4. FRAMEWORK FOR GOOD PRACTICES IN HIV/AIDS PREVENTION*

Mary Ann Castle, Ph.D. Team Leader Barbara Fisher, Ph.D. Janneke Roos, M.A.

This framework is of best practices for the three major HEI HIV/AIDS prevention components. It is not an exhaustive listing of service delivery systems. It focuses on core elements necessary for behavior change in people at risk for contracting/transmitting the HIV virus.

[posted on PAC website February 2013]

GOOD PRACTICES	INDICATORS
Behavioral Change Theory	
Good practices in prevention programs have theoretical underpinnings	Programs use theory that enable them to focus on the most comprehensive aspects of prevention for individual or group interventions
Voluntary Counseling and Testing (VCT)	
VCT counseling is based on Behavior Change Theory, including (but not limited to) empowerment theory and social network theory	Clients demonstrate raised awareness of risk behaviors Clients are able to formulate an action plan for behavioral try-out Theory is applied to design, implementation, and evaluation of the program
Timely access to counselling services	Clients receive same day services
Client-centered services (youth friendly and gender and culturally sensitive)	Clients express satisfaction with services Counselors focus on issues/needs of clients Program design reflects client-centered/youth friendly approach Program design reflects gender and cultural sensitive approach Staff is sensitive to service needs of specific client populations
Institutional and Senior Management Support	Administration adequately funds VCT program, including for the purchase of commodities Admin. provides appropriate training for all staff positions Adequate supervision is provided for staff Supervisory structures and procedures for staff are in place (e.g., evaluation process)
HIV/AIDS workplace policies	Written HIV/AIDS policy and procedures are posted Staff are trained in policies and procedures, including DOH guidelines on voluntary nature of VCT, confidentiality, gender sensitivity and testing, and infection control Social support structures for staff are in place

Outreach efforts coordinated with peer educators and other appropriate groups on campus	Students "buy-in" to VCT services
High standards for staff development	Routine training for staff and supervisors in client centered, youth-friendly, cultural and gender sensitive and stigma-reduction approach Routine training for staff and supervisors for maintaining and improving job performance Routine training for staff in syndromic case management (STIs) Routine training for staff on treatment education for clients
Good relationships with community based and campus based services to which clients are referred, e.g., HIV prevention, peer education, treatment, support groups, psychological counseling, family planning, domestic violence counseling, etc.	Staff initiates and maintains good working relationships with CBOs, NGOs, and DOH for client referrals to needed services Staff initiates and maintains good working relationships with campus-based prevention programs and with media for marketing and outreach
Procedures for rapid testing and confirmatory lab tests for HIV+	Staff follows DOH guidelines
Procedures to follow-up with clients for confirmatory lab test results	Clients are followed-up by staff
Procedures for referrals to counselling & other support networks	Clients are referred to counselling and support networks on and off campus
Post-test counseling clubs (PTC) are offered	Private space is identified and used for PTC
Written Quality Assurance policies and procedures	Quality Assurance Team is established and meets monthly Services are provided for: ➢ HIV/AIDS Information is provided (verbal and written) ➢ Variety of delivery methods are used in counselling ➢ Problem solving counselling is provided ➢ Consistent supplies (ARVs, condoms, rapid tests, Elisa laboratory tests, contraceptives, emergency contraceptive, etc.) are available ➢ Referrals are made and followed up
STI management and referrals for medical care	Clients are managed for STI
For full range health clinics, distribute ARVs, diagnose and manage (or refer) opportunistic infections	Clients receive full range of care/treatment for HIV/AIDs
Separate rooms or provisions for privacy to ensure confidentiality	Clients are provided privacy in counseling, testing
Offer a range of health and/or social services to encourage student use of VCT services	Additional services have been incorporated into VCT facility
VCT services are free	Clients receive free services

GOOD PRACTICES	INDICATORS
Prevention Interventions, Peer Education	
Programs are theory driven (empowerment, social network, Transtheoretical Stages of Change (SOC)	Programs use the theories that enable them to provide comprehensive prevention programs
Rigorous Peer Education Selection	Peer educators are recruited who have positive characteristics and non judgmental attitudes towards their peers Peer educators are prepared and willing to discuss dynamics of male-female relationships and effect of gender on sexual health
Compensation for Peer Educators' Compensation.	Funds are adequate to compensate peer educators Peers are compensated for their work, promoting respect, maintaining morale and commitment and preventing attrition
Meaningfully integrate PLWHAs as Peer Educators	PLWHA peer educators are implementing programs, involved in program planning and co-training with other peer educators, etc. PLWHA peer educators are provided with appropriate and needed supports
Written roles and responsibilities of the Peer Educators	Peer educators and supervisors are knowledgeable about specific roles and responsibilities of the job and their limitations (i.e., providing information, education and as a source of referral.)
Peer Educator Training:	Peer educators demonstrate knowledge and use of behavioral change theory and associated techniques

Content of Peer Educators' Training (See good practices section for details of content of training) Methods Used in Peer Education Interventions A Comprehensive Peer Education Program see good practices for list of activities) Delivery of peer education group activities/sessions:	Programs have comprehensive curricula for each training program Peer educators demonstrate knowledge and use of curricula Peer educators demonstrate communication, mobilization, group dynamics, IEC, anti-stigma campaigns, and participatory learning activities Peer educators demonstrate use of multiple methods, e.g. role play, scenarios, conflict management, negotiation skills Peer Educators provide a full range of activities for students Peer educators provide a minimum number of sessions, depending on the activity Peer educators provide booster sessions for maintenance and support for behavioral change post intervention
Strong University based, Community Linkages and Other Partnerships	Peer educators have knowledge of and refer students to university based VCT clinic, health and mental health services, post-test clubs on or off campus Peer educators have knowledge of community groups and individuals and access them for IEC activities and to support students
Routine Supervision of Peer Educators	Written procedures are in place for supervisors Routine supervision of peer educators is provided including case conferencing, assessment and evaluation, gradual integration of responsibilities, booster training, mentoring, and coaching.
Professional Development for Supervisors	Supervisors are trained on behavioral theories, methods, etc. of the peer education program Supervisors' are trained in methods of coaching, mentoring of Peer Educators, in the development or identification of and retraining of peers in new interventions. Supervisors demonstrate commitment to gender and cultural equity and non judgmental attitudes

CURRICULUM INTEGRATION	Indicators
Administrative support for curriculum integration	Facility are offered incentives to share curriculum inter and intra-university Admin. has provided funding to hire consultants to assist faculty to develop new curricula New curricula is "fast-tracked" through approval system
Professional Development for Faculty (See good practices for content)	Faculty is knowledgeable about HIV/AIDS-related issues Faculty demonstrates pedagogic techniques, including participatory learning techniques Faculty uses basic guidance skills, demonstrates knowledge of and refers students to appropriate services, as needed
Interdisciplinary sub-committee on HIV	Inter-disciplinary sub committees meet and collaborate, e.g. conduct seminars, Exchange information, Create a co-teaching course, Create annotated bibliography on research, Create new internships for students
Policies and procedures for sanctions and no-tolerance approach to staff-student transactional or coercive sex	Sanctions and no-tolerance procedures are followed
Incorporate undergraduate and graduate students in course-based research on HIV prevention issues	Students have opportunities to participate in HIV prevention program research
Standard requirements for basic and advanced courses on HIV in each discipline	Students register for required basic and advanced courses on HIV/AIDS
Collaborative Education: distance learning and complex educational games	Faculty are provided an introduction to modalities of collaborative education including distance learning and complex educational games Faculty work in teams with professors from other departments to develop curriculum for distance learning

Monitoring and Evaluation	**Indicators**
Routine evaluations of staff and supervisors	All staff and supervisors are evaluated, at least yearly
Students evaluate new courses	Student evaluation surveys are distributed at end of new course
Clients evaluate VCT services	Client satisfaction surveys are distributed to all clients
Programs/classes evaluated for gender-based, cultural, PLWHA sensitivity	Programs and classes are evaluated to ensure no bias or discrimination is occurring
Data base for program outcomes	Data base is established Data entry person is identified Data is routinely entered on outcomes (e.g. behavior change data: delayed initiation of sex, consistent condom use with main partner, decrease in number of partners, decrease in alcohol/drug use, counselling and testing statistics, # and type of clients, demographics of clients, referrals, follow-ups; and type of peer educator activities, etc.
Institution-wide MIS	Data is backed up and sent to MIS system
Report writing	Reports are produced monthly and annually