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Best practices in HIV/AIDS programming for non-governmental organizations [research project]

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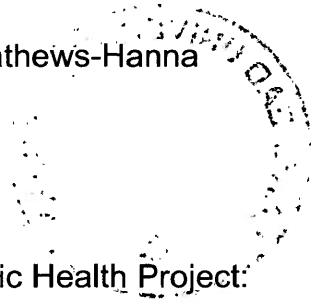

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Best Practices in HIV/AIDS Programming for Non-Governmental Organizations

HIV/AIDS is the most devastating illness of modern day. There were thirty-three million people living with HIV/AIDS in 2007, and there were two million AIDS deaths. In his book *Race Against Time,* Stephen Lewis explains that there are 14 million orphan children in sub-Saharan Africa alone and this number will be 20 million by 2010 (Lewis, 2008). HIV/AIDS also accounts for about 20% of all deaths and disability-adjusted life-years lost in Africa, which makes it the biggest single component of the continent's disease burden (Creese, Floyd, Alban and Guinness, 2002).

This paper is to serve as a resource to Non-Governmental Organizations working in the field of HIV/AIDS. It will begin with a background to the Pandemic, and then discuss Best Practices in the Field by drawing on current successful non-governmental organizations. It will also discuss solutions and approaches at the macro, meso and micro levels.

To provide a brief background to the HIV/AIDS pandemic, there are many social determinants of health that are at play here, including gender equity, nutrition rates, poverty and so forth. Due to the fact that this issue is multifaceted and complex, a multifaceted solution is required by means of an integrated public health approach.

The HIV/AIDS pandemic has been especially devastating to women. Quinn and Overbaugh (2005) explain that several social determinants of health make women especially vulnerable to this disease. These include gender disparities, poverty, cultural

and sexual norms, lack of education, and violence. In addition, women are physiologically more susceptible due to such factors as hormonal changes, vaginal physiology, and a higher prevalence of sexually transmitted disease. Correspondingly, prevention strategies must target gender inequalities and empower women.

At a systemic level, HIV/AIDS also wreaks havoc on the economies of less developed countries that are already shaken as the strongest members of society are dying off; hence their ability to contribute to productive pursuits at the household, community and national level are greatly diminished. This impacts several social sectors, predominantly that of education as many teachers are passing away.

Structural inequalities continue to fuel the epidemic in all societies, and HIV infection has increasingly been concentrated in the poorest, most marginalized sectors of society in all countries. Richard Parker (2002) explains that the relationship between HIV/AIDS and social and economic development has become a pivotal component of policy discussions regarding the most impactful responses to the epidemic. As a result, it is important to examine the economic self-sufficiency and development of entire countries as a means of preventing AIDS. This will be explored further on.

This tremendously multi-faceted issue requires a multi-faceted solution that spans numerous sectors and cuts across the micro, meso and macro levels. According to the World Health Organization progress report published in June 2006, United Nations Member states agreed to work towards the goal of "universal access to comprehensive prevention programmes, treatment, care and support" by 2010. The World Health Organization established priorities for its technical work based on five strategic

directions. These directions must each be targeted in order to make progress in achieving universal access to the above. This includes:

1. Enabling people to know their HIV status.
2. Maximizing the health sector's contribution to HIV prevention.
3. Quickening HIV/AIDS treatment and care scale-up.
4. Strengthening and expanding health systems.
5. Investing in strategic information to inform effective responses.

(World Health Organization Progress Report)

The authors of this report provide an excellent summary of the overarching activities needed to begin to fight this disease and help all people achieve universal access to prevention, treatment, care and support. These targets are directed at the institutional level, particularly improving the health sector's capacity and response in order to provide individuals with more effective coverage and service. These five strategic directions are the goals that all stakeholders working in this field must work towards. This includes grassroots organizations as well as all levels of Government.

If we examine the HIV/AIDS pandemic in terms of primary, secondary and tertiary prevention, then we can categorize HIV/AIDS practices as awareness, advocacy and treatment. This paper will initially outline the importance of raising awareness amongst different populations. The remainder of this paper will focus on best practices according to primary, secondary and tertiary prevention.

Primary Prevention

Numerous academic studies have been carried out on raising awareness. This is a primary mode of prevention, and can also be highly effective if it reaches a wide spectrum of people and inculcates the seriousness of protecting oneself from HIV/AIDS. Many Non-Governmental Organizations do awareness-raising activities as a part of their 'suite of services.' As well, numerous NGOs have worked closely with municipal, provincial and national governments to spread the message of how to protect oneself from HIV/AIDS through advertisements and social messages. One prominent example of a social message is the ABC campaign – Abstain, Be Faithful, and Wear a Condom if necessary. Many Non-Governmental Organizations as well as some levels of Governments are promoting a healthy environment for those infected and affected by HIV/AIDS. Some NGOs use cultural dramas to spread the message of prevention. Some organizations have spread this message through story-telling sagas in the media. Other NGOs or Ministries of Health have put cautionary messages on billboards that are accessible to literate and non-literate individuals. Wilson, Ruxin, Teixeira, and Barcarolo (2003) in their UNAIDS Background paper stress that awareness campaigns must be designed to reach all sectors of society. There are strong disparities in HIV knowledge between various groups such as mean and women, rural and urban populations, and individuals of different education levels. UNAIDS describes that in addition, "Campaigns must also provide emotional and social motivation for change." This is a vital component that must be integrated in all forms of social messaging. It needs to reach individuals on a deeper level that will prompt them to change risky behaviours and integrate and adopt healthy behaviours.

Prevention efforts are immensely important in helping people change their behaviours and stop the spread of HIV. Piot and Seck (2001) echo the sentiment of many practitioners and academics in this field: Prevention efforts are crucial amongst young people. The authors state, "In every country where HIV transmission has been reduced, it has been among young people that the most spectacular reductions have occurred." (Piot and Seck, 2001, page 3). In addition to targeting young people in social awareness and behaviour change, social mobilization must also take place at the community level to aid in the prevention of this disease. Numerous social actors must be used to support and empower community action. In some cases these include religious leadership. For example, an important factor in Senegal's success at keeping HIV prevalence low, in comparison to surrounding countries; is the active involvement of religious leaders as part of a sustained effort at society-wide mobilization, (Piot and Seck, 2001). JP Ruger (2004) vehemently states that education about HIV and prevention training should be an international priority that targets individuals working in educational roles such as healthcare workers, teachers and community leaders. These individuals can spread the message throughout society. Current educational tools must also be adapted to a variety of literacy levels and local cultures. Closely related to this is incorporating Voluntary Counseling and Testing (VCT) into health care. This will be discussed further on as a means of helping individuals prevent themselves from transmitting infection.

Inherent in mobilizing a community to respond to the crisis is creating a supportive environment. There are two national success stories that provide an excellent example for the International community, Governments and Non-Governmental Organizations. Thailand is one such example. Piot and Seck (2001) explain that the

success of the "100% condom use" campaign in Thailand is because it was part of a package: HIV prevention became part of Thailand's "national sense of destiny", from the Prime Minister down. There was a nationwide debate on sexual mores, together with structural solutions such as regulation of the sex industry, education, skills development and peer interventions with sex workers and clients of sex workers.

Another good avenue for social messaging to influence positive behaviours are people is in the workplace. It becomes a daily occurrence. Wilson et al. (2003) describe the role that multinational corporations (MNCs) have to play in this, since numerous MNCs are operating in less developed countries. In Southern African countries for example, 40% of companies provided free condoms to employees and free counseling services. The International Labour Organization, (one of the agencies sponsoring UNAIDS), and the Global Business Coalition on HIV/AIDS are actively promoting and supporting workplace programs.

In terms of the social return on investment, data on the cost-effectiveness of HIV prevention in sub-Saharan Africa and on highly active antiretroviral therapy (HAART) indicate that prevention is over 28 times more cost effective than HAART. These authors argue that funding should be directed primarily to prevention as opposed to anti-retroviral therapy. Economic evidence, together with the social impacts on individual and population health; point to the fact that Prevention efforts must be a central component of any HIV/AIDS response.

Eliminating HIV/AIDS Stigma

Closely related to increased public consciousness about protecting oneself from HIV/AIDS is creating an enabling environment and reducing stigma. This is vital because in many parts of the world, the stigma of having HIV and AIDS is quite high. Some individuals are quite frightened that their neighbours and friends may come to learn of their status and extricate them from social life for fear of contracting the disease. In some ways, learning that one is HIV positive is a death sentence. According to Aggleton, Wood, Malcolm and Coram (2005), HIV-related stigma may be the greatest obstacle to action against HIV/AIDS for individuals and communities as well as political, business and religious leaders. These authors argue that an effort against stigma will not only improve the quality of life of people living with HIV and those who are most vulnerable to infection, but meet one of the necessary conditions of a comprehensive and effective response to the epidemic.

It is important to address this social stigma because people need to feel free to talk about causes and prevention of HIV/AIDS, get tested for the virus, and also get necessary treatment. An environment free of stigma will also contribute to the psychosocial well being of infected and affected individuals, as they will no longer need to live in fear of someone finding out that they are HIV positive. This coincides again with the necessity of awareness and enabling environment as it results in a holistic response of individuals getting tested, treated and having their psychosocial needs taken care of. As a result, working to reduce and eliminate stigma is a vital practice for a Non-Governmental Organizations working in the field of HIV/AIDS.

Ghana has had some great successes in reducing HIV/AIDS Stigma. In February 2000, several national and international organizations came together to launch the "Stop AIDS, Love Life" national communication program in Ghana. These partners include the Ghana Ministries of Information and Health, the Ghana Social Marketing Foundation, and the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP) with support from the U.S. Agency for International Development, (USAID). The most recent program phase is called, "Reach Out, Show Compassion," through the partnership of the Christian Council of Ghana. This phase was to encourage support and compassion for those living with HIV/AIDS. Several Muslim and Christian leaders made a commitment via communication to Ghana's vice president, to collaborate with the government to deal with HIV/AIDS and associated issues. The "Reach Out, Show Compassion" program aims to continually increase the number of religious organizations, congregations, and humanitarian groups engaged in responding to HIV/AIDS issues. Activities include training programs for 900 clergy, Imams, and other religious leaders to create compassion programs, in addition to television and radio advertisements encouraging a compassionate response to people living with HIV/AIDS through direct quotes from the Bible and Koran that emphasize compassionate behaviour. This has been a highly effective way of reducing HIV/AIDS stigma and provides a strong example for other countries to follow.

Protecting Women's Rights

The AIDS epidemic is taking a devastating toll on families and communities worldwide. Inherent in the progression of this disease is a growing burden of caring for the sick, the dying, and those left behind. Up to 90% of home-based care is provided by women and girls (Oxfam America, 2008). Because of this tremendous physical and psychological burden, caregivers need more economic, technical, and social support for providing this essential service. Oxfam America stresses that this support must also be made central to AIDS strategies. The UNAIDS-led Global Coalition on Women and AIDS is making greater support for caregivers a top priority. In some countries, nongovernmental organizations (NGOs) and faith-based organizations (FBOs) have developed home-based care projects using community volunteers. Some programs are linked to formal care and support services, but more regulation is still required for this essential service. The programs range from basic home visits to more comprehensive treatment and care programs. It is vital to ensure that responsibilities are not downloaded to already burdened women.

In addition to empowering caregivers who are predominantly women, it is vital to empower women to realize their rights. As several academics and practitioners like Oxfam America explain, the HIV/AIDS pandemic is a gendered disease. It has impacted women most heavily because they are the poorest and least powerful in society. They also experience discrimination through various laws and traditions that deny them basic rights. "The intersection of the HIV/AIDS crisis with poverty, unemployment, lack of education and responsibility for caring for sick family members further limits opportunities for women and girls." Oxfam America is enhancing its programs to address

gender inequalities that are contributing to the severity of the HIV/AIDS epidemic. Oxfam is supporting the work of organizations to reduce the vulnerability of women through changing cultural practices and improving policies and laws that advance and protect women's rights.

Oxfam has important partnerships in South Africa. The National Strategic Plan for HIV and AIDS and STIs in South Africa has placed the number of new HIV infections one of its main targets, and aims to extend treatment to 80 percent of those with AIDS by 2011. This rollout plan is the biggest in the world with some 300,000 people currently on anti-retroviral treatment, against a target of over 700,000. Since 2005, the Southern Africa Regional Office (SARO) of Oxfam America has implemented a regional HIV/AIDS, policy, law, and women's rights partnership program in Zimbabwe, Mozambique, and South Africa. Oxfam works with cultural leadership to change or modify harmful practices that increase women's vulnerability to HIV/AIDS. They also help those living with HIV/AIDS get affordable treatment for infections and illness. Oxfam also works to enhance women's rights through legal reform. One prominent development is that after several years of advocacy and lobbying by women's groups and NGOs, a *Domestic Violence Law* was introduced. This law allows women to claim and defend their legal rights. Oxfam partners represent civil society on the Anti-Domestic Violence Council, which reviews cases of domestic violence, distributes information, and promotes assistance to victims of domestic violence, (Oxfam America, 2008).

Oxfam is one of the few organizations that are directly targeting gender imbalances as a means of addressing the social impacts of HIV/AIDS on women in particular. In addressing the crucial underlying factors of women's vulnerability to this

disease, organizations will be addressing one of the basic social determinants of health. The emancipation of women through various means will also help prevent the spread and transmission of HIV/AIDS.

Youth Programming

Several HIV/AIDS NGOs operate on the principle that young people are most effective at changing the risk behaviours of their peers and at shaping a better future for themselves and their families. One of the most highly effective programming practices implemented by NGOs is that of *Peer Educators* amongst youth. For example, anti-AIDS club members of Zambia are one such example of the effectiveness of young people in influencing behavioural change in their peers. Secondary school students who have been empowered through HIV/AIDS education are now educating other families and communities about HIV/AIDS. With USAID funding through the Horizons Program, the Population Council developed a joint training program. The program trained 12 local health professionals, who then trained 300 male and female youths from 30 anti-AIDS clubs in two districts to provide a variety of care giving services, including domestic and personal-care tasks. This assistance has greatly enhanced the quality of life for people living with HIV/AIDS and their caregivers. In addition, the fact that more male youths are participating in care giving means that they are sharing roles traditionally carried out by women. Young caregivers have also taken active roles in assisting the children of infected individuals by involving them in recreational activities, advocating with their schools to realize and answer to their needs. This role has also helped infected individuals and the surrounding community to become more accepting of their status. This program

has done an excellent job of instilling compassion in this younger generation in addition to challenging and changing existing inequitable gender roles. It is a fantastic programmatic example for other NGOs.

In the Fiji islands, HIV/AIDS and sexually transmitted infections (STIs) are highest among youth. Jenkins (2005) explains that due to the fact that young people comprise 65% of the population, the Asia Development Bank (ADB) and Red Cross have worked together to develop HIV prevention programs. The ADP has funded HIV/AIDS outreach among 3,000 youth. This program has trained peer educators and they visit remote communities to educate and encourage behavioural change amongst youth. This program has four goals: Strengthen personnel by building their capacity to provide prevention and support services; train young people as peer educators against STIs and HIV/AIDS; help communities reduce vulnerabilities to HIV/AIDS; and promote support for people living with HIV/AIDS, (Jenkins, 2005).

In this approach, youth peer educators are an important element of an overall program that also strengthens personnel and communities and helps them adequately respond to HIV/AIDS. It is a wise approach to use youth educators to target youth and families remote communities as these have the least access to information and correspondingly higher rates of HIV infection.

The Mbeya region of Tanzania is another example of success in reducing HIV/AIDS transmission amongst in-school youth. Arthur Ammann, (2003) explains that Tanzania is currently scaling up successful school programs. The programming components involve a combination of peer and life skills education, school-parent AIDS committees to increase the community's awareness of HIV/AIDS as well as guardian

programs to counter the sexual harassment of young women. These three examples emphasize the importance of a comprehensive approach that simultaneously builds local capacity and a supportive environment. In each case, it was a community-wide approach that both involved and targeted individuals at all levels of society (Ammann, 2003). This is another extremely wise approach that addresses one of the gendered issues of HIV/AIDS. The example of guardian programs that help reduce the vulnerability of girls and young women to contracting HIV is another excellent programmatic principle for other NGOs.

According to the Global Health Council (2008), the Ethiopian Ministry of Youth, Sports and Culture is another example of empowering youth to educate and disseminate information across society. This ministry involved youth from all over Ethiopia in policy and planning action. The program was based on "Participatory Learning and Action" methodology or PLA. The process began with selection of fifty youth leaders and training by regional HIV/AIDS Prevention and Control. After training, the youth leaders began:

- Implementing peer education initiatives with over 800 other youths in the country.
- Conducting participatory assessments with youth and adults in both rural and urban areas.
- Analyzing resulting data.
- Leading workshops and synthesizing findings in their youth charter and action plan.

The youth leaders used several participatory tools including "body mapping," where participants draw representations of the human body. This demonstrates participants' knowledge about reproduction and other health functions, as well as determining

knowledge gaps and incorrect information. This allows youth leaders to discuss issues related to sexuality. The second component was a "universe-mapping" tool, where participants depicted family and community networks, and examined sexual and reproductive health issues from a variety of perspectives. Other important tools were assessments of youth-friendliness, cost, and accessibility of existing reproductive health and HIV/AIDS services. As well, the charters and action plans developed by youth will serve to capture local knowledge and channel into a national arena (Global Health Council, 2008).

Wilson et al. (2004) also discuss the importance of youth-focused programs. They explain that a comprehensive approach should involve school-based prevention programs offering practical training in relevant life skills as well as information; peer programs; condom distribution; community-based projects for young people not in school; and programs to reach young men in the army, in the workplace, and in prisons.

According to these perspectives and programming practices, youth peer educators can truly accomplish a lot and reach several sectors of society through coordinated efforts. Investing in young people is an excellent use of resources and it builds a positive foundation for the future of nations. From the examples seen, youth can help break down gender barriers and imbalances, educate hard-to-reach populations as well as do assessments and education with fellow peers and adults. Maximizing the potential of youth and equipping them with vital skills is a necessary strategy in dealing with the HIV/AIDS crisis.

Adult Male Circumcision

Another HIV prevention strategy that has been proven effective is male circumcision. Researchers in Kenya and Uganda determined that medically supervised adult male circumcision reduced the risk of African men being infected with HIV by over 50 percent, (AIDS Alliance 2007). The public health impact of increased access to male circumcision has been predicted to be most pronounced in those areas with low rates of male circumcision and high rates of heterosexually transmitted HIV. Adult male circumcision is beginning to be implemented internationally as part of the President's Emergency Plan for AIDS Relief, (PEPFAR). (AIDS Alliance 2007).

AIDS alliance explains that the potential role of religious and traditional practitioners needs careful consideration. The WHO and UNAIDS need to develop technical guidelines in the months ahead. They explain that a comprehensive male circumcision is needed with strong pre and post-operative care; in addition to community mobilization and participation in a suite of HIV/AIDS service delivery. This issue needs to be discussed at the community level and full participation is needed. (AIDS Alliance 2007). Although adult male circumcision as a programming element has not yet been implemented; this certainly is a promising practice that will reduce the number of sexually transmitted and AIDS infections. This procedure will require more research and evidence-based practice, and NGOs can follow World Health Organization guidelines on this procedure, which is expected in 2009.

Voluntary Counseling and Testing

The second stage in the public health spectrum is primary/secondary prevention. This closely follows awareness raising and the creation of an enabling environment as stated earlier. An enabling environment will help make individuals feel better about learning their HIV status, and will also help them change behaviours so that they do not transmit the disease to anyone else. Voluntary Counseling and Testing, (VCT) needs to be incorporated into health care. Many Non-Governmental Organizations working in prevention suggest this as the next essential step. According to Wilson et al. (2004), voluntary counselling and testing (VCT) services are central to tackling stigma because these services are the entry point for care and treatment, and it is at this point that patients are at their most vulnerable to stigma.

According to Thomas Painter (2001) most HIV infections in sub-Saharan Africa occur during heterosexual intercourse between persons in couple relationships. Women who are infected by HIV positive partners risk infecting their infants in turn. Many studies point out that VCT has considerable potential for HIV prevention among other heterosexual couples, and recommend that VCT for couples be practiced more widely in Africa. In particular, increased attention to couples-focused VCT provides a high-leverage HIV prevention intervention for African countries. The authors state, however, that applied social and behavioural research is needed to improve knowledge about how couples in sub-Saharan Africa deal with the risks of HIV infection.

Another initiative is to train Traditional Birth Attendants (TBAs) in VCT as well as administering anti-retroviral drugs. Butlerys, Fowler, Shaffer, Tih, Greenberg, and Karita, De Cock (2002) explain that every year, one million women infected with HIV

deliver babies without professional help. They suggest that TBAs be involved in preventing prenatal transmission of HIV by offering services such as HIV testing and counselling and short courses of antiretroviral drugs. This is yet another highly effective resource-efficient means of building local capacity to respond to this crisis. By targeting individuals working at the grassroots levels, there is a higher chance of reaching infected women with these vital services.

Correspondingly, health centres need to have Voluntary Counseling and Testing facilities VCT services need to be expanded to more antenatal clinics...VCT certainly needs to be scaled up in order to prevent further HIV transmissions from individuals who are unaware of their status. As a result, an enabling environment is a necessary pre-cursor to making this a reality. More rigorous VCT will also enhance monitoring of HIV prevalence and a decline in transmissions will also signify successes in work to stop the spread of HIV. VCT is yet another vital programmatic element in a comprehensive AIDS program.

Interaction with Other Diseases

The AIDS prevention, treatment and advocacy discussion would not be complete without examining the interaction HIV has with other diseases. Bates, Fenton, Gruber, Lalloo, Lara, Squire, Theoald, Thomson and Tolhurst (2004) explain that a high burden of malaria, tuberculosis and HIV infection contributes to national and individual poverty. This arises mainly due to factors producing vulnerability to progression to disease. The World Health Organization has identified the 1.2 billion people worldwide living in

absolute poverty as those most vulnerable to infectious diseases such as malaria, tuberculosis, and HIV infection. HIV control programs have begun to take account of vulnerability in the context of broad social issues, or an approach that is based on the *social determinants of health.* Bates et al. (2004) state that up to 70% of adults in Africa with tuberculosis are infected with HIV.

With respect to malaria, HIV infection may interfere with pregnancy-specific immunity acquired during first and second pregnancies and increases the chance of contracting malaria, according to De Cock, Mbori-Ngacha and Marum (2003). The efficacy of malaria treatments is decreased in HIV-infected pregnant women, and they may require more treatment as a result. In regards to Tuberculosis, (TB) more than ten million people are estimated to be co-infected with tuberculosis and HIV, and tuberculosis is the leading cause of death in HIV-infected individuals in Africa. TB-related: treatment of HIV infection with antiretroviral therapy has been shown to reduce TB risk by 80-90% in both developed and developing countries. Thus, expanding ARV therapy can both extend the lives of people living with HIV and play an important role in controlling the equally devastating tuberculosis epidemic. Another solution is multi-vitamin supplementation in HIV-infected pregnant women because this substantially decreases adverse pregnancy outcomes such as low birth weight and preterm birth, and increases maternal T-cell counts.

Due to the fact that Malaria, Tuberculosis and HIV/AIDS arise due to similar social determinants of health, it follows that any initiative to stop the spread of one disease will help decrease prevalence of the others. To this end, it is vital to work towards the eradication of not only these diseases but also the socio-economic factors that make

people susceptible to them. Additionally, HIV/AIDS health personnel must continuously monitor these co-infections and treat them accordingly. This component will also be an important element for monitoring, evaluation and surveillance of this disease around the world.

Working with Traditional Healers

Another important element in the discussion of secondary prevention is working closely with traditional healers to ensure that development work is culturally sensitive. Some NGOs have trained traditional health practitioners in HIV/AIDS and other sexually transmitted infections (STIs). PROMETRA, an international organization for the preservation and restoration of the ancient arts of traditional medicine, explains that appropriate training has encouraged traditional health practitioners to replace harmful practices with safer practices, and has helped them diagnose HIV and other STIs. Research into a variety of traditional treatments also suggests that some of these treatments offer potential relief from HIV-related infections (Prometra, 2008). There are several benefits in biomedical and traditional health practitioners collaborating as both parties can learn valuable lessons from each other that will inform best practices in treating the symptoms of HIV/AIDS.

Dr Sandra Anderson of UNAIDS, South Africa, also echoes the sentiment of collaboration by saying that "traditional health practitioners occupy a critical role in African societies and are making a valuable contribution to AIDS prevention and care". THETA director, Dr Donna Kabatesi, cited clinical data on Ugandan herbal treatments effective against herpes zoster and HIV-associated chronic diarrhoea and weight loss.

Professor Charles Wambebe, head of Nigeria's National Institute for Pharmaceutical Research and Development, reported preliminary clinical data on a Nigerian herbal medicine that increases CD4-cell counts and lead to improvements in HIV-related illness. The authors cite that poor documentation, a lack of standardisation, and the absence of regulatory mechanisms for traditional health-care practice are challenges that need to be addressed in order to make traditional medicine a part of a comprehensive HIV/AIDS approach (Bodekar. 2005).

Several studies point to the efficacy of traditional practices in curing HIV-related ailments. It is necessary to work with traditional healers to professionalize traditional treatments. At the policy level, traditional medicine needs to be integrated with western medicine. At the program level and until traditional medicine becomes more standardized, NGO and health workers can work with traditional healers to implement traditional treatments for infections as a part of the treatment component. NGO workers will need to pay close attention to developments in this area as well as regional specifications for which local plants and herbs can be used for treatments.

Preventing Mother-to-Child Transmission

Perhaps the most salient issue in this discussion is the Prevention of Mother-to-Child Transmission of HIV/AIDS or PMTCT. This is the next stage in the public health spectrum that links HIV prevention with HIV treatment. According to the World Health Organization, pregnant women with HIV are at risk of transmitting HIV to their infants during pregnancy, birth or breast-feeding. Without any interventions, between 20% and 45% of infants may become infected. Of the estimated 2.3 million children aged less than

15 years living with HIV, well over 90% are thought to have become infected through mother-to-child transmission. Mother-to-Child transmission is largely preventable through interventions such as HIV screening during antenatal care, administering antiretrovirals to mother and child, and providing alternatives to breastfeeding such as formula (Piot and Seck 2001). However, these interventions may not always be readily available in resource-poor countries which makes access to life-saving drugs an absolute necessity for the developing world.

The all-encompassing best practice in this field is to *integrate* PMTCT with maternal and reproductive health care. These services should be a part of obstetric services. In terms of a community-oriented response, this also includes training village midwives. The WHO has listed four steps of comprehensive PMTCT:

1. The primary prevention of HIV infection among women.
2. The prevention of unintended pregnancies among HIV-infected women.
3. The prevention of HIV transmission from HIV-infected women to their infants.
4. The provision of appropriate treatment, care and support to HIV-infected mothers and their infants and families, (De Cock, 2003).

This list takes into account all components of reproduction and maternal child health care. Initially it is about stopping HIV transmission particularly amongst women. Preventing unintended pregnancies are necessary because women may not know their HIV status due to the fact that VCT percentages are quite low throughout the world. Duer, Hurst, Kourtis and Rutenberg (2004) state that family planning can also be provided for women seeking VCT and PMTCT services. Women can be counselled on birth spacing, which can reduce infant, child and maternal mortality rates or avoid future

pregnancies. In addition, limiting the number of births may result in fewer orphans and vulnerable children. Sexually active VCT clients may also be at risk for an unintended pregnancy. Counseling for HIV/AIDS is an opportune time to discuss family planning and high-risk fertility behaviour. The third WHO step is the specific prevention of mother to child transmission through administering anti-retroviral drugs during pregnancy and at birth, as well as finding alternatives to breast-feeding. The fourth step follows the concept of tertiary prevention which is about providing treatment and support to mothers and children infected and affected by HIV/AIDS. These four WHO steps comprise an effective maternal childcare program; which also comprises part of a comprehensive response to this crisis.

As in all aspects of Community Development program, it is vital to begin with a baseline needs assessment. The needs assessment serves to identify the specific needs and assets of the population as well as serving as a starting point upon which to measure program successes over time. Family Health International has developed several baseline assessment tools for PMTCT. This helps ensure safe and proper application of PMTCT in Antenatal Care and Maternal Child Health care. The tools also allow for monitoring and evaluation of existing services. The six tools are: PMTCT Maternity Tool which assesses maternity, post-natal and PMTCT services; Laboratory Assessment tool to assess supplies, tests and protocols; a Health Provider Assessment tool to assess health care provider qualifications, and a Client Exit Interview to assess client experiences and attitudes. These are all excellent tools that will help practitioners monitor the quality of their care and work towards continuous quality improvement. It is also helpful because it

provides standards of high quality care, which will enable health clinics to achieve the best in care by following these guidelines.

High-Risk Populations

Reaching high-risk populations with social messaging including harm reduction and VCT services is another important component in the prevention of HIV/AIDS. Sex Worker interventions play an important role in halting the spread of HIV/AIDS. The objective of these interventions is to increase the use of condoms in contacts between female sex workers and their client. Piot and Seck (2001), in their focus on India and Botswana; explain that the use of condoms during sex worker–client contacts is generally low. Focused interventions have proved very effective in increasing condom use in this context. This reduces HIV transmission among sex workers, their clients, and in the general population. Many *Peer-Mediated Female Sex Worker Intervention Programs* in India and Africa have reported increases in condom use of 80% or more among those reached.

Another high-risk group is *Injection Drug Users*, living predominantly in urban areas. Outreach workers are effective tools in any HIV/AIDS prevention, advocacy and treatment program; whether it be rural or urban. One area in which they are particularly useful is with injection drug users. According to Needle, Burrows, Friedman, and Dorabjee (2005), outreach workers often provide risk reduction messages related to drug use, injecting, and safer sex as well as risk reduction supplies to assist IDUs in using safer practices. "When possible, outreach workers also refer IDUs to other services including VCT, drug dependence treatment and other health services and referral for HIV

treatment". According to Rossi, Goltzman, Touze and Weissenbacher (2003), thirty-nine percent of Argentineans living with AIDS were infected with HIV through the injection of drugs. In the 1990s, "Harm Reduction Programs" were created. Research and outreach projects were developed to identify and interact with the hidden injection drug user (IDU) population. Rapid assessment and response methodology led to the creation of Argentina's first syringe exchange program. Prevalence studies and focused prevention campaigns targeting IDUs and their sex partners and children have been developed. Collaborations between government and nongovernmental organizations in various cities supported the distribution of prevention and harm reduction messages to 900 IDUs within a 3-month period. Ongoing research, community-based interventions, and collaborative work among different organizations allow for more frequent and more consistent contact with the IDU population of Argentina.

Another extremely vulnerable population is individuals that have been affected by natural disasters, drought, famines and conflict. Wilson et al. (2003) has an excellent recommended solution for HIV prevention and treatment: "Use should be made of the often considerable UN (peacekeepers, UNHRC, UNICEF, WHO etc) and NGO (Red Cross, Oxfam, Doctors without Borders, etc.) presence in these areas." These organizations are best suited to coordinating prevention and treatment activities. These multilateral organizations and large NGOs will need to have personnel with HIV/AIDS programming expertise as a result.

The examples above are excellent practices for NGOs to follow. Community-based outreach to these high-risk populations, including support and harm reduction messages, are vital and highly successful. However as stated earlier, this must be part of a

comprehensive AIDS program whether that be through an NGO suite of services or partnering with NGOs working in a complimentary realm of HIV/AIDS programming. However, an approach based solely on targeting high-risk groups is controversial, as it targets a symptom more than the underlying problem. NGOs must therefore be cautious to not focus solely on high-risk populations, but also work and partner with other organizations to attack social and economic factors contributing to the incidence and prevalence of HIV/AIDS. It is certainly vital to target high-risk groups, but NGOs need to also address underlying social and economic factors that may cause individuals to make unhealthy choices.

HIV/AIDS and Nutrition Programming

One of the most prominent social determinants of health (SDOH) relating to this disease is nutritional status. Most of the world's 40 million people currently living with HIV/AIDS reside in communities already suffering from poverty and malnutrition (USAID, 2008). In order to slow the development of HIV into a full-blown virus, it is important to have proper nutrition. According to Anabwani and Navario (2005), HIV/AIDS is exacerbated by the presence of other common conditions such as malnutrition and opportunistic infections. The Food and Agriculture Organization has estimated that since 1985, in the 27 most affected countries, over 7 million farmers have died of AIDS. Households lose not only the income and food production of sick individuals but also the economic contributions of family members who care for them. Anabwani and Navario (2005) succinctly state "Nutritional and micronutrient deficiencies play an important additive role in immune-degradation and impaired development in children. Careful implementation of antiretroviral drugs, complimented

by simultaneous efforts to ensure proper nutrition among HIV-infected children and adults are essential components of an effective response to the HIV/AIDS pandemic in Africa and elsewhere" (Anabwani & Navario, 2005: 97).

USAID is one of the funding bodies committed to improving food security of those impacted by HIV/AIDS. In Rwanda for example, USAID is working to improve food security for Rwanda's most vulnerable children. Non-governmental organizations provide food to approximately 29,000 children affected by HIV/AIDS as part of a comprehensive package of services that also includes HIV/AIDS education, counseling, home-based care, vocational training, payment of school fees, and assistance to help households earn more income. Food assistance is expected to improve the ability of households to care for children affected by HIV/AIDS. The program targets approximately 60,000 individuals who have HIV/AIDS or live in households where providing HIV/AIDS care is undermining the ability to meet food and nutrition needs. The target population receives intensive nutrition education in addition to food aid. The program involves communities in food distribution in order to raise awareness, reduce stigma, and mobilize community involvement in HIV/AIDS activities (USAID, 2005).

In addition to food aid, food and nutrition programs often provide HIV/AIDS prevention and care services such as counselling and home-based care. Agriculture and other multi-sectoral activities help preserve livelihoods and increase food security. As more programs integrate anti-retroviral therapy into their HIV/AIDS, there will be an increasing need for nutritional inputs. The subject of nutrition automatically brings one to other items like productive household assets and good agriculture. It points to the

necessity of multi-sectoral programming in order to restore individual's livelihoods as well as nutritional and health status.

Home-Based Care

Home-Based Care is yet another important ingredient in caring for those impacted by HIV/AIDS. Many Non-Governmental Organizations train home-based volunteers and equip them with medical kits to assist and help treat those who are infected by HIV/AIDS. These programs, often run by NGOs and/or faith-based organizations (FBOs), range from assisting older caregivers with the cost of providing medical expenses and support for orphans and vulnerable children, to improving access to HIV services for both caregivers and those they are caring for, to offering basic training in delivering home-based care. According to a UNAIDS *Women and HIV/AIDS* report, the HIV Equity Initiative in Haiti has developed a low-cost way of providing in-home health services by training and paying community health workers, most of whom are women, to administer basic medications for AIDS and other diseases and to provide social support. Preliminary outcomes of the Initiative showed reduced mortality, hospitalizations, and opportunistic infections among those receiving such care.

According to Akintola (2005), the most important services are support for affected families and services for orphans or other dependent children. Women caregivers need support and training, access to basic supplies, (blankets, aspirin, sleeping mats, etc.) Other integrated public health approaches include the following:

- Expand economic support to caregivers by increasing their access to affordable basic shelter, land to grow crops or raise animals, and other income-generating opportunities.
- Address the overall health and specific psychosocial needs of caregivers, in particular older women and young girls, through the provision of counseling and other assistance.
- Ensure that organizations and individuals working with caregivers are involved in the design, implementation, and monitoring of HIV prevention, treatment, care, and support programs at the national and community level.
- Encourage and support men and boys in sharing the responsibility of caring for those living with HIV.
- Increase support for families and communities that are caring for children orphaned and made vulnerable by AIDS, including basic health care, psychological counseling, school fees, succession planning, and access to HIV information and services.

These recommendations touch on community support, psychosocial counselling, empowerment of women, access to microcredit services and several other programming components. One extremely important recommendation is to have caregivers playing an integral role in the design and implementation of community care programs. This is an excellent approach that will help give caregivers a greater voice in their community, allow other community members to understand their unique needs, and hopefully serve as a catalyst for a community approach to care giving. Through these multi-facted

recommendations UNAIDS has highlighted the needs for a multi-sectoral response to HIV/AIDS, which has been the central focus of this resource.

Palliative Care

An often neglected aspect of HIV/AIDS programming is Palliative care. This is actually a vital part of Orphan care, as will be discussed further on in this paper. Sepulveda (2003) explains that since the mid-1990s, treatment therapies have been evolving and now HIV/AIDS practitioners face a complex decision-making process with these. As a result, AIDS has become increasingly medicalized and there has been a shift away from issues related to end-of-life care. Palliative Care must not be forgotten, but be embedded in a well-rounded HIV/AIDS program. Additionally, it is an essential bridge to orphan care as it allows children to process the loss of a loved one. The World Health Organization defines Palliative care for children as, "The active total care of the child's body, mind and spirit, and also involves giving support to the family" (Sepulveda, 2003: 92).

Stjernsward (2005) strongly emphasizes the importance of community palliative care projects; which is consistent with other Community Development academic literature in non-institutionalized and community-driven care. The Neighbourhood Network of Palliative Care is a community-oriented solution in how to achieve meaningful coverage and care for the terminally ill. The author explains that meaningful palliative care requires a combination of socio-economic, cultural, and medical solutions. The Neighbourhood Network of Palliative Care have shown that "local communities can be empowered to identify the chronically ill (e.g. also paralyzed and bedridden) and the

terminally ill, regardless of disease or cause, and to support them and their families with self-sustainable community led services despite limited economic resources and without any outside economic support" (Stejernsward 2005: 113). Stjernsward explains that the four principal needs identified for care are as follows: social support, psycho-spiritual support, nursing care, and medical clinical management. The community approach of the NNPC addresses the first three, and partially the fourth. Many districts in Northern Kerala, India have doctors that have taken extra courses in pain relief and palliative care, and they are able to provide generic immediate release morphine. Community members in this area have also raised the necessary financing for all the people in their local districts. They have take ownership of the program, thus creating economic self-sustainability. The NNPC has shown that the key problems of the chronically ill and terminally ill within the categories of social support, psychosocial support, nursing care and even medical clinical management can be covered by empowered volunteers and laymen. This is an excellent example of community-oriented palliative care through the empowerment of lay people. Non-Governmental Organizations can assist in this regard by providing education and training for community caregivers and also providing and/or advocating for affordable morphine. Additionally, NGOs can partner with other micro-finance organizations or implement a microfinance program to generate income to help solve the issue of paying for morphine.

Orphan Care

Some components to HIV and AIDS programming goes far beyond treatment, but is necessary for the survival and health of children. This is the care of orphans. This issue is particularly relevant for Sub-Saharan Africa due to the tragically growing number of orphans as stated earlier. This is also a growing phenomenon in many parts of the developing world. It really gives credence to the importance of firstly prevention, and secondly treatment so that children will have their parents in their lives for longer periods. It is vital to ensure that family structures do not break down in the developing world, and that children are cared for. Above everything else in this entire discussion, it is absolutely essential that the rights and basic needs of children are met.

Often, Grandparents care for the needs of their orphaned grandchildren. Stephen Lewis (2005) describes them as the "Unsung heroes of the continent" because they are caring for so many orphans at a time, (Lewis, 2005: 3). Several Child Sponsorship organizations work to get orphaned and vulnerable children (OVC) sponsored and place them in the home of an extended family member or neighbour. World Vision has `Hope Child Sponsorship` which allows children impacted by HIV and AIDS to get sponsored. In addition, there are specific HIV and AIDS prevention, advocacy and treatment activities taking place in their communities. Basically, cchildren receive HIV-prevention activities through values-based life skills training, and home visitors care for Orphans and vulnerable children and chronically-ill persons through "Community Care Coalitions". This sponsorship also helps OVCs to receive an education and also improve their nutritional status. Initially, community members who choose to are trained through the

Channels of Hope, which is a three-day intensive and interactive workshop. This helps educate them on the stigma and caring for those infected and affected by HIV/AIDS. This programming is also youth-focused because Teachers are trained in value based life skills education, students are trained in life skill education through *Healthy Living Clubs* in schools, and pupil peer educators are identified and trained to impact other pupils. With respect to agriculture, farmers are being trained in successful agricultural practices and animal husbandry, thereby resulting in higher rates of nutrition for children. In addition, vulnerable sponsored children are receiving livestock to rear as a way to earn money to provide for them, and women are being trained in poultry production. (World Vision Programming Documents, 2007).

According to Otieno, Erick, Simiyu and Aagaard-Hansen (2003), the HIV/AIDS pandemic has created major demographic changes. The main problems faced by orphans are the lack of school fees, food and access to medical care. The high number of orphans has overwhelmed traditional mechanisms for orphan care, which were based on matrilineal kinship ties. The authors explain that community-based interventions are most sustainable and culturally sound, but this must be taken into consideration with Community Development efforts and systemic changes in order to find truly sustainable solutions. The authors go on to explain that the local context of kinship support structures, HIV/AIDS prevalence, poverty levels, social position and family income of caretakers, and availability of religious or community-based groups and other social support networks should be taken into consideration. Beard (2005) explains that there are three local types of primary care strategies: Community-based orphan care, Institutional and Residential care and Self-care.

A) *Community-Based Orphan Care:* CBOC programs provide for social and spiritual well being of children and give them a sense of belonging to a community. In this strategy, the extended family is still the most effective community response to the AIDS crisis. Orphaned children are integrated into the families of relatives or conscientious guardians, and supplemental programs are provided through the community. Skills training is also an important component of most CBOC programs. This training is intended to help orphans develop skills to support themselves. Examples of skills include wood carving; carpentry; tailoring; sewing; knitting; cooking; baking; tinsmithing; mechanics, such as bicycle repair; indigenous skills, such as making mats and mud bricks; and farming. Some CBOC programs also try to support orphans as they continue into secondary school. However, as Beard explains, the need for school fees is so pervasive that it is nearly impossible to ever fully meet this need.

Adult Education and Widow Support also falls under CBOC. It includes literacy, basic first aid and child safety, nutrition, cooking, hygiene, record keeping, child development, discipline, and household management. Issues related specifically to widow support involve help with legal rights such as wills and advice on how to deal with property grabbing by relatives (Beard, 2005).

B) *Crisis Nursery:* Crisis nurseries are critical for the care of very young infants and babies (birth to 2 years old). Children are admitted with no parents or with only a father who cannot take care of the young baby. These children are nurtured to health. When they are healthy, they may be returned to someone in their family or village or placed in foster care or adopted.

C) *Children's Home or Village:* This category of institutional care groups orphans into family units. It provides a home environment for orphans who have no relatives capable of raising them. Children raised in this setting usually have all of their needs covered. They have health care, schooling, job training, social activities, and food security. These villages often contribute to community development through efforts such as provision of clean water via boreholes (Beard, 2005).

The first two solutions listed here for orphan care are highly sustainable and culturally appropriate. Most importantly, these strategies are localized and help encourage community development. It is the framework listed here by which non-governmental organizations must approach their work. In fact, many grassroots initiatives led by local communities and/or NGOs involve skills training, nutrition, schooling and so forth. These types of programs need to work closely with other HIV/AIDS programs, and/or intentionally place orphan care in their mandate of service provision. Orphan care should be methodical and integrated with other grassroots community development initiatives in a seamless transition. This is the best way to provide for orphaned and vulnerable children and ensure that they will have a secure successful future, one in which each of their basic human rights are met.

Anti-Retroviral Drugs

Thus far, the paper has talked about primary and secondary prevention in comprehensive HIV/AIDS programming. This section will discuss tertiary prevention by

means of medical treatment of HIV/AIDS. The first part of this discussion is for western governments to increase their foreign aid to provide more Anti-Retroviral drugs to those living with HIV/AIDS. The World Health Organization estimates that by December 2006, 2.2 million people with HIV/AIDS were receiving treatment in low- and middle-income countries, representing 28% of the estimated 7.1 million people in need. According to Sarah Price (2003) of the World Health Organization, "Anti-Retroviral Therapy (ART) consists of the use of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. Huge reductions have been seen in rates of death and suffering when a potent ARV regimen is used" (Price, 2008: 7). Price goes on to explain that there are two challenges with ART. These are affordable access to this treatment, as well as intensive supervision of health care providers because of possible development of a strain that may become resistant to these drugs. Health care professionals to ensure that they continue to positively impact the health status of a population must closely monitor ARV provision. This is a necessary component in monitoring and evaluation efforts.

According to UNAIDS, using ARVs in resource-poor settings will require simplified diagnostic methods, simpler regimens, and cheaper, easier ways to monitor treatment success and side effects. Aggleton et al (2005) describe that the World Health Organization has recently issued guidelines for drug treatment in resource-poor environments that begin to address many of these issues. It is possible to decrease transmission by 50% with a single dose of one medicine administered to the mother at the beginning of labour and then another given to the newborn within the first three days. Lallemant, Jourdain, Le Coeur, Yves, Giang, Koetsawant, Kanshana, McIntosh, and

Thaineau (2004) report that short doses of nevirapine followed by combination drugs six months later is an effective anti-AIDS treatment for both a pregnant woman and her child. However, many women in poor countries do not have access to this intervention. The building of local health systems capacity is greatly needed to deliver these services and provide proper prenatal care. PMTCT is also a promising entry point for ARV therapy, providing an opportunity for treatment of the family.

Surveillance

Surveillance is a critical component in the fight against HIV/AIDS. Monitoring of programs through epidemiological surveillance is vital to determine firstly the incidence and prevalence of the disease, but equally as important is to measure progress in the fight against HIV/AIDS. In this measurement of progress, specific information must be captured, including: impacts of intervention efforts, impact of treatment, ARV coverage, gaps in practice and so forth. According to UNAIDS, the World Health Organization launched the HIV second-generation surveillance methodology for improving HIV surveillance. This strategy promotes the adaptation of information systems to the epidemic characteristics of specific countries and links different sources of information, including data on sexual behaviour and HIV prevalence. Most countries have adopted this approach, although quality and trends have varied over time in different places (UNAIDS 2004).

The above information exemplifies the importance of surveillance on the disease, behaviour change and health impact through the use of information systems. A global database is vital to have global data that can then be disaggregated according to regional,

national, provincial and local levels. The challenge in this is being able to establish a common data to which each health ministry and non-governmental organization monitors and reports.

Conclusion

The all-encompassing best practice in the field of International Public Health and International Development as whole is to strengthen entire health care systems in the developing world so that they can adequately respond to this crisis. This will take a large amount of funding as well as coordinated efforts on all players in international, national and municipal politics. The specific programming practices that comprise best practices in the fields of International HIV/AIDS programming are as follows:

Primary Prevention

- Awareness-raising through various media. These campaigns must be culturally relevant, accessible to all sectors and members of society, and must provide motivation for behavioural change.
- Targeting young people in behaviour change and engaging them in this work through peer education
- Use religious and community leadership to help mobilize entire society
- Provide an enabling environment, e.g. Thailand's "100 condom use" campaign

- Work towards including large employers especially multinational corporations to develop ethical workplace programs including free condoms and counseling services.
- Incorporate Voluntary Counseling and Testing (VCT) into health care system
- Adapt all educational tools to culture and varying literacy levels

Eliminating HIV/AIDS Stigma

- Create an enabling environment and reducing stigma to improve infected peoples' quality of life as well as raise awareness for those most vulnerable to infection Organizations working in the field of HIV/AIDS.

Protecting Women's Rights

- Work to sensitize boys and men on the importance of being caregivers to those living with HIV/AIDS
- Caregivers need more economic, technical, and social support for providing this essential service.
- Empower women to realize their rights by working to change cultural practices and improving policies and laws that advance and protect women's rights.

Youth Programming

- Empower youth with the knowledge and opportunities they need to scale up and expand their initiatives.
- Develop health clubs where young people influence behavioural change in their peers.

- Train health professionals who in turn train male and female youths in care giving.
- Have peer educators visit remote communities where applicable to inform, educate and raise awareness in distant populations.
- Strengthen personnel by building their capacity to provide prevention and support services.
- Empower youth to discuss issues related to sexuality and reproductive health with fellow community members.
- Work with youth to lead school-based prevention programs that offer skills training.
- Involve youth in community-based projects for community members not in school.

Adult Male Circumcision

- Gather perspectives of religious and traditional practitioners with respect to adult male circumcision.
- Pay close attention to upcoming World Health Organization guidelines of this practice

Voluntary Counseling and Testing

- Incorporate Voluntary Counseling and Testing, (VCT) into local health care.
- Build partner counseling into VCT programming
- Incorporate Family Planning into VCT and PMTCT services

Interaction with Other Diseases

- Expand ARV therapy to extend lives of those infected with tuberculosis
- Nutrition: Give multi-vitamins to pregnant women to decrease adverse pregnancy outcomes associated with HIV/AIDS and tuberculosis.

Work with Traditional Healers

- Education traditional health practitioners in prevention of HIV/AIDS transmission and other sexually transmitted infections (STIs).
- Incorporate effective traditional treatments into the continuum of care at the treatment stage.

Preventing Mother-to-Child-Transmission

- Integrate PMTCT with maternal and reproductive health care. These services should be a part of obstetric services.
- Conduct HIV screening during antenatal care
- Incorporate Family Planning into VCT and PMTCT services
- Train midwives and traditional birth attendants in administering ARV where accessible
- Provide alternatives to breastfeeding such as formula

High-Risk Populations

- Reach high-risk populations with social messaging including harm reduction and VCT services
- Peer-Mediated Female Sex worker interventions to increase condom usage
- Be cautious not to focus solely on high-risk populations, but also work and partner with other organizations to attack social and economic factors contributing to the incidence and prevalence of HIV/AIDS.
- Conflict Populations: NGOs and UN organizations can coordinate prevention and treatment of HIV/AIDS in extreme circumstances.

HIV/AIDS and Nutrition Programming

- Careful implementation of antiretroviral drugs, complemented by simultaneous efforts to ensure proper nutrition among HIV-infected children and adults are essential components of an effective response to the HIV/AIDS pandemic in Africa and elsewhere.
- Improve food security of those most vulnerable through nutrition education and food aid where necessary.
- Agriculture and other multi-sectoral activities help preserve or increase household assets, strengthen resilience, and ensure food security.

Home-Based Care

- Train and pay community health workers to administer basic medications for AIDS and other diseases and to provide social support.

- Expand economic support to caregivers by increasing their access to affordable basic shelter, land to grow crops or raise animals, and other income-generating Opportunities, including microcredit programs.
- Address the overall health and specific psychosocial needs of caregivers, in particular older women and young girls, through the provision of counseling and other assistance.
- Ensure that organizations and individuals working with caregivers are involved in the design, implementation, and monitoring of HIV prevention, treatment, care, and support programs at the national and community level.
- Encourage and support men and boys in sharing the responsibility of caring for those living with HIV.
- Increase support for families and communities that are caring for children orphaned and made vulnerable by AIDS, including basic health care, psychological counseling, school fees, succession planning, and access to HIV information and services.

Palliative Care

- Empower local communities to identify the chronically ill and the terminally ill and to support them and their families with self-sustainable community led services
- Work to meet the four principal needs: social support, psycho-spiritual support, nursing care, and medical clinical management.

- Non-Governmental Organizations can assist in this regard by providing education and training for community caregivers and also providing and/or advocating for affordable morphine.
- NGOs can partner with other micro-finance organizations or implement a microfinance program to generate income to help solve the issue of paying for morphine and other medical costs.

Orphan Care

- Combine orphan care with prevention, advocacy and treatment activities
- Establish "Community Care Coalitions" to help OVCs receive an education and also improve their nutritional status
- *Community-Based Orphan Care:* Integrate orphaned children into the families of relatives or conscientious guardians. Provide community programs, such as: (a) CBOC, (b) multipurpose buildings, (c) feeding and nutrition, (d) Saturday programs, (e) skills training, (f) income-generating activities and loan programs, (g) adult education and widow support, and (h) school fees.
- Skills training to help orphans develop skills to support themselves. Examples of skills include wood carving; carpentry; tailoring; sewing; knitting; cooking; baking; tinsmithing; mechanics, such as bicycle repair; indigenous skills, such as making mats and mud bricks; and farming.
- Adult Education and Widow Support: Adult education includes topics such as literacy, basic first aid and child safety, nutrition, cooking, hygiene, record keeping, child development, discipline, and household management.

- Engage in multi-sectoral initiatives such as training community farmers in successful agricultural practices and animal husbandry to achieve higher rates of nutrition for children.
- Provide livestock to OVCs and widows as a way to earn money to provide for themselves.

Anti-Retroviral Drugs

- Administer nevirapine to pregnant women when labour begins and administer single doses of liquid nevirapine in the baby's mouth after birth.

Surveillance

- Use World Health Organization and Family Health International tools to do baseline assessments and monitoring and evaluation. This will enable you to collect to the same dataset in order to carry out eventual macro-level analyses.
- Use WHO second-generation surveillance methodology information system

It may not be possible for one Non-Governmental Organization to work in the fifteen areas of HIV/AIDS programming outlined here. It depends on the context of the project, for example a sex-worker intervention will be more targeted with fewer programmatic approaches than a rural awareness program. Hence, *synergism* between other organizations providing complimentary services is necessary. This may be with organizations serving specific populations or addressing certain specific causes within the

realm of AIDS. It is necessary that NGOs collaborate with other Community Development organizations such as those involved in Microfinance, Agriculture and Nutrition, Water, and so forth. This will serve to enhance and strengthen your programming and truly be able to meet the needs of your beneficiaries in a holistic and comprehensive way.

According to the World Health Organization progress report, there are several major challenges ahead, particularly prioritizing surveillance in order to inform coverage as well as further best practices to be developed (Piot et al 2001). Within this framework, building entire public health systems in developing countries are a must in order to make them responsive to the health need of the population; particularly with respect to HIV/AIDS. WHO also states that a concerted global effort is needed to accelerate the scale-up of comprehensive PMTCT interventions. This is one of the most vital global components in stopping the transmission of this disease and saving the next generations of children. The WHO has done a fantastic job through involvement in almost every country. Sarah Price (2003) also explains that while partnering with global institutions within and outside the UN, the WHO HIV/AIDS Department works in policy development, technical guidance, country health sector capacity building, securing adequate supply of medicines, tools and other services; and advocating for higher global commitment to HIV/AIDS. In order to succeed with AIDS programming, all NGOs will need to work closely with and under the guidance of the World Health Organization.

A vital underlying element that must be addressed is improved economic, cultural, political and social conditions for women so that they can "choose safer life strategies and conditions for themselves and their children. This includes employment,

ownership of assets, and political and civic opportunities" (Ruger 2004: 122). Ruger also points to the successes of other world regions that have reduced rates of HIV transmissions and infections. They describe that in North America, western Europe, Australia, Thailand, Senegal, Uganda, and Brazil the spread of HIV/AIDS has been slowed through multiple prevention strategies, such as: health education, behaviour modification, social, economic, and political environments that allow individuals to protect themselves against infection, promotion of condoms, HIV testing and counselling, reducing mother to child transmission, needle exchange and blood safety programmes, and treatments for sexually transmitted diseases. These are the same basic ingredients that are needed today particularly in the developing world to combat this pandemic.

This paper has captured the essential best practices in providing an integrated public health approach to HIV/AIDS. In the field of International Development, it is a commonly held view that Development work must be holistic and multi-sectoral. The same applies for HIV/AIDS work because the aforementioned components are all essential ingredients in providing a holistic program that truly caters to those infected and affected and mobilizes the local, national and international communities to respond compassionately and comprehensively. The next step is for the international community to firstly provide more and better funding to build into public health systems around the world so that they have the capacity to adequately respond to the HIV/AIDS crisis, and secondly for the international community to work with Governments of countries severely impacted by HIV/AIDS and Non-Governmental organizations for a targeted national response framework that also meets the needs of individuals on a local level. Donor funds should be disbursed among a network of local public health organizations.

Finally, national and global institutions must place a strong emphasis on meeting the rights and needs of individuals impacted by HIV/AIDS. JP Ruger (2004) captures the sentiment of tackling the HIV/AIDS crisis by stating:

"It calls for expanding the voice and power of all people, especially those with HIV/AIDS in developing countries, to advocate for their interests, shape their destiny, and help themselves and each other" (Ruger 2004: 123).

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