sexual and injecting drug behaviours. However it is difficult to change customs, attitudes and behaviour. Some people argue that change only really occurs as deaths mount. Village counsellors in the PNG Highlands have reported that people are not taking the risks seriously.

Where there is awareness - Change often occurs more readily in communities where many people have experienced the death of friends or relatives, where large numbers of people need care and where there is more awareness of the risks. However in Uganda where there is high awareness some NGOs report that changes in sexual behaviour have not occurred in the sample populations. ACORD found that amongst youth HIV/AIDS did not appear to be raising concern, reflected in widespread sexual activity among school students and very low condom use. World Vision reached similar conclusions but believed the number of sexual partners had decreased.

Changing behaviour at the personal level - A study by British NGOs (UK AIDS Consortium) concluded that the rates of change achieved in personal sexual behaviour seem inadequate to halt the epidemic. Change still seems to be limited with low condom use and although partner change is reduced people still have several partners. This is mainly attributed to cultural values and social practices. Linked to this is the relative powerlessness of women in relation to their sexual and economic lives. The NGOs concluded that behavioural change will only be achieved slowly and with extensive involvement by state institutions at all levels.

Professionals more responsive - Behaviour change for health professionals and sex workers is easier to facilitate and measure. Workshops have been found to be more effective for professional groups than the wider population.

Behaviour of health workers - Behaviour change activities are not limited to sexual behaviour. They also need to include the attitudes and behaviours of health workers. Too often health workers blame HIV positive people and hold exaggerated perceptions of professional risk.
REMOVING OBSTACLES TO THE ADOPTION OF LOWER RISK BEHAVIOURS

Key Guiding Question
What interventions are proposed to make the social, economic and political environment more supportive of behavioural change?

Auxiliary Guiding Questions
- Do the national and/or provincial governments recognise that the HIV/AIDS epidemic has serious social, economic and political consequences?
- Are laws and policies supportive of behavioural change? Is HIV prevention on the agenda of local, district, provincial, and the national government?
- What are the social constraints? Is HIV/AIDS discussed openly? Is the society supportive of PLWHA?
- What are the cultural constraints? How do inequities in gender relations contribute?
- What are the economic constraints? What role does poverty play in vulnerability? Are alternative livelihoods required for some groups?

Lessons learned
Main impediments - Individual behaviour change is impeded by a number of social, cultural and economic realities in developing countries. Overcoming these factors is the hardest part in reducing risk behaviour and vulnerability.

Without independent means for example, women may be unable to buy condoms, leave harmful relationships, or refuse cash for sex work. Additional activities such as improving women's access to credit, will always be needed to overcome such impediments. At a wider level interventions might include changes to legislation, policies, official and public attitudes. At the national and provincial levels interventions might involve strengthening institutions and community organisations.

Another example is health promotion. While health promotion has proved itself repeatedly to be one of the most effective elements of PHC systems, it is often limited by scarce resources (funds, personnel, support systems, experience), a bias in health systems towards the medical model and political disinterest in empowerment.

Overcoming social, cultural and economic obstacles is seen by some as a long-term strategy that is not immediately achievable. One might think here of gender equality, eradicating poverty and universal education. But these strategies exist within a continuum where short-term interventions may support long term changes. For example, one intervention might provide women and girls with basic education about health and sexuality. This would impact on a culture of female ignorance on sexual and reproductive health and thereby contribute to the efficacy of HIV/AIDS education. Social change, together with prevention strategies, may have synergistic effects beyond those currently achieved. (USAID evaluation of ATSP).

Preparation period - It can take many years to prepare the ground for behavioural change. Thailand and Uganda are regarded as success stories in relation to the openness that exists to HIV/AIDS prevention and care. However one should not forget that in both countries serious efforts to confront the epidemic started ten years ago.

Seek guidance from affected communities - When there is uncertainty about what contextual changes are appropriate, it is often best to ask those people closest to the problem for options and one can then experiment with different approaches to see what works. Donors need to 'support a transference of governance from distant donors to affected communities' by giving communities the assistance to decide how best to respond to the epidemic. By setting priorities and making decisions locally, proposals for contextual change can be identified and supported (International HIV Alliance).

Continued...
Weakness of interventions - The success of programs may be limited by the relative weakness of available interventions (e.g., condom promotion) compared to the strength of the contextual factors.

Contextual changes accompanying prevention activities - The success of HIV prevention activities may depend on specific contextual changes that have otherwise demanded minimal attention. For example, the policy of 100% condom use in brothels has been very important for sex workers requesting condom use. Contextual approaches often require new qualitative and quantitative performance indicators.

Open up discussion - In many societies there is a reluctance to talk about HIV/AIDS because people are loath to discuss sex and fear illness. However people cannot act collectively if they cannot discuss the problem. Activities have to try to work through the cultural sensitivities surrounding these issues.

**POWER TO CHANGE BEHAVIOUR**

**Key Guiding Question**

Does the target group have the power to control the circumstances that give rise to the risk or in which prevention must occur?

**Auxiliary Guiding Questions**

- What is the social, cultural, economic and political context in which behavioural change is supposed to take place?
- What would have to change to enable people to act on information about risk behaviour?
- Have any strategies and activities been included to empower the target group? Are they realistic? Did members of the target group participate in devising them?

**Lessons learned**

Knowledge and power - IEC will not necessarily bring about behavioural change because knowing what has to be done to protect yourself from HIV/AIDS is meaningless if you have no power to control the circumstances that give rise to the risk or in which prevention must occur.

No negotiation - Women may be aware of the risks of infection but not be able to negotiate safer sex with their partners. For a woman to ask a man to have an HIV test or use a condom may be perceived to imply a lack of trust.

Community empowerment - Lack of power is a fundamental health problem. Health promotion emphasises the importance of improving the ability of communities to change their situations - resulting in gains to health as well as other social needs. The first step is to help people realise that they can do something about HIV prevention in their community.
OPPOSITION AND SUPPORT

Key Guiding Question
What institutions, groups or individuals are likely to support or oppose the activity?

Auxiliary Guiding Questions
- Has a strategy been adopted to engage supporters and opponents?
- Does the activity require an advocacy component?

Lessons learned
Political will - Unless governments recognise that the HIV/AIDS epidemic has serious economic, political and social consequences, they are unlikely to respond in an effective way. In many countries there is a sharp dichotomy between what people imagine to be common sexual practice and the reality. Governments have a responsibility to create the environments that enable individuals and communities to take effective HIV prevention action.

Cultural and religious institutions - Religious institutions can be powerful supporters and opponents of prevention strategies. In Manipur, India religious leaders have provided support for an extremely successful harm reduction project. Elsewhere, however, religious groups have opposed prevention strategies such as condom promotion campaigns.

Official attitudes - In Southern Africa denial and blame towards HIV/AIDS and PLWHA by some governments has led to a similar attitude in the community. If governments pursue a policy of denial or are hostile to HIV/AIDS interventions then prevention will have only limited success - no matter how well managed or how many people are reached. By contrast, in Uganda government support has helped change people's perspective about HIV/AIDS and PLWHA.

Dangerous areas - International borders are major problem areas for HIV transmission but they are also areas of social, economic, political and sometimes military tension. Much of what goes on is illegal or secret and project activities may not be at all welcome. Work in border areas can entail very high risks to staff and to project success, which may not warrant establishing HIV/AIDS activities there.

EMPOWERING WOMEN AND GIRLS

Key Guiding Question
What strategy has been adopted to empower women and girls to protect themselves?

Auxiliary Guiding Questions
- Which women and girls are to be targeted? Who has been left out?
- How sound is the social research and gender analysis underlying the strategy? Whose analysis is it - were women involved?
- What implicit assumptions have been made about the interventions that women and girls can and will respond to?

Lessons learned
Successful strategies - Successful strategies for women address cultural views of sexuality, public discussion about sex and promote greater community and peer support to help women negotiate with their partners. Men are included in these activities to ensure that HIV/AIDS is not seen as a woman's problem and that men take responsibility for their actions.

Without men's consent - In many societies women are expected to agree to a husband's sexual advances, regardless of the risks to their health. This has led many to conclude that if women are to protect themselves from HIV then they need to be able to do so in a way that does not depend on the consent of men. For example, an effective vaginal microbicide would revolutionise HIV prevention but this is still a remote prospect.

Openness - Social norms in most parts of the world discourage open discussion about sex and sexuality and discussions about sex and sexuality are even uncommon between couples. Yet opportunities to discuss and inform are critical to helping women overcome social norms that
define a 'good' woman as one who is ignorant about sex and passive in sexual interactions.

Contraceptives - Most contraceptives effective in preventing pregnancy - the pill, intra-uterine devices, implants and sterilisation - offer little or no protection from STDs. Some studies suggest oral contraceptives and intra-uterine devices may even increase the risk of HIV infection.

Safe procreation - Couples who wish to have children are often reluctant to test for HIV prior to conceiving a child. In parts of eastern Africa, studies have documented increasing rates of HIV infection among monogamous married women who have both an understanding of heterosexual HIV transmission and access to condoms. A similar trend has emerged in Thailand.

Accepting/negotiating condom use - The association of the condom with paid sex in countries like Thailand makes it nearly impossible for the vast majority of wives to request its use, particularly if the stated intention is protection rather than birth control. The issue may strike at the core of the relationship, implying distrust or unfaithfulness. As well, wives may simply find it emotionally difficult to use something perceived to be for use by brothel workers. The commercial sex connotations also hinder condom purchases by youth, especially young women. This is an area where progress remains slow and requires further innovation.

Polygamy - Aid programs are not yet well equipped to deal with polygamous families and it is reported that these families have the greatest difficulties in coming to terms with HIV/AIDS issues. There is a role for better evaluation, monitoring, social action and social research to address the ramifications of HIV/AIDS within polygamous systems.

Communication skills - Women need to be given the opportunity to articulate their own concerns about their sexual lives so that services reflect their realities. Interventions need to focus on increasing women’s confidence in communicating with their partners, helping women analyse their own situations, determine their own risk, and identify personal priorities for prevention, pregnancy and relationships.

Economic independence - If women can achieve greater economic independence they can avoid some of the situations where risk of infection exists.

Additional materials
Guide to Gender and Development AusAID
Women and AIDS: UNAIDS Point of View
UNAIDS Best Practice Collection, Oct. 1997

INVolVING MEN

Key Guiding Question
How will men be involved in the activity?

Auxiliary Guiding Questions

- What aspects of male-female relations will be focused on?
- In what role will men be involved?
- What strategy will be used to engage men in the activity or to promote behavioural change?

Lessons learned

Men have power - Men are often in positions of power in sexual negotiation and therefore must be involved for prevention and care strategies to be effective. Involving men in discussions of gender relations, sexuality, condom use and STD treatment is important.

Social roles of men - Addressing men in their roles as fathers, husbands, workers and community leaders has been found to be an effective communication strategy. Providing men and women with the skills to talk about sexuality and relationships has also been found to be an effective IEC prevention strategy.

Fear of husbands - Many women may find it difficult or impossible to raise the subject of HIV infection with their husbands without external support. Women often have few alternatives to remaining in a marriage. Prejudices against women need to be overcome. As such changes occur over many years, donors should provide peer support, strengthen women’s organisations and help women support themselves and their children.
Socialised behaviour - Men are often socialised into behaviour that endangers themselves and their partners. Campaigns to change high risk sexual behaviour have to address this and adopt realistic strategies to transform social expectations about male sexual behaviour. Amongst other things this may involve placing greater expectations on the role of men in preventing HIV. It may also include changing perceptions about visiting sex workers, given the risk to men's partners.

Alcohol - In many countries commercial sex is largely based in and around bars and preceded by drinking. A University of Zimbabwe study on men's sexual behaviour found that 98% of commercial sex acts were preceded by alcohol consumption. This raises the question: are campaigns to reduce alcohol consumption one way to lower high risk sexual behaviour?

No winners - It is simplistic to think in terms of evil transmitters and innocent victims. 'In the AIDS game there are no winners and losers, just losers. Men must be helped to understand that by protecting others, they are protecting themselves.' (Peter Piot, UNAIDS)

MEN WHO HAVE SEX WITH MEN

Key Guiding Question
Should the needs of gay men/ men who have sex with men be included in the proposed activity?

Auxiliary Guiding Questions

- Is it assumed in the society that sex between men occurs rarely if ever? Is this right?
- What information is there on sex between men - for example, epidemiological information on HIV transmission through male-to-male sex?
- Is there any attention to male-to-male sex in national HIV/AIDS policy or programming?
- How could gay men be reached and what assistance could be provided?

Lessons learned

Denial - In India, male sexual activity with other men is common amongst male migrant workers. Although such behaviour is denied the infection of women by partners returning home on yearly visits is a factor driving the epidemic.

Lack of awareness - Staff at health facilities, including STD clinics, are often unaware or insensitive about the existence of anal, rectal or oral STDs. Health staff need to be educated to overcome ignorance and prejudice against men who have sex with men and gay identifying men. Opposition can be expected from health officials, doctors and others involved in the planning and delivery of health services.

Information - The best informants about the occurrence of sex between men are good outreach workers.

Gay groups - Most men who have sex with men in developing countries do not identify as gay or homosexual and do not mobilise in this way. Gay groups have been formed in the Philippines and Malaysia and are now active in their country’s responses. Australia has considerable expertise in assisting men who have sex with men and PLWHA organise, advocate and provide peer support.

Condoms - Men who have sex with men may be more willing to adopt safe sex behaviour, including using condoms, than men who have sex with women. It is therefore important to ensure that high-quality condoms and water-based lubricants are readily accessible.
Peer education - The most effective form of communication about prevention for men who have sex with men is likely to be peer education.

Discrimination - Identifying homosexuals as a high risk group can lead to generalised discrimination and police harassment of gay men. This occurred in Brazil at the beginning of the epidemic. Target the risk behaviour not the group.

Additional materials
AIDS and Men who have Sex with Men: UNAIDS Technical Update UNAIDS Best Practice Collection, Oct. 1997

IEC MATERIALS AND ACTIVITIES

Key Guiding Question
Have the means of communication been tailored to the target group?

Auxiliary Guiding Questions
- Have the needs and concerns of the target group been identified?
- Is generic IEC to be used? Is it appropriate for the target community or group?
- What languages will be used in materials and activities?
- Is it proposed that the same IEC be used in different environments (across provinces, in both rural and urban areas, etc)? Will this work?
- Has the IEC been piloted or is it to be piloted? How will its effectiveness be monitored and what action will be taken?

Lessons learned
Appropriateness - Messages and activities have to be culturally and socially appropriate. Populations within countries are diverse. For example, it is not effective to use materials depicting an agrarian lifestyle to cattle-keepers - it won't be meaningful and may convey the impression that those people are at risk, not us. The most appropriate methods of reaching people need to be considered, including where and how messages are presented.

Targeting - A key task is to identify the needs and concerns of the target group and work with them to tailor the most effective means of communication. Targeted groups may include women, men, intravenous drug users, sex workers, truck drivers, youth, men who have sex with men, gay men, government officers, health professionals and health workers, educators, parents and religious leaders.

Ownership and identification - The effectiveness of IEC varies according to the stage of the epidemic and the people targeted. But for any target group, ownership of and identification with the message and the means of dissemination helps to create change. For example, language amongst youths is dynamic and often has unique patterns. Messages must reflect this. It is also important to use key community leaders as agents for change.

Options for change from a credible source - The key factor in the success of prevention programs lies in providing realistic options for behavioural change. It is important that these options are provided and supported by a credible source and that there is community and peer group support for behaviour change. Mass media campaigns need to be complemented by prevention education campaigns, such as peer education counseling.

Continues ...
Context and culture specific - It is often necessary to delegate decisions to those closest to the concerns and realities of affected communities to ensure activities are contextually and culturally appropriate.

Use of generic materials - Thai NGOs are now producing their own IEC and are more selective about using government IEC. In PNG provincial differences have become more and more apparent, indicating the need for specific approaches for each province.

Capacity building - Communities and groups can be trained in the identification, design and utilisation of their own IEC. People will then be involved directly in activities such as safe sex and condom promotion drives.

Appropriate IEC - Different techniques work in different situations and for different groups. To change individual behaviour, counselling and peer group pressure appears to work best. Workshops are appropriate for professional groups. Drama groups have been effective for populations that had no previous knowledge, but less so at a later stage in the epidemic and a better informed population.

Health professionals - Across a range of contexts and stages of the epidemic, the most effective techniques for changing the behaviour of health professionals appear to be workshops, seminars and training of peer groups. The role and qualities of the trainer are crucial, and ideally the trainer should be from the same group as those being trained. It is more effective to have women trainers for groups of women, or traditional healers for groups of traditional healers.

Activities must be culturally specific. Drama groups, posters and pamphlets are not viewed as effective activities for changing professional behaviours.

Traditional performers - World Vision Australia found in the Myanmar HIV/AIDS Project that traditional performers can be very good disseminators of information, particularly in more isolated communities.

Piloting, monitoring - IEC must include careful piloting, subsequent monitoring, evaluation, analysis and follow up.

Myanmar HIV/AIDS Project
World Vision Australia found that Burmese language IEC is not always suitable for Burmese speaking people. Many ethnic minorities speak Burmese out of economic necessity but do not read the language. All written materials had to be written in the minority languages.

Video IECs were found to be very popular and an efficient way to reach hard to access segments of the population. Women went to video houses up to twice a week. Locally produced videos, often featuring local villagers, were very well received. Project Completion Report, July 1998 (Australian Government funded project)

The Bamrasnaradura Hospital HIV/AIDS Ambulatory Care Project, Thailand
In the Project Design Document it was proposed that the preparation and printing of IEC for patients, carers and families would be undertaken as single activities in Year One. The Mid Term Review concluded that this did not allow for the ongoing development of IEC that would be responsive to the changes and broadening of HIV/AIDS issues. It was noted that IEC needs would continue to be identified by the advisers and their Thai counterparts, and during ongoing training sessions. It was recommended that a phased approach over the lifetime of the project be taken for the development of IEC. Technical and Mid Term Review June 1998 (Australian Government funded project)
POSITIVE AND NEGATIVE MESSAGES

Key Guiding Question
What impact will the proposed IEC message or activity have on PLWHA and how will it affect their acceptance in the community?

Auxiliary Guiding Questions
- Does the message or activity focus on the more devastating attention-getting aspects of HIV/AIDS?
- If it does, could this further stigmatise people living with HIV/AIDS?
- Does the message include any hope for PLWHA?

Lessons learned
Scare tactics - Frightening information is generally highly counter-productive. In some instances, prevention information appears to have led to behaviours that are more damaging, for example adopting a fatalistic attitude and failing to take any precautions.

Genuine dialogue - Approaches that are genuinely participative and challenge people to confront, reflect on, develop their own responses to and build a normative consensus concerning sexual behaviour should be encouraged. Didactic and prescriptive approaches should be abandoned.

General vulnerability - Identifying risk behaviour with socially marginalised groups like sex workers, injecting drug users and gay men can convey the message that HIV/AIDS can only happen to somebody else. IEC needs to convince the public, without resorting to scare tactics, that they are also vulnerable and would be likely to suffer stigmatisation if infected.

Stigmatisation - Fear-based media campaigns to promote behavioural change can also lead to stigmatisation and violence against people living with HIV/AIDS. This is reported to have occurred, for example, in Tamil Nadu, India. Identifying risk behaviour with socially marginalised groups like sex workers, injecting drug users and gay men can increase prejudice. If particular groups are targeted by IEC, the messages or activities should avoid stigmatising them.

Counterproductive - Discrimination and stigmatisation undermines public health efforts by driving away those who would benefit from counselling and medical care, thus depriving them of help and the community of credible bearers of HIV prevention messages. It also discourages open discussion about HIV/AIDS prevention and care.

Positive messages and activities - IEC messages and activities should provide clear information about HIV transmission, risk behaviour and protection without making negative value judgements about behaviour and stigmatising PLWHA. Messages concerning PLWHA should be positive, advising PLWHA what they can do and how they can remain integrated in the community or reintegrate themselves if they have been ostracised and encouraging the community to support them.

Build on personal experiences - IEC should encourage people to adopt positive attitudes towards PLWHA. In some countries almost everyone has been touched by HIV/AIDS in one way or another. IEC messages and activities could build on these experiences.

Easing taboos - One of the most important outcomes of reducing stigmatising attitudes towards HIV positive people is the easing of taboos on open discussion of sex and prevention.

Northern Thailand
The ‘care not scare’ lesson is well exemplified in Northern Thailand. The region experienced an alarming increase in HIV/AIDS in 1991. A national campaign to prevent HIV used graphic photographs of the worst symptoms of the final stages of HIV-related illnesses. The fear this engendered resulted in PLWHA being rejected. Those with symptoms were often confined to animal shelters. The children of people known to be HIV positive were refused school entry. Stigmatisation caused individuals to both deny and hide their HIV status. The key is to focus on the positive: what people living with HIV/AIDS can do and how they can become a fully integrated part of the community.
COMMUNITY WORKERS, COUNSELLORS AND PEER EDUCATORS

Key Guiding Question
If the prevention activity relies on community workers, counsellors or peer educators, how well has their mode of operation been structured?

Auxiliary Guiding Questions
- Will the activity rely on volunteers or personnel receiving incentives but no salary? Is this feasible? How well have the needs of community workers and counsellors been assessed?
- Is there a risk that the community workers, counsellors or peer supporters will identify and/or stigmatise the people they visit or see?
- Is community prevention work purely focused on HIV/AIDS activities? Could objectives be better achieved by widening the scope of activities at the community level?

Lessons learned
The limits of volunteers - Volunteer counsellors and peer educators are a cost-effective means of disseminating information about risk behaviour and its avoidance. However, the use of volunteers is not sustainable in all settings and requires careful thought. Volunteers will not necessarily sustain work over long periods and burn-out in HIV/AIDS work is high. Incentives can be used to provide some financial security and motivation but this can lead to providing more and more rewards to maintain commitment and retain scarce human resources.

Effective activities - A study by British NGOs (UK AIDS Consortium) reports that the most effective way to change sexual behaviour at the personal level is counselling and peer group pressure.

Informal social networks, made up of friends, siblings, and trusted peers who have changed their behaviour, can be persuasive role models.

Home visits - Home visits may be more effective than large community meetings.

Counselling families - Counselling families of PLWHA can be just as important as counselling PLWHA, particularly if it strengthens the family and provides a more understanding and support environment for PLWHA.

Stigmatisation - If community workers are described as HIV/AIDS workers, members of the community are likely to shun them for fear of being identified, falsely or otherwise. A broader title and a broader range of tasks avoids this obstacle.

Building trust - It can take years to build trust with people. Accordingly, counsellors and educators should be placed in an area for at least two to three years according to one NGO (ACCESS).

Further training - Staff counsellors need a chance to study after a number of years. The ability to get out and see what others are doing is essential.

Widen the scope of activities - In PNG, several churches have found that village HIV prevention programs are best undertaken by widening the scope of activities to include other concerns. One approach with potential is to promote overall self-respect and ensure supportive networks are developed to assist families with general life problems. This allows HIV/AIDS village workers to work under broader titles and take on other duties. Workers can then visit PLWHA and maintain confidentiality about their clients' status since their role is not limited to HIV/AIDS counselling.

Additional materials
Counselling and HIV/AIDS, UNAIDS Technical Update UNAIDS Best Practice Collection, November 1997

Uganda
The AIDS Support Organisation (TASO) in Uganda started a project with volunteer community workers known as ‘AIDS Community Workers’ but the name stigmatised the workers and hobbled them in attempts to communicate and counsel people. New volunteers became simply known as ‘Peer Educators.’ These educators were tasked with facilitating a broader range of life skills and a more holistic approach to HIV/AIDS including social, economic and cultural factors, as well those relating to infection. The result was greater community acceptance and more effective counselling. In other projects it was found that being a peer educator gave girls social legitimacy to talk about sex without the risk of being stigmatised as sexually promiscuous.
### Effective HIV/AIDS activities

<table>
<thead>
<tr>
<th>Most effective activities</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formation of Anti-HIV/AIDS Clubs</strong></td>
<td>- wide participation at regional and national levels</td>
</tr>
<tr>
<td></td>
<td>- extra curricular activity</td>
</tr>
<tr>
<td><strong>Counselling with home visits</strong></td>
<td>- personal contact and family involvement</td>
</tr>
<tr>
<td><strong>Production of educational materials</strong></td>
<td>- before projects start there are often no materials available for HIV/AIDS education in schools</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Less effective activities</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV testing and free clinics</strong></td>
<td>- not enough personal contact</td>
</tr>
<tr>
<td></td>
<td>- insufficient follow up</td>
</tr>
<tr>
<td><strong>Workshops and seminars</strong></td>
<td>- only a small proportion of the population is reached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Least effective activities</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counselling at drop-in centres</strong></td>
<td>- lack of counselling skills of staff</td>
</tr>
<tr>
<td></td>
<td>- not wanting to be seen attending</td>
</tr>
<tr>
<td></td>
<td>- out of the way location</td>
</tr>
<tr>
<td><strong>Single drama productions</strong></td>
<td>- no follow up</td>
</tr>
<tr>
<td></td>
<td>- distant location of the target group</td>
</tr>
</tbody>
</table>

Effective HIV Activities: NGO work in developing countries UK NGO Consortium.

Note that this study is a synthesis of the views of the NGOs involved based on the outcomes of HIV/AIDS activities they implemented or supported. Others may have a different experience and reach different conclusions about the effectiveness of the same approaches. It also depends on context. The most important point is to ensure a monitoring or review mechanism is in place to test the effectiveness of the approach adopted.
Other prevention activities

Strategies and options

Prevent transmission through blood and other body fluids and tissues

- promotion, distribution and marketing of condoms
- management and treatment of STDs
- improvement in collection and use of blood and blood products
- targeting of unsafe and unethical medical practices
- HIV/AIDS—testing and counselling
- needle exchanges and harm reduction strategies for injecting drug users
- use of HIV/AIDS inhibiting drugs (anti-viral drugs)
- introduction of infection control guidelines in clinical and care settings

Focus on particular groups

- pregnant women (mother-to-child transmission)
- sex workers
- injecting drug users
- military personnel and transport workers
- men who have sex with men
- young people

Facilitate alternative incomes

- for sex workers (see Income Generating Activities below)
- vocational training for youth
Promotion and provision of condoms

Key Guiding Question
What assumptions have been made about the anticipated adoption of condom use?

Auxiliary Guiding Questions

- Who is condom use targeted at? Are women and girls expected to negotiate condom use?
- Has any research been conducted to ascertain feasibility and acceptability?
- Is condom use associated with paid sex? What will be done to overcome this?
- Is there an existing demand for condoms? How are the condoms to be distributed/marketed?

Lessons learned

Efficacy - Condoms are an affordable and accessible means of greatly reducing the risk of HIV transmission. The global failure rate for condoms is 12% but this is largely due to poor or inconsistent use rather than poor quality.

Contextual factors - Condom promotion is a relatively weak intervention in many contexts. Women are often unable to negotiate the use of condoms with sexual partners. The association of the condom with paid sex in countries like Thailand hinders condom use by women. Moreover, it is unrealistic to regard condoms as a viable long-term option for couples in ongoing relationships.

Desire for children - Most people have a strong desire to have children, which mitigates against the use of condoms. Some HIV positive people may decide to continue to have unprotected sex to produce a child. Where one partner in a relationship is positive, couples who wish to engage in unprotected sex to have children are still able to minimise the risk of infection for the negative partner. Counsellors should be aware of strategies to minimise the risk of infection and discuss these with HIV positive people who may wish to have children.

Condoms and sex workers - Studies have shown that promoting condom use can be very successful amongst sex workers.

Female condoms - PNG trials resulted in favourable reports from many of the women who were willing to use female condoms. However, actual level of acceptance has not been fully determined. Boiling and reuse appears to be a viable option.

Marketing - Funding the distribution of condoms can undermine commercial retailers. In the Philippines, the retail sector now supplies very few of the country’s condoms because donors have flooded the market. Eliminating commercial retailers does not promote sustainability and may increase the burden on the public health system. In countries where people can afford to pay, donors should target free condoms to areas where there is market failure leading to underuse of condoms.

Wholesaling condoms to intermediaries for resale has proved effective, even in reaching remote communities. For example in the Congo small quantities are sold to hawkers who travel to remote areas selling condoms to passengers on river barges and at ports.

Additional materials

Population Guiding Principles and Population Checklist AusAID

Note: The Population Checklist must be completed for all Australian aid projects with a family planning component to ensure compliance with the Guiding Principles for Australian Assistance for Population Activities. The checklist is not required for HIV/AIDS education and prevention projects that, for example, simply distribute condoms.
STD MANAGEMENT

Key Guiding Question
How well are the obstacles to STD management understood and how are they to be overcome?

Auxiliary Guiding Questions
- What stigma or taboos are associated with STDs in the district or country concerned? Are supportive IEC campaigns proposed to promote sexual and reproductive health?
- Will the facility providing STD management be run by men? Will women have the option of a female health worker?
- Is STD management to be targeted at men or women? Is syndromic management alone proposed?
- Is STD management to be implemented exclusively through the formal or public medical system?
- Will health service and STD clinic staff be trained to be sensitive and non-judgemental?

Lessons learned
High prevalence of STDs - A World Bank study found STD prevalence rates in Africa as high as 43% among pregnant women, 13% among truck drivers and 9% among military men. It is very common for sex workers to have multiple infections. Most study participants do not know they are infected and do not believe they are at risk of STDs. Thus sex with multiple partners is common amongst men and condom use is rare.

Synergy between STDs and HIV infection - Treatment of STDs reduces the risk of HIV transmission because the presence of STDs increases vulnerability to HIV infection several fold. Moreover, studies suggest that HIV positive people infected with an STD are more likely to be infectious or to pass HIV on to their sexual partner because of an increase in the number of HIV infected cells in their semen (Cohen et al., 1997).

Low use of clinics - Most people who seek treatment for STDs do not use the formal medical system. For many people there are no specialised STD services in their area. People with STDs may not visit clinics because health workers are judgemental; clinics insist that people bring their partners for treatment; STDs are taboo; or they do not know the service exists. If health services are run by men women are often reluctant to seek sexual and reproductive health services, particularly if it is in their local area. IEC campaigns need to try to overcome the stigma attached to STDs and promote sexual and reproductive health.

Needs of women - Men outnumber women at STD clinics by three to one. Whilst syndromic management of STDs is proving effective for men who can more readily detect symptoms of infection, it is proving less effective for women. Women may be asymptomatic or tolerate vaginal symptoms. STD services need to be made more accessible to women in the general population.

Gender relations - STDs are a social as well as a medical problem. Effective clinical programs require preventive strategies, such as counselling and education to promote behaviour change and to address the gender relations in which males dominate sexual and reproductive decision making. However, without gender strategies that reach and include men, integrated programs are likely to have only limited effect.

Laboratory support - While STD management is most likely to be syndromic treatment, the choice of appropriate drug combinations will be determined by monitoring the types of STDs and their response to different antibiotics. This constitutes a form of surveillance for which laboratory support is critical.

Sensitivity training for staff - Women tend to stay away from government STD clinics in PNG because of the verbal abuse they commonly meet with from nurses. Training is needed to ensure greater professionalism by health workers. Promotion of a client focus must be ongoing and subject to regular review.

Counselling clients about linkage to HIV - If an individual tests positive to syphilis it indicates that he or she is many times more likely to be infected with HIV. This raises ethical and practical dilemmas that cannot be dealt with summarily. If a decision is made to inform the client about the increased risk after careful consideration then counselling should be provided.

PNG - Heterosexual intercourse with multiple partners, in the context of very high rates of STDs and poor coverage of STD services, is the main mode of HIV transmission in PNG.
Mwanza study: Syndromic management of STDs

A trial evaluating the impact of improved STD case management in PHC facilities in Tanzania found that a 42% reduction in new sexually transmitted HIV infection had occurred in the intervention community over two years. The study provides evidence that treatment of symptomatic STDs can contribute to the reduction of HIV infection in a community (Grosshurth et al., 1995).

IMPROVING BLOOD PRODUCTS AND MEDICAL PRACTICES

Key Guiding Question
What is assumed about blood products and medical practices and what can be done to overcome problems?

Auxiliary Guiding Questions
■ How is blood for transfusion obtained? Will there be continued use of paid donors if this is the practice?
■ What is to be done about unethical medical practices, including the use of unscreened blood?
■ Will unsafe practices in the commercial sector be addressed?
■ Have universal precautions been introduced?
■ Have infection control guidelines been developed?

Lessons learned
Risk from blood transfusions - The chance that someone who has received a transfusion with HIV-infected blood will become infected is estimated to be 90% (UNAIDS).

Blood quality assurance - Several studies have shown that careful selection of low risk donors is a more efficient way of minimising the risk of HIV transmission than testing for HIV antigen. The safest blood donors are volunteers as paid donors are often in poor health, undernourished and have infections. Where informal payments occur, paid donors are often falsely presented as close relatives of a patient.

Medical accountability - In many health facilities, even in the cities, there is poor sterilisation of needles, syringes and equipment; and unethical practices by medical staff, including the use of unscreened blood transfusions, which make patients and health workers susceptible to HIV infection. It is wise to assume the worst. Practices of traditional healers and traditional birth attendants should also be examined.

Injections - Little effort is made to sterilise needles in thousands of private ‘clinics’. Many of these operate from shops that provide malaria and other injections. IEC messages and activities could address this by creating awareness of the risk and consumer demand for safer practice.

Additional materials
Blood Safety and AIDS UNAIDS Best Practice Collection, October 1997
HIV TESTING

Key Guiding Question
Why test for HIV?

Auxiliary Guiding Questions
- What is the rationale for the program?
- Which test method is to be used?
- How will the results be used and who will have access to the information?
- How is counselling to be undertaken?
- What will be the social impact of testing?
- What legal and ethical considerations are raised by the proposed testing program?

Lessons learned
Caution - Testing for HIV must be approached with great caution. Informed consent is often not sought, the human rights of positive people are not always respected and access to services for PLWHA such as counselling and treatment may not exist. HIV testing programs may be based upon incorrect assumptions about transmission of HIV or a need to appear to be taking visible action against the HIV problem. Testing programs can be intrusive, cost-ineffective, divert resources from more effective activities and - if the necessary support services are absent - do more harm than good.

Mandatory testing - Testing without informed consent, mandatory or otherwise, has no place in HIV/AIDS programs. It is wrong for consent to be sought only after blood taken for another purpose has been tested for HIV. Women often learn they are HIV positive when they are pregnant, attend a clinic and are tested without their consent. This is a violation of their rights.

A place for voluntary testing - Testing provided on a voluntary basis with confidential or anonymous results and associated counselling has a place. It enables young men and women to determine their status before marriage, and for people who believe they are HIV positive to seek confirmation. In these respects it should be regarded primarily as a service. It can also lead to behavioural change. People who know they are infected can choose to use condoms to protect their sex partners and children. However, few people tend to take tests if they are asymptomatic.

Demand for services - Donors should be aware that following public education campaigns about HIV/AIDS, a public demand for confidential testing and counselling is created. It would be poor practice to raise people's concern over HIV/AIDS and then fail to ensure that appropriate services are in place.

Counselling - HIV testing should not be conducted if counselling before and after the test is not available.

Combining STD management and HIV testing - For health clinics to offer HIV tests to people with STDs is, in principle, an effective practice. However every effort should be taken to reassure people that tests were voluntary, otherwise attendance at STD clinics could potentially decline.

Additional materials
Counselling and HIV/AIDS: UNAIDS Technical Update, UNAIDS Best Practice Collection, November 1997
MOTHER-TO-CHILD TRANSMISSION

Key Guiding Question
Does the activity address mother-to-child HIV transmission? If so, has a viable strategy been adopted?

Auxiliary Guiding Questions
■ Will testing be part of the activity?
■ Will HIV inhibiting drugs be used?
■ How will the use of these drugs be 'contained'?
■ Will mothers be advised not to breastfeed? How will this impact on other health messages? What assistance will be provided to mothers to access substitute milk/food and maintain the hygiene of feeding equipment?

Lessons learned
HIV inhibiting drugs - AZT reduces mother-to-child HIV transmission and combination therapy involving additional drugs can produce more rapid and greater reductions, even with only 2 or 3 weeks of pre-partum therapy. This raises the problem of translating an expensive and perhaps prolonged intervention, successful in a controlled trial situation, into an efficient and cost-effective therapeutic field intervention. Even if HIV inhibiting drugs can be successfully used to reduce mother-to-child transmission we are left with the ethical dilemma of justifying not treating the mother in her own right. This also involves a practical consideration because the infant’s chances of survival will be greatly reduced if the mother becomes ill and/or dies.

The breastfeeding dilemma - HIV can also be transmitted through breast milk making breastfeeding risky. This runs counter to the thrust of so many health campaigns - for example 'Breast is Best'. It also raises the practical problem for the mother of accessing an alternative to breast milk. Most mothers in developing countries cannot afford to buy milk formula. Even if they could, the use of feeding bottles that cannot or are not sterilised also presents a serious risk to the infant.

PNG - Perinatal HIV is the second largest known means of transmission (following heterosexual transmission) in PNG. This is a major challenge because breast feeding is one of the foundation stones of PNG child health and nutrition programs.

Cost - In the end decisions often come down to what donors believe can be spent to prevent mother-to-child transmission. Providing short-course antiretrovirals to pregnant women and alternatives to breastfeeding can help stem the increase in child deaths. To be most effective, counselling, voluntary testing and access to care should be provided.

Zimbabwe
In Zimbabwe the prevalence of HIV in the general population and therefore among women of child bearing age, is extremely high. A project has now been initiated in the light of recent studies that have demonstrated the protective value to the unborn child of maternal AZT therapy in the last four weeks of pregnancy where the mother does not subsequently breastfeed. The community based initiative will investigate issues concerning the impact of confidential HIV testing and counselling on decisions that face HIV pregnant women in relation to antiviral drug therapy and breastfeeding.

(Funded by the Australian Government)
SEX WORKERS

Key Guiding Question
Will the activity help sex workers to protect themselves and access care?

Auxiliary Guiding Questions
- Will the activity help sex workers mobilise their own networks and resources for prevention and care?
- How will sex workers be supported in insisting on protection measures, including condoms?
- Have the needs of the children living with sex worker mothers been anticipated?

If alternative incomes/livelihoods are proposed, are they feasible?
- Are the alternatives proposed realistic? Have they been adopted by other sex workers? What market analysis has been conducted?
- Will ongoing advice and support be provided?
- How do the benefits of the proposed alternative income/livelihood compare with sex work?

Lessons learned
- Mutual support - Given the limit on resources, communities including sex workers must ultimately mobilise their own resources to ensure sustainable care for the duration of the epidemic. The challenge in relation to sex workers is to develop care clusters amongst women to begin caring for themselves.

- Condom adoption - Sex workers more readily adopt condom use than the general population, however adoption is greatest when it is supported by workplace policy, as it was in brothels in Thailand.

- Prison visits - Visiting sex workers while they are in prison has been found to be an effective means of conveying information and building networks.

- Alternative incomes - Income generating activities as alternatives to sex work must generate more income, or other benefits, than the sex work if they are to succeed.

- Cooperative ventures - Cooperative business ventures, at least for former sex workers, are more likely to fail than business ventures for individuals.

- Targeting commercial sex - The emphasis in some countries on sex workers as a high risk group has led people to believe that non-paid sex is not high risk. Thus women who are monogamous or practice serial monogamy may not perceive themselves to be at risk, which is certainly not the case if their husbands have other sexual partners.

Dar Es Salaam Street Girl Kwetu
Alternative income generating activities in this project are devised on a client centred basis and preceded by 3 to 6 months of training. The training is a considerable commitment towards adopting a more mainstream lifestyle. Project staff continue to visit clients after they have repaid their loans. The vast majority of income generating activities which focused on individual business ventures have been successful. In contrast, attempts to promote cooperative income generating activities failed.

(Supported by Salvation Army/Australian Government)

Mumbai, India
Women rendered homeless due to HIV infection are being cared for in a residential unit established on the outskirts of Mumbai. This residential centre provides health care, shelter together with vocational training for women and local school entry for their children. The project, Purnata Bhavan, also seeks to develop a model of integration of women and their children back into supported lifestyles in Mumbai or the nearby township where the project is based. (A project of OASIS India, supported by the Australian Government).
INJECTING DRUG USERS

Key Guiding Question
Does the proposed activity incorporate the range of components necessary to have an impact on risk?

Auxiliary Guiding Questions
- What elements of effective injecting drug use programs are included (see components below) and which are omitted? How much government support is there?
- Will drug users have cheap and easy access to sterile syringes through pharmacies or needle-exchange programs? If not, what is the impediment?
- How will injecting drug users be reached? Does the activity use a community outreach or peer counselling model? If not, what is the approach?

Lessons learned
Change in risk behaviours - Contrary to initial expectations, evidence now exists that injecting drug users have reduced their HIV risk behaviours in response to a wide variety of interventions. Evidence also indicates that after learning about HIV/AIDS through the media and their own word of mouth networks, injecting drug users have reduced their risk behaviours even in the absence of formal prevention programs.

Components - Just as in the case of sexual HIV transmission, the prevention of injecting drug transmission calls for a package whose components operate simultaneously. For maximum impact, the following components should be part of this package:
- education for drug users and their sex partners on HIV and other diseases that can spread through blood
- training in skills such as decision making skills on drug use and safer drug use
- access to sterile injecting equipment, or access to means of cleaning equipment
- access to condoms
- treatment programs to help users cut down or stop injecting
- information and education to reduce the demand for injected drugs.

Successful approach - A recent comparison of cities with high and low HIV prevalence in drug injectors showed that those with success in averting a drug user epidemic had three features in common. First, they used community outreach or peer education to reach and educate drug users. Second, they ensured that drug users had cheap and easy access to sterile syringes through pharmacies or needle-exchange programs. Thirdly, they all started their programs early on. Mathematical modelling demonstrates that once more than 10% of the drug-injecting population is infected with HIV, this almost invariably rises to 40% or 50% within a few years.

Community outreach - Prevention strategies are most effective if information and services are brought actively to drug users, rather than relying on users to seek them out. Community outreach programs greatly increase the coverage of programs designed to promote safer behaviour.

Drug rehabilitation - There is a need for a drug rehabilitation model that is appropriate in developing country settings. The western model involving some months of institutionalisation followed by counselling and support is usually not affordable.

Churachandpur, Manipur, north east India
A program encouraging abstinence for drug users through health, religious, legal reform institutions and the police never reached more than half the town’s drug users. When the SHALOM community outreach project started to distribute bleach, participation shot up to 80% in six months. (Report on the Global HIV/AIDS Epidemic, UNAIDS/WHO, June 1998)
The SHALOM project also established India’s first needle exchange program. In so doing it not only established an approach now being adopted elsewhere in the region, but was the catalyst for the adoption of harm reduction within the Manipur State HIV/AIDS policy. This approach has been acknowledged as best practice for the region by both the National AIDS Control Organisation of India and UNAIDS. (Supported by the Australian Government)
Asian Harm Reduction Network (AHRN)

AHRN was established in 1995 to share experience and best practice in Asia based on the principles of harm reduction. The network, started in Australia, is now based in Chiangmai, Thailand. It has over five hundred members and has recently released a manual to support the development of further initiatives in Asia. (Initially supported by the Australian Government)

OTHER HIGH RISK GROUPS

Key Guiding Question

Has a viable strategy been adopted to reach the high risk group?

Auxiliary Guiding Questions

- What research has been conducted or is relied on? How will change in risk behaviour be monitored?
- How will high risk groups be reached? What intermediaries are to be used?
- Has any attempt been made to deal with problems underlying the risk such as the vulnerability of refugee women, discipline of military personnel and needs of prisoners?

Lessons learned

Refugees and migrants - There is epidemiological evidence that many border areas have a higher than average incidence of HIV. Population migration is very closely associated with high risk behaviour for HIV transmission. Studies indicate that many migrant groups are especially vulnerable to HIV transmission or prone to transmitting HIV to others if they are already infected.

Transport workers and military personnel - In several countries the spread of HIV has been linked to truck drivers and military personnel barracked in district towns. Mukono is a busy town outside Kampala on the main East African truck route running from Mombassa, Kenya to Kampala, Rwanda and to the Democratic Republic of the Congo. Trucks commonly stop overnight in Mukono and this has been linked to extraordinarily high HIV rates amongst secondary school girls in the town, many of whom pay for their school fees by engaging in commercial sex.

Provision of condoms - A number of successful projects have provided condoms and information to both sex workers and truck drivers at locations convenient to both such as truck stops. Military personnel have been provided with condoms through their units.

Additional materials

Refugees and AIDS: UNAIDS Technical Update
UNAIDS Best Practice Collection, September 1997

AIDS and the Military: UNAIDS Point of View
UNAIDS Best Practice Collection, May 1998

Border populations

World Vision Australia developed HIV/AIDS initiatives on either side of the Thai-Myanmar border at major crossing points. WVA concluded that cross-border activities have a greater and more lasting impact on beneficiaries than activities focused on individual villages on either side of a border. Project Completion Report, July 1998. (Australian Government funded project).
Mitigating the impact on individuals and on society

STRATEGIES AND OPTIONS

The main focus of attention for the global community in the past 15 years has been preventing further HIV infections. However, over 35 million people are now living with HIV/AIDS and access to treatment and care has become urgent. Moreover, it is often counterproductive to separate prevention and care objectives. For example, counselling for people diagnosed as HIV positive can also help them to take steps to prevent infecting sexual partners or their babies.

Treatment, care and support strategies include:

- developing standard treatment guidelines for HIV-related infections
- community and home based care for PLWHA
- social and economic support for PLWHA and their carers
- income generating activities for PLWHA
- care and support for orphans and HIV positive children
- harm minimisation for injecting drug users
- development of national policy, legislation and work place policy and practice
- Combining prevention and care activities.

Treatment of HIV-related infections is an important part of any response to the epidemic. Common infections include shingles, candidiasis, tuberculosis, dental diseases, pneumonia, meningitis, retinitis and herpes. Whilst the latest combination therapies remain too costly for public health systems in developing countries - in Uganda intensive pharmaceutical therapy for one person over a year costs more than US$20,000 - many highly effective primary health care interventions may be provided.

Donors can also help by improving public health systems because between 25% and 50% of health costs in some countries are now spent treating HIV-related infections.

One of the most significant impacts of the epidemic on people is psychological. Wherever possible, HIV/AIDS activities should offer people hope - whether it is they who are infected or others who they fear are at risk. The best way of creating hope, even if it is for another generation, is to help people to understand the epidemic and take some action.
COMMUNITY AND HOME BASED CARE

Key Guiding Questions
What impact will the support to communities and carers have on the physical well-being, quality of life and acceptance of PLWHA?

Auxiliary Guiding Questions
- Will the support improve the nutrition, treatment, housing and community acceptance of PLWHA?
- Will the activity seek to foster self-sufficiency for PLWHA? Is this a realistic expectation?
- What commitment to the care and support of PLWHA is the community making or willing to make?
- What impact will the support have on carers and survivors?
- Does the proposed care activity link with existing services? How will the care and support be sustained after the project is completed?
- Are PLWHA willing to be identified or have their status confirmed?
- Will identification/confirmation lead to their discrimination within the community?
- Is there any way of providing care and support without identifying/confirming status?

Will the care and support activities involve identifying the status of PLWHA?

Lessons learned
Home based care is effective but requires medical support - Community based care, where people are cared for at home or on an outpatient basis, is generally regarded as the most effective method of care. It provides maximum community support for PLWHA, is cost-effective and raises community awareness of HIV/AIDS and community acceptance of affected individuals. Quality of life for PLWHA improves with home care and counselling.

Good community based care requires effective support from district primary health care services. Essential drugs to treat HIV-related infections such as tuberculosis and sexually transmitted diseases should be available. Too often however, these elementary health care needs are not met.

Home based care shifts costs to the community - While decentralising care reduces hospital costs, it also shifts financial and physical costs on to the families and friends of people with HIV/AIDS. Families can be impoverished as they try to meet the medical expenses of sick ones.

Danger of home based neglect - There is a world of difference between home based care with assistance from a clinic operating support services and staying at home because no medical care is available. In many developing countries, the lack of resources for health care may mean that home based care may become home based neglect.

Create effective systems early - Health services should move early to create effective home based care networks for PLWHA rather than wait until the number of patients starts to overwhelm the hospital system. This is now a relevant issue for PNG.

Mobilise the community - HIV/AIDS activities and inputs have to be paced to match the level of community commitment to HIV/AIDS prevention and care. Ideally, projects should strive to minimise dependency and maximise independent action.

Training for carers - Effective forms of assistance include home care kits for PLWHA, and training in caring for PLWHA. Families need special assistance if they are caring for people with highly infectious conditions related to HIV/AIDS such as tuberculosis.
Additional materials
Counselling and HIV/AIDS, UNAIDS Technical Update UNAIDS Best Practice Collection, November 1997
Tuberculosis and AIDS, UNAIDS Point of View UNAIDS Best Practice Collection, October 1997

Salvation Army Chikankata Mission Hospital, Zambia
This project is used as a model of home based care, community counselling, school education and HIV management training. Twelve hundred people from 28 countries have been trained in this model of care. It is based upon strengthening indigenous systems within an already well structured community including the extended family and the traditional codes of behaviour and mutual accountability (Aboagye-Kwarteng 1997). (The project is supported by the Australian Government.)

The Phayamengrai Community Understands AIDS Project, Thailand
A holistic approach to care at Phayamengrai Hospital was triggered by an HIV/AIDS patient whose weight had fallen from 70 to 35 kilograms and was admitted for palliative care. Another PLWHA came in to support the patient, stressing that it was not time to give up and that with proper diet, massage, counselling, peer support, family and community participation and medication life could go on. The individual responded extremely well to gain 30 kilos. Hospital staff have adopted a holistic approach to treatment ever since. In these and other ways the project demonstrated that government health professionals and community groups can work together in developing a model for HIV/AIDS that incorporates both traditional and modern treatment.

The Parliamentary Secretary for Foreign Affairs, Mrs Kathy Sullivan, meets HIV positive people in Soweto, South Africa on a project where young people are helping each other adjust to living with the virus.
SOCIAL AND ECONOMIC SUPPORT

Key Guiding Question
What is the social and economic impact of HIV/AIDS on the community and those directly affected, including PLWHA and their carers?

Auxiliary Guiding Questions
- What assessments were conducted, or relied on, to determine support needs? Who was consulted? How have needs been prioritised?
- Are physical, social and psychological needs going to be addressed?
- Will the support strengthen what the community and people affected are trying to achieve? Will it complement what government and other agencies are trying to achieve?
- How will the support be provided? If an intermediary organisation is to be used, how will it operate in the community? Will it strengthen local capacity? What proportion of funds will be spent on the overheads of the intermediary organisation?

Lessons learned
Impact assessment - The impact of HIV/AIDS on the community in general and women in particular needs first to be examined to ascertain what care and support is needed and what is feasible. There is frequently inadequate attention to assessment, leading to poorly conceived and unsustainable interventions.

Priorities - Meeting the basic needs of PLWHA, their families and other carers should be the first priority. Only then should options to help them engage in productive activity be pursued.

Planning for the future - Helping PLWHA plan for the future of their partner, children and parents can be extremely significant, lifting a terrible burden from people. Very small grants, for example, may be used to help families buy iron sheets to replace the roof on the family home. The community may become involved in such activities thereby demonstrating to PLWHA that they are accepted and their families will not be shunned. Planning might also involve facilitating a discussion amongst relatives about how to keep siblings together.

Fear, shame and denial - The fear, shame and denial of infection undermine effective systems of care for PLWHA within communities because many people don’t want to consider the implications of HIV/AIDS.

Role of CBOs - CBOs can play a central role in the provision of care and support for persons with HIV/AIDS and their families due to their responsiveness to community needs.

Role of youth in mobilising community - Youth are often very effective in mobilising community assistance for PLWHA. Information programs which target youth can help to create sensitivity and compassion in young people, making them more willing to accept and help PLWHA.

Capacity to cope - Coping involves caring for the sick and dying, sustaining hope, keeping communities and families from breaking up and passing values and skills on to the next generation. Community and counselling workers should seek to encourage communities and families to accept PLWHA as a crucial part of coping strategies.

The next generation - In communities where HIV/AIDS is prevalent, parents fear for their children. Projects that identify children as the future of the community are particularly effective. Parents often say that whilst they may not escape the scourge of HIV/AIDS, they would be content if they could protect their children and ensure the names of their families are carried forth. Parents respond well to activities that help them understand how best to protect their children. Many parents are not sure how HIV is transmitted or how to teach their children to reduce risk behaviour.

Funerals - In Africa, one effective form of community aid is to contribute to funeral costs and transport costs for PLWHA wishing to return home to spend their last days with family.
INCOME GENERATING ACTIVITIES

Key Guiding Question
Are the proposed income generating activities feasible and sustainable?

Auxiliary Guiding Questions

- What is the ultimate objective of supporting income generating activities? Are such activities the best means to that end?
- What analysis has been conducted to determine the interests and capacity of the target group? Will any training be provided?
- What ongoing market analysis is to be conducted and how will it be made available to producers/traders?
- What attention has there been to determining real costs and profits, the maintenance/replacement of capital items, means of transportation and how to innovate and learn from others?

Lessons learned

Learn from past experience - Income generating activities are high risk interventions with variable, often poor, results. As a rule they should not be attempted as mere 'add-ons' to HIV/AIDS activities. Activities intended to provide an alternative to sex work or to lessen HIV/AIDS impact on families need to learn the lessons from income generating activities in mainstream development work. There is a wealth of information in this broader arena.

Be realistic - Vocational training and skills transfer at the village level are often not sufficient to produce competitive products. Closely check market requirements and the feasibility of meeting them given the capacity and resources of the target group.

Ongoing research - Research has to be ongoing because the informal sector is highly volatile and quick to change. Information quickly becomes stale and loses its relevance.

Spreading loan risks - When providing income generating loans to PLWHA, family members may be asked to act as guarantors because of the risk of sickness and death of PLWHA. It may be better to offer shorter term loans to avoid the negative messages such actions may send.

NGOs overwhelmed by poverty - Some NGOs working in community HIV/AIDS prevention and care may feel compelled to create income generation and credit schemes for poor families despite not wanting to become involved in such activities. In some circumstances, the basic needs of HIV positive people may overwhelm NGOs.

Drug users are high risk - Drug users pose particular problems for income generation activities. The Dar Es Salaam Street Girls project found that amongst sex workers, drug users were extremely high failure risks. Following failures project staff concluded they could not accept drug users into such schemes.

See also the section on sex workers.
ORPHANS AND HIV POSITIVE CHILDREN

Key Guiding Question
Will the proposed arrangement provide the most supportive environment possible for the child?

Auxiliary Guiding Questions
- Will the emotional needs of the child be met by the proposed arrangement? Does the child have hopes and expectations for the future?
- What consultations are to be made before instituting the proposed arrangement? What agreements have been reached?
- Will a child's status be disclosed to them? Will it be disclosed to others?
- Will the need for care be provided in the proposed arrangement?

Lessons learned
Institutionalisation - It is preferable for orphans and HIV positive children to remain in the community. The emotional needs of the child are met much more fully within a family setting. Moreover, once people are aware that an orphanage has been established, the institution may be overwhelmed as children are abandoned and brought in from outlying villages.

Orphans - In many developing countries nieces and nephews are regarded as sons and daughters in a way unfamiliar in industrialised countries. The word 'orphan' does not have the same resonance. The most appropriate activity will normally be to support those members of the extended family who are caring for the 'orphaned' child.

Fostering HIV positive children and AIDS orphans into the community - If a child lacks relatives and is to be fostered within the community then it is essential to make adequate preparations beforehand. This could include gaining the confidence of village leaders, mobilising the community, establishing effective partnerships with government agencies that can assist and educating and sensitising all stakeholders.

Disclosure - It may not be in children's best interest to be told they are HIV positive. While children need special care, including dietary care and quick treatment for infections and illness, the psychological burden can significantly affect their health. Disclosure must be accompanied by counselling and most importantly, must take place in the context of a supportive, ideally family, environment.

Disclosure at school - Parents or guardians are not obliged to disclose the status of children to school authorities or teachers. However if HIV is not prevalent or if the school takes no precautions, a parent or guardian should be encouraged to put the school on notice that an HIV positive child is in attendance. This can be by way of an anonymous letter. This allows the school to establish or review preventative measures such as caution in handling cuts and abrasions.

Acceptance at school - If the HIV status of a child is known then acceptance at school by students and parents may be difficult. Rejection is harmful for the child physically and emotionally. An awareness program should be developed with the school. Parents need to understand why HIV positive children should stay at school, the low level of risk to other children and what safety procedures should be followed. Careful preparations need to be made before approaching parents because they can react negatively.
COMBINING PREVENTION AND CARE

Key Guiding Question
Should prevention and care activities be combined?

Auxiliary Guiding Questions
If the focus is on prevention:
- Is it appropriate for prevention to be pursued in isolation from care?
- Would the inclusion of care activities help to mobilise affected communities and individuals?

If the focus is on care:
- What existing prevention activities could be linked or combined with the care and support activities?
- Do the care and support activities offer any opportunities to introduce new prevention activities?

Lessons learned
Prevention is a higher priority early on - Prevention should be a higher priority than care in situations where AIDS cases are not visible, where HIV positive individuals are unwilling to make their condition public or where the epidemic is yet to strike despite the target group's risks. Preventing the virus from spreading in the first place is the most effective way of reducing the impact of the epidemic.

Prevention and care often go together - It is often artificial to separate prevention and care objectives, particularly as the epidemic advances. Prevention campaigns create demand for testing services. These in turn require counselling services that often help HIV positive people take action to reduce the risk of infecting sexual partners or their children. Support networks of PLWHA are often instrumental in overcoming discrimination and providing effective communicators who are so important for public health campaigns.

For communities living with a mature epidemic, prevention, care and the social and economic impact of HIV/AIDS should be considered holistically. Where people are becoming increasingly concerned about caring for people with HIV-related illnesses there is greater will to prevent further infection. Home care is a very effective entry point for helping communities to prevent HIV by supporting sexual behaviour change.

Winning the support of PLWHA is important. If many in the community are HIV positive then their needs must be met. Counselling, support groups, medical treatment and community care are all important. Overlooking the needs of PLWHA is a poor prevention strategy as PLWHA are vital in designing and implementing effective prevention campaigns.

Integrating care and prevention themes at funerals
A small Thai NGO, Clear Skies, has as its objective the care and support of PLWHA. As a result of their home visit program, they were increasingly invited to funerals of people dying from HIV-related illnesses. Funerals proved conducive to IEC work. People spontaneously questioned the team and were more open to discussing sensitive issues. Some families have invited the NGO to speak to guests at funerals. As they are HIV positive themselves, they provide living examples of PLWHA.
Proudly supported by the Australian Government

Empower One Woman
One Child
TODAY
Tomorrow's Nation
is Empowered
FOREVER

Nika'mandla Umama
Nergane namhlane
Ukuze Umphakathi
Wakheke
Kunaphakade

AusAID
WOLANANI EMBRACE
Design and implementation

BASIC DESIGN ISSUES

Key Guiding Question
Is the design of a high quality? Are there any areas in which it is deficient?

Auxiliary Guiding Questions

- Can the design documents be used as implementation tools and are they accessible to all stakeholders including PLWHA?
- Are the objectives clear, focused and attainable? Have risks and assumptions been adequately assessed? How will risks be managed?
- Are monitoring systems and procedures in place? Is there provision for ongoing needs analysis and project modification?
- Is the activity adequately resourced including staffing and tendered costs?

Lessons learned

Objectives - The Review of HIV/AIDS Policy and Programming in AusAID concluded that objective setting in Australian Government funded activities generally needs to be more rigorous.

Constraints on performance - The review also found that although many activities funded by the Australian Government had performed well, a number had performed poorly due to under-resourcing of activities, lack of political commitment, lack of counterparts, lack of skilled staff, lack of follow-up activity and cultural difficulties. Some of these are design problems or were risks that could have been anticipated.

Responsiveness/flexibility - Adequate time must be allowed to develop activities. Managers should be encouraged to be responsive, adaptable and flexible. This is critical in the development and implementation of successful activities. A design neither can nor should attempt to foresee all future developments, particularly in the field of HIV/AIDS. Rather the design should be flexible and have a robust foundation, including solid back-up capacity. A phased approach to program implementation in HIV/AIDS activities is generally necessary.

Participatory research - Project interventions cannot be determined too far in advance given the importance of basing and planning interventions on the results of participatory research.

Ongoing analysis - It is appropriate to continue needs analysis during the course of HIV/AIDS activities, even if this results in design changes during the course of implementation.

Inappropriate designs - HIDNA has expressed concern that competition and unrealistic expectations have pushed contractors into complicated designs that may adversely affect the quality of STD/HIV programming. Australia’s experience does not automatically translate to resource poor settings, including rural settings and this has contributed to some projects being resource intensive or designed with unrealistic expectations of outcomes.

Training costs - NGOs and contractors tend to underestimate the costs of training, or tender unrealistically, which diminishes training outcomes. Training design and costs must reflect the reality of training needs.

Insufficient funds - AusAID has found in southern Africa that a major constraint on the success of projects is insufficient funds to undertake the proposed activities. This comes about when the scale of the problem proves to be larger than envisaged when designing the project.

Additional materials


Population Guiding Principles and Population Checklist AusAID
Myanmar HIV/AIDS Project

World Vision Australia concluded from this project that activities should not be determined too far in advance because it is important to base and plan all interventions on the results of participatory research. Project Completion Report, July 1998 (Australian Government funded project)

SCALE OF ACTIVITIES AND DELIVERY MECHANISMS

Key Guiding Question
Does the activity contribute to a balance between bilateral, multilateral and NGO delivery mechanisms?

Auxiliary Guiding Questions
- In the case of small scale interventions, are they cost-effective and can they be monitored?
- In the case of larger scale activities, can they be adequately supported by the AusAID staff overseas?
- What value will the designated NGO, contractor or agency add to the activity?

Lessons learned
Effective use of aid funds - Although small, community based interventions may not be the most effective as they are relatively expensive to implement and their small size makes them difficult to monitor and evaluate. In HIV/AIDS programming, the continued use of small interventions should be assessed against the new NGO accreditation and funding mechanisms. The integration of HIV and STD prevention activities into larger PHC programs could make management and monitoring more practicable.

Supporting large bilateral projects - Some donors with a substantial involvement in bilateral HIV/AIDS activities have found that their country programs needed larger numbers of employees than was originally foreseen in order to support the various components they had included. (AIDSCAP, 1997)

Smaller NGOs and CBOs - In Thailand, which has a long history of NGO involvement, the smaller NGOs and CBOs generally produce timely results. Larger institutions such as universities and the larger NGOs take much longer time to show results.

Reliance on NGOs - In the Pacific NGOs tend to be very conservative. Effective prevention strategies may be difficult to implement through such NGOs if their views allow them, for example, to provide condoms only to married couples and adolescents are simply urged to abstain from sex. In this circumstance, the first challenge is to explain to potential partner NGOs the need for new prevention strategies.

Budgetary considerations - In Africa, where Australia’s aid budget allocations are modest, it may be more effective to focus on supporting community based NGO activities.

Nam Bor Luang Love and Care Group, Thailand

This PLWHA self-help group received only $1,500 (through NAPAC, previously supported by the Australian Government) but has used it to show the potential for initiative and innovation at the village level amongst people with little formal education and very little funding support.
SUSTAINABILITY

Key Guiding Question
Has the issue of sustainability been adequately addressed?

Auxiliary Guiding Questions
- What components should continue beyond the life of the project? Has adequate provision been made?
- Are expectations of sustainability reasonably founded? Have the risks been realistically assessed?
- What provision has been made for sustainability where PLWHA are involved in management and/or implementation?

Lessons learned
Inadequate attention - The Review of HIV/AIDS Policy and Programming in AusAID concluded that sustainability was perhaps the least effectively treated aspect in design documents. 57 per cent of designs did not address this adequately. It should be noted however that sustainability is not a goal in itself but depends on the nature of the intervention.

The problem outlives the project - HIV/AIDS is an ongoing problem and designs must address this. For example, training for carers will be required beyond the life of the project and arrangements should be made for these activities to continue.

Self-sufficiency - Self-sufficiency for PLWHA and their families, carers and communities can be addressed by income generating activities. However, successes in this area have not been high.

Groups headed by PLWHA - The issue of sustainability is particularly difficult where groups are headed by PLWHA because in the absence of expensive therapies they may face premature death. One means to overcome this is to break down the division between HIV positive and HIV negative groups and create a homogenous group with common goals. This requires the building of awareness, empathy and trust.
MONITORING MECHANISMS

Key Guiding Question
Will it be possible to monitor and evaluate the activity efficiently and effectively?

Auxiliary Guiding Questions
- Has baseline data been collected against which progress and impact can be measured?
- Has a monitoring system been designed or put in place? Is the primary objective to meet reporting requirements or to serve managers, enabling them to make better decisions and increase the performance of the activity?
- What reviews will be conducted and what will their purpose be? Is an evaluation anticipated? What provision is to be made for it in terms of data collection and performance measurement?
- What will monitoring and review cost?

Lessons learned
Weakness of Evaluation - The Review of HIV/AIDS Policy and Programming in AusAID concluded that the lack of formal monitoring, review and evaluation mechanisms has been a weakness of Australian Government funded activities. NGOs have tended to pay inadequate attention in design to baseline data, verifiable outputs and workplans. The review concluded that monitoring and evaluation frameworks have to be strengthened in order to:
- better target activities
- have information on which to make necessary changes particularly through annual plans
- determine the impact of activities
- apply the benefits of experience to new projects.

Monitoring and Evaluation design - Monitoring and evaluation have to be designed into projects from the outset, not tacked on at the end. There should be specific components covering both process and outcome. Designs and implementation plans should map out verifiable indicators, activities, outputs and time frames. The emphasis should be on establishing a system that provides information to managers and stakeholders to enable them to take action to correct problems and build on successes.

Monitoring behavioural change - Behavioural change is hard to determine by conventional project design means. However some meaningful quantitative indicators can be used such as the number of pregnancies in a high school, the number of sexual partners, the level of knowledge about methods of prevention, and the level of condom use.

Monitoring, surveillance and impact assessment are particularly important in the implementation of prevention activities relying on behavioural change, as it allows for ongoing refinement to ensure that activities are having the desired effect. Timely results allow for the building of feedback loops enabling modifications to activities as appropriate.

Unfortunately, many projects do not have sufficient monitoring mechanisms in place to be able to say that an intervention has had an impact on risk behaviour.
Baseline data - It should be possible to compare outcome data to baseline data to demonstrate behavioural change amongst the target population. However very little baseline data is typically available for the evaluation of Australian Government funded activities. This forces evaluators to rely on qualitative analysis. Social action or operational research can partially compensate for the lack of baseline data.

Monitor to modify interventions - Nothing stays the same forever and this is true of the sex industry. The use of condoms by sex workers in Thailand has been promoted very successfully, resulting in increased condom use in brothels. However brothel patronage is declining. More and more sex workers are locating themselves at discos, restaurants and karaoke bars where there are less formal controls. Sexual risk behaviours must continue to be monitored and interventions modified accordingly.

Specialist assistance - It is common when seeking to establish baseline data and set up monitoring systems to collect too much data and subsequently learn that it can’t be processed or analysed in a cost-effective or timely manner. Specialist assistance with the design of baseline studies and monitoring systems should be considered.

Build on government data collection systems - Data collection systems should not be set up in parallel to government data collection systems. This is likely to overburden the people who are expected to gather, process and analyse the data. Projects should seek to strengthen and support government data collection systems.

Annual monitoring/review - Provision should be made for annual internal reviews, leading into the annual planning process.

Effective tools - There is a need for simple, effective and ongoing monitoring tools to be developed and used.

National level impact - USAID’s experience is that it is unrealistic to anticipate being able to measure national level impact on HIV incidence in a country.

Experimentation - USAID has found that focusing on only a few projects to make a recognisable impact provides no space for experimentation or risk taking. Some funds should be kept aside for piloting new approaches, particularly where large investments are being made over long periods.

Justifying benefits - While comprehensive baseline data would make evaluation easier, it is often prohibitively expensive or impractical. Any research or evaluation initiatives should demonstrate clear practical or programmable outcomes and should complement practical program initiatives, rather than be an end in themselves.

Additional materials

PERFORMANCE INDICATORS

Key Guiding Question
What indicators are being used and will they reliably measure changes in risk behaviour?

Auxiliary Guiding Questions
- Were stakeholders involved in setting targets and indicators to measure change? If not, do they at least make sense to them?
- Do monitoring tools rely on just one or a number of mutually reinforcing indicators of success? Do the indicators include both qualitative and quantitative measures?
- Are the objectives and performance indicators focused on discrete target groups?

Lessons learned
Measuring impact - The Review of HIV/AIDS Policy and Programming in AusAID concluded that the objectives and performance indicators of past projects have often been too broad, making it difficult to measure impact. Objectives and performance indicators have to be focused on discrete target groups. Monitoring tools and indicators obviously face limitations in ever completely revealing cause and effect, but they should be as finely honed as possible and better supported by appropriate expertise.

Range of indicators - Ideally, monitoring should rely on a number of mutually reinforcing indicators that address a range of factors from community awareness to changes in community norms. Similarly, monitoring should rely on a combination of qualitative and quantitative measures and should examine process as well as outcomes and impact.

Measuring outcomes - STD surveillance, condom sales and distribution and attitudinal change using behavioural sentinel surveillance, have been used to measure prevention outcomes. Clearly a range of indicators gives a more reliable result.

Measuring process - Process is generally the most difficult aspect of an activity to measure. Proxy indicators of success include the involvement of the people affected in meetings, the formation and/or level of activity of NGOs and whether or not PLWHA challenge decisions made on their behalf (a positive sign).

Measuring capacity - Capacity indicators have included skills and financial audits, and ability to adapt project designs.

Relevance to people affected - Monitoring should be relevant to the people affected and provide them with a measure of shared success. The indicators should therefore be determined jointly by the designers and the people affected. Indeed, they are in a good position to provide input on the relevance and efficacy of indicators. That means that both implementers and 'beneficiaries' should be involved in setting the appropriate indicators and targets for program effectiveness. This enhances the appropriateness of monitoring tools.
ADMINISTRATION AND MANAGEMENT

Key Guiding Questions
Has there been adequate attention to the administration and management of the activity? Are there any deficiencies and how could they be remedied?

Auxiliary Guiding Questions
- What strategic and contingency planning has taken place? Will it be carried forward into the project?
- Has adequate technical and managerial support been provided? Are staffing arrangements sound?
- Are arrangements in place to ensure all stakeholders work productively together?

Lessons learned
Administration and management - The review of Australian Government funded HIV/AIDS activities found that project administration and management are areas requiring substantial attention. There is a tendency to underestimate management requirements. Assessment of management requirements needs to be more rigorous. There is a clear need for better technical support, increased networking and improved reporting, accounting, and strategic planning. Increased resources would assist in achieving these needs.

Innovation and back-up strategies for counterparts - A more innovative solution for the provision of counterparts remains a requirement for PNG projects. Counterparts have proven highly transient and often unavailable. Designs require back-up strategies to sustain skills and information transfers when the first tier or initiative for counterparts fails to take place, or collapses mid-stream.

Financial security of staff - If staff, including government seconded staff, are offered a good wage they don't have to consider supplementation and can dedicate themselves to the job.

Specialists or generalists - Some HIV/AIDS activities have been weakened by the use of generalist managers rather than specialists in the relevant HIV/AIDS activity. The reviewers involved in the Review of HIV/AIDS Policy and Programming in AusAID found this to be the case with Australian Government funded activities in Malawi (UNICEF) and Uganda (TASO).

Project Coordination Committee - Incorporate the PCC process into monitoring and planning. The PCC should be used to reflect on what has been learned over the period between meetings and to feed this back to the project managers and into annual work plans. (Review field notes, Kwetu)

Communication - Problems of communication between authorities and people working with activities have arisen with Australian Government funded HIV/AIDS activities. Better systems are needed to channel grassroots experience, concerns and success to policy makers. There is an ongoing need to establish mutual respect amongst the various stakeholders. Linking government policy and decision making to the reality of events on the ground will improve effectiveness.

Linkages with other Australian aid projects - Australian Government funded HIV/AIDS activities have generally not developed linkages with other projects. Linkages would generally be beneficial. This is an area that needs improvement.

Prejudice - Within government departments, prejudices can still be found similar to those remaining in urban communities and rural villages. It is important to mobilise the people themselves and focus on effective partnerships within government agencies, while working to educate and sensitise both groups to the others' concerns.
SOURCES


AusAID (1997) Issues and Trends in International Health by M Toole and M Whittaker


UNAIDS (1999) AIDS: 5 Years Since ICPD - Emerging Issues and Challenges for Women, Young People and Infants


UNAIDS Best Practice Collection (http://www.unaids.org/)


World Bank (1996) ‘Best Practice in AIDS Prevention and Mitigation’ in Findings, Africa Region March

Feedback Form

AusAID Officers

<table>
<thead>
<tr>
<th>Name</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Others

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did you use the Guide?


Was it easy to use? Why/why not? How can this be improved?


Which sections of the Guide did you find most useful? Please say why.


<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which sections of the Guide did you find least useful? Please say why.</td>
<td></td>
</tr>
<tr>
<td>How do you think the Guide can be made more useful?</td>
<td></td>
</tr>
<tr>
<td>What suggestions do you have for future editions of the Guide?</td>
<td></td>
</tr>
<tr>
<td>Do you have examples of strategies you have used to address HIV issues in the project cycle that you would be willing to have included in the Guide in the future?</td>
<td></td>
</tr>
<tr>
<td>Do you have lessons learned and/or case examples that illustrate lessons learned that you would be willing to have included in the Guide in the future?</td>
<td></td>
</tr>
</tbody>
</table>
The Australian Aid Program
Guide to HIV/AIDS and Development

Australia’s health aid seeks to improve the health of the poor in developing countries by providing primary health care.

One of the highest priorities for Australia’s health aid is to prevent the advance of HIV/AIDS, mitigate its impact on people and communities, and respond to the social and economic needs created by the disease.

The Guide to HIV/AIDS and Development seeks to ensure that Australia’s aid program delivers high quality health projects in the area of HIV/AIDS.

It presents policy principles, documents lessons learned and poses guiding questions for the design and implementation of HIV/AIDS activities in developing countries.

The Guide reflects the experience of many Australians working with development NGOs, HIV/AIDS community organisations, public health institutes and government departments.

Whilst it is primarily intended for use on Australian Government HIV/AIDS projects in developing countries, the Guide may also prove to be a useful reference for policy makers and health professionals in developing countries as well as other international aid donors.

For more copies of this publication contact:
Bibliotech
GPO Box 4
Canberra ACT 2601
Tel: 02 6249 2479  Fax: 02 6249 5677
Email: books@bibliotech.com.au

For further information contact:
Director, Health Group
AusAID
GPO Box 887
Canberra ACT 2601
Tel: 02 6206 4660  Fax: 02 6206 4870
Internet: www.ausaid.gov.au