

*A guide for
including HIV/AIDS
prevention in
PVO Child Survival projects*

*Recommendations for Child Survival
Project Managers*

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*Report of a special task force on including
HIV/AIDS prevention in child survival projects*

On August 3, 1994, a task force on Including HIV/AIDS Prevention in PVO Child Survival Projects was convened by the PVO Child Survival Support Program at the AIDS CAP offices of Family Health International in Arlington, Virginia. The purpose of the meeting was to provide practical advice to PVOs that wished to include in their Child Survival projects interventions for the prevention of HIV/AIDS. The meeting resulted in a set of recommendations to guide field project managers in the process of deciding whether or not to include HIV/AIDS prevention in their projects, in determining the types of strategies that would be most appropriate for a given setting, and in setting realistic objectives for the activity.

Acknowledgments

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The editors would like to acknowledge the contributions of PVO staff throughout the world, and of the communities they serve, who are becoming involved in the global effort to reduce the spread of HIV/AIDS. Successful strategies will ultimately emerge through their efforts to empower communities to protect themselves from the epidemic, and to safeguard the rights of persons living with HIV infection and AIDS in those communities.

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I. Purpose

This document is the report of a special task force meeting organized by The Johns Hopkins University PVO Child Survival Support Program in August, 1994. The task force aimed to provide advice to private voluntary organizations (PVOs) that wish to include HIV/AIDS prevention activities in their Child Survival (CS) projects. It is a synthesis of the ideas discussed at the task force meeting about the relationships between child survival and HIV/AIDS prevention. The report is meant to provide information to PVO field staff of Child Survival projects funded by the United States Agency for International Development (USAID), as well as others involved in similar activities, to help them in conceptualizing and planning their HIV/AIDS prevention activities in the context of a Child Survival project.

The guidelines and indicators presented here are meant to provide helpful advice or guidance, and are not meant to be prescriptive or binding for PVO Child Survival projects. This report is a first step in defining the most feasible approaches to HIV/AIDS prevention that are consistent with other child survival activities of the PVO projects. Field staff must take the next step to test and provide comments on these recommendations. Feedback to USAID and the PVO Child Survival Support Program about the usefulness of this document, and suggestions for its improvement, is appreciated.

II. Background

The goal of the global Child Survival effort is to reduce morbidity and increase the survival of children and mothers in developing countries by using simple, low-cost technologies implemented at the community level. Since 1985 the Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (BHR/PVC) at USAID has supported a grants program for U.S.-based private voluntary organizations to enhance their abilities to carry out Child Survival programs in Asia, Africa and Latin America. The PVO Child Survival projects focus on reducing infant, child and maternal mortality and morbidity by increasing immunization coverage, management of diarrheal diseases, control of pneumonia, prevention of malnutrition (including vitamin A supplementation), promotion of maternal care, control of malaria and, in recent years, the prevention of HIV/AIDS. BHR/PVC currently funds more than 70 PVO Child Survival projects worldwide.

Although individual PVOs and PVO Child Survival projects vary, the PVC-funded Child Survival projects have a number of characteristics in common. They:

- are community-based and have the confidence and trust of the community because of their long-term presence

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- frequently include other health or development activities in addition to child survival
 - receive funding in 3- or 4-year cycles
 - contain multiple child survival interventions, often as many as six or eight
 - provide services for women of child bearing age (15-49) and infants and small children
 - focus on education and capacity building
 - work in rural and poor urban settings, often with hard-to-reach populations
 - use a set of standardized indicators to measure child survival-related knowledge, practice and service coverage (KPC) for project evaluation

During the past several decades there have been considerable decreases in infant and child mortality in every region of the world. However, just as the Child Survival Program's realized these successes, the global epidemic of the human immunodeficiency virus (HIV) and AIDS began to gain a stronghold in the same regions. According to World Health Organization (WHO) estimates, as of 1994 nearly 15 million people worldwide are believed to be infected with HIV (PAHO, 1994).

Between 13 percent and 40 percent of infants born to HIV-infected women will be themselves infected with HIV (Way and Stanecki, 1994). As the prevalence of HIV/AIDS and the importance of heterosexual transmission continue to grow, increasing numbers of women are being infected with HIV. As a direct result of this trend, already seen in several sub-Saharan African countries, infant and child morbidity and mortality rates attributable to perinatal transmission of HIV are increasing. During the first decade of the HIV/AIDS pandemic, WHO estimates that about 500,000 cases of AIDS occurred in women and children, most of which were unrecognized. Projections indicate that an additional three million or more women and children will die from AIDS during the 1990s. Projections also indicate that in several of the countries most affected, child mortality will triple by the year 2010 due to the effects of HIV and AIDS-related mortality (Way and Stanecki, 1994). Thus, the HIV pandemic threatens to undermine much of the progress that Child Survival programs have made since 1985.

Furthermore, the loss of mothers to AIDS, whether or not they have transmitted the virus to their infants, has a profound impact on the health and well being of all children left behind. Orphaned children, particularly infants, have a greater chance of suffering increased morbidity and early mortality than those with living mothers. Children who are HIV positive may not re-

spond as expected to standard treatment regimens; consequently, the life-saving effects of the traditional child survival interventions, such as growth monitoring and promotion, are likely to have less than the expected effect on HIV-associated mortality in children (Mann et al, 1992).

In the early stages of the HIV/AIDS epidemic in a given setting, the danger posed to infants and young children was often not considered, and knowledge of maternal transmission was low. Even today, well into our second decade of living with HIV/AIDS, there is still a strong association of HIV infection and AIDS with prostitution, drug use, homosexuality and "loose morals," and not with mothers and children. The PVO Child Survival program can address the reality of HIV infection in developing countries by focusing on the effects of the pandemic on mothers and children at the community level. Changing community perceptions and capabilities to stem the course of the HIV pandemic may be the most valuable contributions PVOs can make to child survival in the long term.

III. PVOs and HIV/AIDS prevention: findings of the task force

Since 1992, an increasing number of PVOs have included HIV/AIDS prevention activities in their Child Survival projects. The Johns Hopkins University PVO Child Survival Support Program (JHU/CSSF), which provides technical support to PVC-funded PVO Child Survival projects, has received numerous requests from PVO field staff for advice and guidance about the most effective approaches to including HIV/AIDS prevention in their Child Survival projects. Questions raised by PVOs include: how does HIV/AIDS affect child survival, both in terms of mortality and of the health problems targeted by the child survival interventions? Which child survival interventions might usefully integrate HIV/AIDS activities? Which additional groups might be included for an HIV/AIDS intervention apart from the usual child survival beneficiary group of mothers and small children? Which factors in a specific child survival setting should be considered in selecting an HIV/AIDS prevention activity? And how can we, at the community level, evaluate the efforts in HIV prevention without access to information about changes in HIV infection rates?

In response to these requests, JHU/CSSP organized a one day task force meeting in which PVO staff and other resource persons experienced in planning and implementing interventions related to HIV/AIDS addressed some of the key questions. The Office of Family Health International/AIDSCAP hosted the meeting. Attending the meeting were four PVO staff, six other technical resource persons, two representatives of USAID, and three JHU/CSSP staff members. The objectives of the meeting were to formulate sug-

gested guidelines for PVOs to help them to make and justify the decision to include HIV/AIDS prevention activities in a Child Survival project, determine appropriate strategies, and suggest useful indicators of progress or success for the intervention.

This task force report, based on the above objectives, was organized as a response to four of the key questions asked by field staff about including HIV/AIDS prevention activities in their Child Survival projects. The questions were:

- How are interventions that respond to HIV/AIDS similar to and different from those we know for child survival?
- How should we decide to include or not include an intervention for HIV/AIDS prevention in our Child Survival project?
- How should we decide the basic strategies and the community groups to include in the HIV/AIDS prevention intervention?
- What indicators will provide the most useful measures of the progress and the success of our HIV/AIDS prevention activities?

Question #1: How is HIV/AIDS prevention similar to and different from those activities we know for child survival?

Many aspects of the problem of preventing further spread of HIV infection are similar to those faced in other health and development efforts, including those of the Child Survival projects. For example, PVO Child Survival projects are usually funded for a three or four year period, with the possibility of extending for a limited time. As has been painfully discovered by countless child survival field staff, three years is too short a time to demonstrate a sustainable impact on many kinds of behaviors related to child survival, certainly for the very personal and deeply-rooted sexual behaviors involved in HIV/AIDS prevention. For both child survival and HIV/AIDS prevention, the most effective approaches, in addition to the delivery of high quality services, are now believed to include community-based, interpersonal efforts at education and motivation, in combination with broader efforts to affect social norms and awareness. Another similarity lies in the issue of community awareness: many of the problems addressed by child survival, such as growth stunting or lack of immunizations, were not initially recognized as problems by community members, just as HIV/AIDS often is not seen as a real threat by a community in its early stages. PVO efforts have required concentrated awareness-raising by project staff before a "demand" for services is evident. Furthermore, both child survival and HIV/AIDS prevention projects rely heavily on community resources and involvement for their implementation.

One of the most important lessons that has emerged from the international effort to combat the HIV pandemic, however, is the need to look at HIV/AIDS as a unique problem requiring a response that is carefully tailored to its characteristics. Although there are other modes of HIV transmission, the most common is through sexual intercourse with an individual who was himself or herself infected through sexual relations with one or more partners. Thus, unlike most other health and development issues, an aura of immorality surrounds HIV transmission in most cultures. This stigma requires that efforts to promote behavior change also support the rights of persons most at risk of HIV infection, so as not to strengthen or perpetuate the immoral connotations of HIV and AIDS.

Early experience with PVOs carrying out HIV/AIDS prevention projects has demonstrated some important differences between the approaches taken in child survival and those needed to deal with HIV/AIDS at the community level. Table 1 shows some of the most basic and important ways in which the interventions that aim to prevent further spread of HIV infection and AIDS are different from the familiar interventions of child survival—immunizations, prevention of malnutrition, control of diarrheal diseases. For each contrasting set of characteristics, some of the possible effects of those differences on a Child Survival project are suggested. Project staff who wish to include an HIV/AIDS prevention component in their Child Survival project should carefully consider how differences and similarities between HIV/AIDS prevention and child survival will affect their overall project.

Question #2: How should we decide to include or not include an intervention for HIV/AIDS prevention in our Child Survival project?

Before deciding to include HIV/AIDS prevention in a Child Survival project, PVO field office and headquarters staff, and the communities they serve, need to consider several important factors in their own project setting that will determine the need for and feasibility of successfully carrying out HIV/AIDS prevention activities. PVOs must recognize the potential for detrimental effects of introducing certain types of HIV/AIDS prevention activities into a Child Survival project if the activities are not carefully designed to consider the prevailing attitudes and sensitivities of the community. An examination of the factors discussed below should help staff to justify including or excluding HIV/AIDS prevention activities for their project.

The "need" for the intervention can be looked at both in terms of the level and distribution of the problem (the epidemiology of HIV and AIDS), and the extent of other programmatic efforts in the area. Table 2 suggests a way in which PVOs might look at the epidemiologic status of HIV/AIDS and other sexually transmitted diseases (STDs), combined with their own presence in an

Table 1
What are the basic differences between
HIV/AIDS prevention and child survival activities?

Differences	
Child Survival	HIV/AIDS
Focus is on infants and small children, women of childbearing age, other caregivers.	Focus is on men and women, adolescents, community leaders, workers, other groups.
CS problems and their interventions are well understood, and most are considered to be "respectable".	Immorality, stigma and shame are associated with HIV/AIDS, leading to intense family and social pressures.
Most CS problems are visible at the community level, and exist at stable or declining rates	AIDS is not apparent until HIV rates are high and even more difficult to control than in earlier stages.
Prevention, treatment and case management protocols for CS are generally available.	No cure, only prevention available; effective prevention approaches still under development.
CS problems lead to infant/child mortality but with few deaths in adults	Adult mortality is the first visible sign of AIDS, leading to massive need for care/support of those ill, AIDS orphans.
Staff skills focus primarily on health worker training and community education	Staff need skills in discussing sexual matters, "taboo" topics
Most of the CS problems are acquired postnatally.	Prenatal or perinatal (mother-to-infant) transmission is common.
Gender/power relations may be important, but usually are not critical for the success of most CS interventions.	Gender and power relations are very important, empowerment of women critical.

Program Implications

May need to expand the usual population focus for CS efforts, to acknowledge the importance of reaching the most vulnerable and/or influential groups, and to try to secure political support for this effort

Build on existing relationships, credibility and understanding of local culture. Include religious leaders. Be prepared to address the controversies of working in HIV/AIDS, including advocating for the support and rights of persons with AIDS

If possible, involve HIV+ persons in education efforts to show the human aspects of AIDS. Emphasize the similarities with CS, e.g., EPI diseases and malnutrition also often went unrecognized before CS. Focus on related problems that are well recognized (e.g., STDs)

Document and evaluate carefully prevention efforts, especially if testing a new approach. Try new approaches. Share results with others in country, area.

Be prepared to refer families and individuals in need of HIV testing, counseling and other supportive services. If these services do not exist, PVO may need to join or initiate efforts to establish them. Try to avoid staff "burnout" through staff support and counseling.

Select and/or train PVO staff for needed new skills and information; this may require more intensive inputs than anticipated from CS experience.

Include as health message for mothers and fathers the need to protect mothers from HIV, and in so doing to protect their children's lives.

Include men and other family members to increase effectiveness of both HIV and CS activities; include community opinion-makers, religious leaders, others. Seek approaches to support and increase women's choices.

Table 2
Epidemiologic and PVO program factors
and priority status of HIV/AIDS prevention activities

Epidemiologic Factors	Program Status	
	New Project	Ongoing Project
Low STD rates Low HIV infection rates	❖	❖❖
High STD rates Low HIV infection rates	❖❖	❖❖❖
High STD rates High or rapidly increasing HIV infection rates	❖❖❖❖	❖❖❖❖

Priority status of HIV intervention: ❖ = very low; ❖❖ = low; ❖❖❖ = medium; ❖❖❖❖ = high

area, to determine the level of priority the intervention might be accorded for their project.

Two factors in the table, in addition to HIV prevalence, are the presence or absence of activities by the PVO in the impact area and the current rates of other STDs. The established presence of the PVO in the impact area is an important factor because of the intense demands that an HIV-related intervention may place on a new project before it has established its credibility and presence in a community. Other STDs are included because they show an increased risk of HIV infection in a population, for two reasons. First, high STD rates are a good indicator of the type of high-risk behavior that is likely to lead to rapid increases in HIV infection rates once the epidemic is established. Secondly, an individual is much more likely to become infected with HIV after exposure to the virus (that is, after unprotected sex with someone infected) if they have an existing STD (Mann et al, 1992).

As shown in the table, it may not be a priority for a new Child Survival project to introduce an HIV prevention component in an area where HIV prevalence rates are low. Other questions related to local epidemiology may be relevant in using this table, such as the validity of the available data on STDs and HIV—epidemiologic data are only useful if they are accurate. In some cases it may be difficult to locate any credible data on rates of HIV infection and other STDs. Another possibility is to use data that in some settings are more regularly collected, for instance, the level and trend of tuberculosis cases in the country or region. Recent substantial increases may indicate that an unrecognized or unacknowledged increase in HIV infections and/or AIDS cases is occurring.

Table 2, above, is meant to be a guide for using epidemiologic information in most situations. However, the PVO needs to consider other factors in their decision making process. Some factors, such as a strong commitment by the community and/or the PVO or country involved, might increase the potential impact of HIV/AIDS prevention where it would otherwise have a lower priority. Other factors, such as the presence of currently existing HIV/AIDS prevention activities with which the Child Survival project can link, might influence the decision by indicating that a relatively small effort devoted to HIV/AIDS prevention could be effective. Table 3 presents several of these added factors.

Question #3: How should we decide the basic strategies and the community groups to include in the HIV/AIDS prevention intervention?

As Table 3 shows, the decision to include an intervention that responds to the problem of HIV/AIDS in a given project setting involves several complex factors. Once the decision is made to develop an HIV/AIDS prevention component, the PVO should ask several critical questions to determine the precise strategies and approaches that are likely to be the most feasible and effective.

The PVO should first address a number of general issues in determining the target groups for the activity. They are:

- What are the likely or documented patterns of HIV transmission in the project area? What behaviors and situations facilitate the spread of HIV? It should be possible to determine if some groups in the community are particularly at risk of infection, or if infection rates are so high that the entire sexually active community (and their infants) must be considered at risk.
- What are the priorities of the community? What groups do community members and leaders believe would be the most useful to involve in implementing the intervention? Which are the groups most likely able to affect HIV transmission patterns and rates?
- Does your project have the resources needed to initiate activities with a totally new beneficiary group (funding, staff time, materials/equipment)? Are there appropriate groups with which your project is already working in some other capacity (child survival or otherwise)? Can these activities be a base for HIV/AIDS prevention activities?
- Are any other organizations presently working with a potential target group, for either HIV/AIDS prevention or other activities? If so, how can your activities be integrated with their activities, or complement them? How will your project relate to the national AIDS control program?

Table 3
Non-epidemiological factors to consider in the decision to include HIV/AIDS prevention in a PVO Child Survival program

Factors

Level of knowledge and attitudes about HIV and HIV prevention in project communities; community priority for action.

Availability of other local resources and services for HIV/AIDS prevention (e.g., PVOs, public sector, religious organizations) in impact area.

Vulnerability of population in service area:

- *Presence of large numbers of street children, migrants or dislocated workers*
 - *Widespread practice of especially high risk behaviors (for example, commercial sex, IV drug use, multiple sexual partners)*
-

PVO capacity

- *Staff with prior experience/training or special interest in HIV/AIDS prevention.*
- *PVO history in project area*

Recognition at national policy level of importance of HIV prevention.

- How will including this population group affect the other child survival interventions in your project? How can children benefit from including this group in your child survival activities?
- What are the benefits that focusing on this group may have on maternal health and the prevention of maternal morbidity and mortality? How else can mothers benefit from including this group in the Child Survival project?

Table 4 explores several population groups that might be included in HIV/AIDS prevention activities for a Child Survival project, and presents a rationale for their inclusion.

Justification for Inclusion

Where basic knowledge is lacking, use established contact with mothers and others to provide HIV/AIDS information and education. However, in most cases PVOs should work in HIV/AIDS prevention only if they are prepared to address the more complex issues of promoting sexual behavior change in project communities. Communities must involve themselves in planning the response to HIV/AIDS from the beginning.

Where the community generally does not perceive HIV as a major problem, other more recognizable problems can be cited, such as high STD rates, adolescent pregnancies, infertility, and other problems indicating behavior that is high risk for HIV transmission.

Collaboration in HIV/AIDS prevention is critical. If PVO resources are limited, it can justify even a small effort if the project links with other groups to coordinate efforts (materials development, workshops, training, condom distribution, STD treatment services)

Listed factors could increase the priority of HIV/AIDS prevention for a project because:

- *All groups listed are especially vulnerable to HIV transmission*
 - *Some practices are known to accelerate substantially the risk of HIV transmission.*
-

Commitment of staff and knowledge/understanding of local culture and beliefs, as well as the trust and confidence of community in a well-established project, are critical to acceptance and success of prevention efforts.

A clear policy may facilitate access to other resources; absence of a policy may indicate a need for PVO to join other groups in lobbying for an official response to the current or potential problem of HIV and AIDS.

Part of basic CS beneficiary group; epidemiologically in highest-risk age/gender group for HIV transmission; can pass on HIV infection to infants; maternal mortality from HIV dramatically affects infant morbidity and mortality; usual care providers for infected family members. Some project beneficiaries may be women with especially high-risk behavior (multiple partners, commercial sex work). Many may already suffer from STDs and STD-related infertility.

Part of basic CS beneficiary group; if infected or ill with HIV disease, may not respond "normally" to interventions for usual CS problems (pneumonia, malnutrition); if orphaned due to AIDS, are at special risk for illness and death.

Men are usually decision-makers about domestic matters, including sexual behavior in the home; transmission of HIV and other STDs by men to women impacts maternal health and infant mortality; economic deterioration of family welfare due to lost income and health care expenses because of illness and/or death of father impacts maternal and infant/child health and mortality.

Some men in community are especially influential and can assist in changing local norms and attitudes regarding at-risk behaviors and situations, once they identify approaches that do not conflict with their own positions and values. If not involved or at least supportive, can block access to at-risk populations and undermine prevention efforts.

Many adolescent girls will soon be mothers; sexual activity by early teens is common in many settings; it is important that both boys and girls set low risk behavior patterns during the adolescent or preadolescent stages, before sexual activity begins and patterns are entrenched; teenage girls are often at highest risk of infection by HIV and other STDs; there is high infant mortality for children of very young mothers, as well as problems of maternal health, and thus there are multiple benefits to adolescents adopting behavior that is low-risk for HIV, other STDs, and pregnancy.

In many settings health care workers are inadequately trained and emotionally unprepared to educate the community about HIV and other STDs; can be influential in improving the care and reducing stigma for persons with HIV infection and AIDS; have access through maternal care services to women of reproductive age who are especially important beneficiaries for services such as syphilis screening, counseling and education; may be part of transmission chain in health care setting if precautions not taken.

The official child survival beneficiary group (used to calculate cost per beneficiary ratios) consists of women of childbearing age (15-49) and

Table 4
Who should be included

Group

Women ages
15-49 years

Infants and small children

Men
(as fathers, husbands,
community and political
leaders, religious leaders)

Pre-adolescents and
adolescents

Health care workers

al HIV/AIDS prevention activities? Why?

Rationale for inclusion in child survival an HIV/AIDS activity

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children under 60 months of age (or children under 72 months for the prevention of vitamin A deficiency). If additional population groups are to be involved in the HIV intervention, the PVO needs to consider many important questions, such as the following: What is the best way to reach this group (for example, formal education, peer education, home visits)? For women, are there existing approaches that might offer women emotional support and encourage them to make choices about their reproductive life? Are women, already included in child survival activities through the larger 15-49 grouping, involved in high risk behaviors, such as trading sex for gifts or money. If yes, what special or added approaches will they need (for example, more aggressive promotion/provision of condoms)? Are adolescent girls at particular risk because they are approached by "sugar daddies"? How are men involved in the PVO's child survival activities? What health related decisions do men make in the family? Are PVOs or any other organizations working with men to promote condom use? What is the community's willingness to accept HIV/AIDS education for children of different ages? What roles do the ministries of health and education play in STD/HIV/AIDS education in schools?

Often, the PVO will need to carry out a focused effort to gather relevant quantitative and qualitative data for clear answers to these and other questions in determining the possibility of working effectively with different groups in HIV/AIDS prevention.

Once basic information is available on possible beneficiary groups, the PVO should select one or two that are of highest priority. Prioritization is, in general, based on the expectation of the greatest effect, both short-term and long-term, on slowing the spread of HIV in the project community. However, the feasibility of the PVO working with a given group, the likelihood that PVO efforts will actually be able to bring about the needed change, and, in particular, community attitudes towards and involvement in a given approach are at least as important as the epidemiologic considerations. A careful definition of the expected outcome of interaction with each prospective beneficiary group should help to identify which are most appropriate to include in the HIV/AIDS prevention effort.

In addition to the choice of community groups that will benefit from the activity, some of the many other questions that should be considered before determining the precise prevention strategy are:

- *What is the level of knowledge and what are the attitudes about STDs, HIV/AIDS and HIV prevention among the project population, including health care workers?*

Targeting increases in knowledge is only justifiable if local studies have shown low levels of understanding of the basic facts about HIV/AIDS.

More often, knowledge of the facts is adequate, but motivation, skills and

resources to change high-risk behavior and situations are needed. However, we need to remember that the task of promoting behavior change is many times more complex and demanding than the simple provision of education, and may require longer-term, sustained commitment to demonstrate impact on behavior. Community involvement in this process is vital.

- *What are the sociocultural and religious factors that will affect the success of HIV/AIDS prevention efforts, such as strong taboos regarding the discussion of sex, or women's lack of authority to make decisions? Which of these factors might facilitate the process of behavior change for HIV prevention?*

HIV/AIDS prevention activities with any group need to be based on a solid understanding of social, cultural and traditional mores and norms found in the community. A firm understanding of these factors should facilitate the identification of culturally sound approaches to promoting behavior change and HIV prevention. PVOs should try to identify the kinds of factors that are most likely to motivate people to change behavior, such as concern for the lives of their as-yet-unborn children. Very often, such approaches will be multisectoral and involve a number of different types of community, political and religious leaders.

- *What child survival funds are available for HIV/AIDS activities, and what are the capabilities of local staff for overcoming obstacles to awareness and action?*

A relatively small effort (for example, less than 15-20% of a Child Survival project budget) for a complex new activity such as HIV/AIDS prevention is only justified if it is clearly linked with other efforts, has strong community and political support and does not overtax staff and resources of other child survival components. More substantial resources mandate more extensive inputs and may allow for a more ambitious effort, involving specialized staff, new beneficiary groups, etc. It is important for long-term sustainability of both HIV/AIDS prevention and the other child survival components that neither overshadows the other.

- *What HIV-related services and commodities (for example, STD and HIV testing, treatment or care, counselling, condoms, educational materials, etc.) are available locally?*

It is critical that appropriate referral sources be available in response to the demand created by educational efforts. If not, the project may need to encourage the development of such resources, or even include some support services or materials in its package of HIV/AIDS prevention services.

- *What simple and tested approaches might be implemented for a minimum of inputs, preferably integrated with other child survival interventions?*

To make the most efficient use of resources, projects should look closely at

existing activities for opportunities to integrate HIV/AIDS prevention activities. For example, a very important co-factor for HIV infection has been found to be the presence of ulcerative STDs, such as syphilis. Are pregnant women routinely tested and treated for syphilis? Can the project aid existing antenatal care services to strengthen or initiate syphilis testing and treatment as a part of its maternal health component? Other examples might be providing training in the use of condoms, which could be an activity of the maternal care/family planning component, expanded to reach both men and women; the training of health care workers in recognition and management of STDs; and the expansion of existing health education curricula to include prevention of HIV/IDS.

Question #4: What indicators will provide the most useful measures of progress and success of our HIV/AIDS prevention activities?

Once the PVO decides to include an HIV/AIDS prevention component in a Child Survival project, project staff must define measurable objectives and indicators of the progress and success of the intervention. Unlike the other child survival interventions, standardized indicators that are appropriate for Child Survival projects have not been developed and tested for HIV/AIDS prevention. Because of the range of interventions possible, the task force did not attempt to develop a comprehensive list of indicators for HIV/AIDS prevention. However, several principles and considerations in the development of the indicators, and some examples, are offered.

As with the other types of child survival interventions, two major types of indicators are needed: process or output indicators, focusing on what is done, and outcome or impact indicators, focusing on the effects of what is done. Although the need to "demonstrate results" is always pressing, and particularly so given the urgency of the problem of HIV and AIDS, PVO staff are urged to remember the difficulty of bringing about sustainable change in sexual behavior in the three or four short years of a project's funding period. Objectives reflecting a balance of process/output indicators and indicators of carefully defined outcome/impact should be the goal for a child survival intervention focusing on HIV/AIDS prevention. Table 5 offers examples of HIV/AIDS prevention outcome objectives, output and outcome indicators for the objectives, and suggested methods for measurement of the outcome indicators.

The approaches listed are categorized as training, education, and support services. For purposes of the table, "training" is understood as empowering someone with a skill so that he or she may then carry out a specific task that addresses the aims of the project. Training includes in-service training (such as health workers, teachers, etc.) and special training sessions which bring to-

gether individuals not otherwise formally organized as a group (such as peer educators, traditional healers or traditional birth attendants). "Education" includes both formal education in institutional settings (such as school health education), and informal education that takes place in health facilities, community, religious or work settings. "Support services" are activities that provide needed goods or services such as counselling, condom distribution and promotion, and social welfare activities (such as support to orphans, educational and medical support, food and shelter, etc.). Any of these approaches may be closely linked with another.

In setting objectives, PVO staff should try to be as realistic as possible about outcomes that are both attainable and measurable within the context of the specific population groups with which they will work. For example, a project that plans to promote condom use with men in the community, as well as women, may wish to target increased condom use. However, a project working primarily with early adolescent girls would be less likely to achieve significant numbers of reported condom use, and might more realistically aim to improve skills in refusing unwanted sexual advances, or to delay the age of first sexual activity.

Measurement methods for process and output indicators are usually based on routinely collected monitoring data (training records, home visits records, number of condoms sold or distributed). Outcomes, however (as seen in the last column of the table), are usually measured through some type of special study, typically a pre- and post-intervention test for participants, or a population-based survey (in child survival, the KPC, or knowledge, practices and coverage survey).

Because the usual participants in the KPC survey are only mothers of small children, using the standard KPC sample may not be the best way to measure project outcomes for HIV/AIDS prevention, unless the project simply aims to increase the knowledge of project women. Some projects may decide to add an additional sample of some other population group that has been involved in project activities, such as men or adolescents, to the survey sample to gain more comprehensive information about changes in practices such as condom use and knowledge of prevention. Alternatively, special "mini-surveys" focusing exclusively on HIV/AIDS-related issues could be conducted. Pre- and post-tests given before and after some types of group interventions, such as classroom education or training, could also provide useful measures of educational or training outcomes. Post-tests should be conducted at the end of training, and repeated several months later to ascertain the level of knowledge and skills that are retained. A follow up survey is the ideal time to investigate changes in behavior that may have occurred as a result of training or educational sessions.

Table 5. Examples of indicators for education, training and support service objectives

Approach	Objective	Output Indicators
Training of field or community staff, health workers	% of [specific group] trained will be competent in [skill to be acquired], e.g., counselling, teaching methods for HIV prevention	# of [specific group] trained in x period of time # of [type of training] sessions held in x period of time
Education, increasing knowledge and skills of community	% of [beneficiary group] will know: 1) modes of HIV transmission, including mother-to-child; 2) methods of HIV/AIDS prevention; 3) correct use of condoms % of [beneficiary group] will be able to negotiate condom use % of [specific group] will report condom use during last act of intercourse with non-regular partner	# of HIV/AIDS educational sessions held with [beneficiary group] in x period of time # of [beneficiary group] educated in x period of time # of [beneficiary group] trained in condom negotiation in x period of time # of [beneficiary group] provided training/motivation in condom use # of condoms distributed during x period of time
Support Services	% of [group] will have access to condoms % of [group] referred to health center for STDs will present for services % of antenatal clinic attendees will be screened and/or treated for syphilis	# of outlets with uninterrupted supply of affordable condoms in last x months # of STD educational sessions held in x period of time # health workers trained in STD referral and/or treatment # syphilis tests done on pregnant women

Outcome Indicators	Evaluation Method
<p>Proportion of [trained group] who are competent in [skill] 6 months after training</p> <p>Proportion of [trained group] using newly acquired skill(s) 6 months later</p>	<p>Training records, pre- and post-tests</p> <p>Observation of care providers, service records</p>
<p>Proportion of [beneficiary group] with correct knowledge of HIV transmission; methods of prevention; condom use</p> <p>Proportion of [beneficiary group] with increased ability to negotiate condom use</p>	<p>Surveys, pre/post-test, condom use demonstration</p> <p>Surveys, pre- and post-tests, observation</p> <p>Surveys</p> <p>Surveys</p> <p>Health service records, referral records</p> <p>Health service records</p> <p>Surveys, pre- and post-tests, observation</p> <p>Surveys</p> <p>Surveys</p>
<p>Proportion of [group] who report condom use during last sex with non-regular partner</p> <p>Proportion of [group] who can name an accessible and affordable source of condoms</p> <p>Proportion of [group] referred for STD symptoms who present for treatment</p> <p>% of antenatal mothers screened for syphilis; % of syphilis+ mothers treated</p>	<p>Health service records, referral records</p> <p>Health service records</p>

IV. Summary and Conclusions

The pandemic of HIV infection and AIDS is a rapidly expanding phenomenon that threatens the gains made in child survival over the past several decades. PVOs involved in child survival are in a unique position to respond to the urgent needs posed by HIV/AIDS. PVO experience and community presence in carrying out child survival and other health and development projects offers a credible base for HIV/AIDS prevention. Their activities to improve the health of mothers and children provide access to the populations most vulnerable to the devastating effects of the HIV pandemic.

However, the expansion of child survival to include HIV/AIDS prevention is not necessarily a smooth one for PVOs. Although some aspects of the interventions are similar, it is important that PVOs recognize and respond to the critical differences between the "respectable" nature of the problems addressed by child survival and the challenge of preventing sexual transmission of HIV infection and AIDS. Some of the differences are reconcilable without major changes in the child survival approach, but others will take a careful rethinking of the types of staff, training, beneficiary groups and community interactions involved when a Child Survival project undertakes HIV/AIDS prevention.

The initial decision to include an intervention for HIV/AIDS prevention should be based on the PVO's existing relationship with the beneficiary community, the priorities of the community, epidemiologically-defined need in the project area, and a number of other factors. Once the decision to include HIV/AIDS prevention in a Child Survival project has been made, the choice of the precise approach will depend on a number of additional factors, such as the resources available, the accessibility of appropriate community groups, the most important needs of those community groups, the feasibility and likely success of possible approaches, and the ways in which the HIV/AIDS intervention will relate to (complement or detract from) the other child survival interventions. Objectives and criteria for evaluation of the intervention should be based on a realistic assessment of what is possible to accomplish in a relatively short time frame.

An important finding of the HIV/AIDS Task Force was the recognition that there are no formulae as to how to incorporate activities for prevention of HIV transmission into a Child Survival project. Current experience with programs for community-based AIDS prevention is not sufficiently evaluated to justify large-scale replication. In addition, the socioeconomic, cultural and political roots of the problem are sufficiently varied and complex that relevant approaches must be tailored to local characteristics of the epidemic. More than for any of the other child survival interventions, the basis for successful HIV prevention lies in the community itself. Only with a clear understanding

of the beliefs, attitudes and understanding of the project population regarding sexual matters, including sexually transmitted diseases and the social meaning of sex and procreation, are project staff likely to be able to develop meaningful strategies to assist the community to protect itself against HIV infection. Very often the process of learning about the community can itself help to build up communication and trust between the PVO and the community.

Rather than seek universal solutions, PVOs and others hoping to curb the growth of HIV at the community level must look to the communities they serve, and to the particular strengths of their own organizations, for guidance as to how to proceed. Particularly important is building on existing relationships with project communities, including a better understanding of the forces that shape the vulnerability of groups in the community to HIV infection. Efforts spent now will benefit child survival and health efforts far into the foreseeable future.

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