

HIV/AIDS Resource Materials

Child Survival Collaborations and Resources
(CORE) Group

December 2002



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Adapted from *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, published in 2001 by Family Health International.



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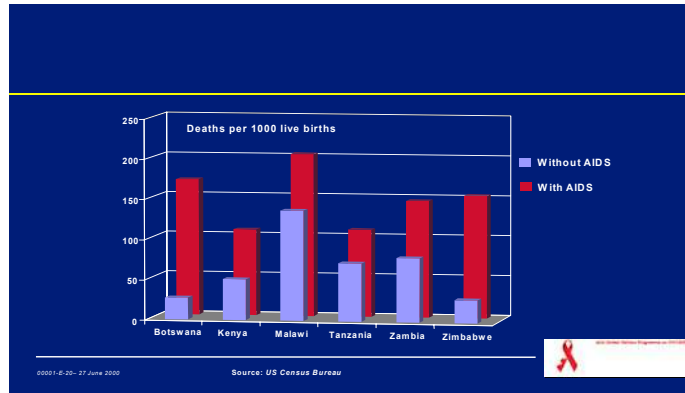
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1. Introduction

1.1 Overview

United Nations projections suggest that by the year 2010, many African countries will have child mortality rates more than double the expected rates in the absence of HIV (Figure 1). In Eastern and Southern Africa, HIV prevalence rates among pregnant women attending antenatal clinics are higher than 30 percent at many sites; estimates for women of reproductive age in the community are even higher. Even if the children of HIV-positive mothers avoid infection, they are likely to be impoverished and orphaned at a young age. A child's greatest protection from the effects of HIV is prevention of infection in the family and community. Once a family member becomes infected, the family must be supported as a unit.

Figure 1: Estimated impact of AIDS on under-5 child mortality rates, selected African countries, 2010



Source: UNAIDS, Report on the Global HIV/AIDS Epidemic, June 2000.
(http://www.unaids.org/epidemic_update/report/epi_ext.ppt)

At the end of 2001, an estimated 40 million people were living with HIV/AIDS worldwide. The pandemic continues to rage, especially in Africa and Asia, but also increasingly in Eastern Europe and the former Soviet Union. All communities must be vigilant.

1.2.1 Chapter Objectives

This document is a guide (not an authority) to help readers consider their needs and abilities to implement any technical aspect of child survival. Because HIV must be addressed at many levels, Family Health International (FHI) and other agencies developed the concept of an expanded and comprehensive response (ECR) to HIV/AIDS. This document is designed to give private voluntary organizations (PVOs) a clearer sense of what is meant by “comprehensive response” to HIV/AIDS, and a

better understanding of where their own interests and strengths are in that response, in their own context.

Specific objectives are to:

- Convey the importance of comprehensive HIV programming in child survival strategies in HIV-affected communities;
- Describe the synergy of interlinking technical interventions, including:
 - combining key technical interventions;
 - grouping interventions for targeted prevention;
 - integrating technical interventions into other services and sectors;
- Discuss ECR issues in implementing technical strategies for HIV prevention, care and support;
- List key questions for different aspects of implementation for ECR technical strategies;
- Outline the role of community groups in implementing and supporting technical interventions;
- Provide references and resources for further reading.

1.2.2 Community HIV Program Components

Required components for community HIV prevention, care and support programming are outlined in Figure 2. These components contribute to an expanded and comprehensive response to HIV/AIDS, which will be necessary to keep pace with and ultimately curb the epidemic. For more information, please see *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, available on the FHI website at www.fhi.org/en/aids/impact/pubs/handbooks/ecrhndbk/ecrintro.html.

When an HIV prevention, care and support program is being planned, basic questions must be answered for rational technical strategy development:

- What are the appropriate technical interventions for a comprehensive response based on?
 - level and type of epidemic?
 - program needs?
 - resources available?
- Of the technical strategies and approaches used internationally and in country, which are the most:
 - effective and successful?
 - cost-effective?
 - sustainable?

The global community has refined key technical strategies for HIV/AIDS prevention and care over the decades since HIV emerged. These strategies impact transmission and mitigation, as demonstrated by numerous pilot and small-scale demonstration projects and a few national-level programs. The next critical step in addressing the epidemic is to move beyond pilot and demonstration projects to increase coverage at the local, regional and national levels.

Interventions targeting individuals have shown success. But individual behavior is strongly influenced by broader factors such as social norms, access to programs and services, social/economic influences and public policy. For HIV/AIDS programs to succeed long-term, interventions at multiple levels must influence individual and societal norms, improve health infrastructure and alleviate structural and environmental constraints to prevention, care and support. Effective programs are tailored to the local context, appropriate to the stage of the epidemic, responsive to donor and host-country needs and targeted to meet strategic objectives.

The key technical elements of HIV prevention, care and support that have been effectively implemented over the last two decades are listed in the following box. Interventions are grouped into two mutually reinforcing categories: 1) prevention; and 2) care and support.

Figure 2: Community HIV Prevention, Care and Support Programming

Technical Strategies for Comprehensive HIV/AIDS Programming	
Prevention	Care and Support
<ul style="list-style-type: none"> ▪ Behavior change communication (BCC) ▪ Condom promotion and availability ▪ Management of sexually transmitted infections (STIs) ▪ Voluntary counseling and testing (VCT) for HIV ▪ Prevention of mother-to-child-transmission (MTCT) of HIV ▪ Blood safety ▪ Harm reduction for injecting drug users (IDUs) ▪ Stigma reduction 	<ul style="list-style-type: none"> ▪ Clinical care <ul style="list-style-type: none"> – Clinical management of opportunistic infections and HIV-related illnesses including preventive therapies – TB prevention and control – Antiretroviral therapies (ARV) ▪ Home-based care ▪ Palliative care ▪ Psychosocial support ▪ Stigma reduction ▪ VCT ▪ Orphans and other vulnerable children (OVC) ▪ Legal support ▪ Nutrition programs ▪ Micro-enterprise and income-generation programs

Source: Lamptey, P., Zeitz, P. and C. Larivee, editors (2001). *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*. Family Health International, Arlington, VA.

The following chart outlines prevention, care and support needs of people in communities affected by HIV/AIDS.

Figure 3: Community HIV Prevention, Care and Support Needs

Uninfected people	Exposed people	People living with HIV	People living with AIDS	People terminally ill and beyond
			Palliative Care	
			Home Based Care	
			Antiretroviral therapy	
	Mother to child transmission prevention			
	Post-exposure prophylaxis			
	Opportunistic infections and related illnesses Diagnosis, treatments, preventive therapies			
	Psycho-social and spiritual support Individual and family, care providers, bereavement, orphans			
VCT				
Prevention STI services, behavior change communication, education, universal precautions...				

Source: Lamptey, P., Zeitz, P. and C. Larivee, editors (2001). *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*. Family Health International, Arlington, VA.

Underlying prevention, care and support strategies is the need to work with and mobilize communities. Nongovernmental organizations (NGOs) and community-based organizations (CBOs) have several qualities that position them to be particularly effective in HIV/AIDS prevention, care and support. These qualities include:

- Expertise in the empowerment approach to behavior change;
- Credibility with communities;
- Experience working at the community level with a “bottom-up” approach;
- Outreach services that can reach populations in need (especially rural populations) with HIV/AIDS-related care and support services.

NGOs and CBOs are in the best position to link with existing services and advocate for services and programs. Areas where NGOs and CBOs have proven effective include: home-based care initiatives; support groups for people with HIV/AIDS (PLHA); broad community education (leading community dialogue about the impact of HIV and local solutions); and referring community members for needed services and commodities. In addition, CBOs can work most adeptly with communities to tackle issues surrounding stigma and discrimination.

NGOs and CBOs do not need to be technical experts in all areas. For example, a CBO may not want to set up VCT services, but could link with and even advocate for such services within the community.

Example: Tateni Home Care Services, South Africa

Tateni Home Care Services in Mamelodi, a township of about 1.5 million people west of Pretoria, began in 1995 with a group of retired nurses identifying a need for home-based care. With support from the Directorate for AIDS and Communicable Diseases, they developed a home-care policy and training materials. In keeping with key principles of decentralization, partnerships and multi-sectorality, the Tateni project complements existing health care services and taps into family and kinship networks for primary care providers and community resources as support services.

Source: (Comfort and Hope, Six Case Studies on mobilizing family and community care for an by people with HIV/AIDS, UNAIDS Case Study, June 1999.)

2. Synergy of Interlinking Technical Interventions

This section examines three methods for interlinking technical interventions to help expand the response to HIV/AIDS and increase its comprehensiveness:

- Method 1: Combining key technical interventions;
- Method 2: Grouping interventions for targeted prevention;
- Method 3: Integrating technical interventions into other services and sectors.

2.1 Method 1: Combining Key Technical Interventions

Technical interventions for HIV/AIDS prevention, care and support programs cannot be implemented in isolation. Community prevention, care and support needs are typically expressed at the same time, and are better addressed comprehensively with combined interventions. Combining technical interventions will likely have a greater impact on the overall epidemic. The multiplier effect of mutually reinforcing technical interventions can maximize benefits. Depending on program goals and the status of the epidemic, different population segments can be targeted with different combinations of technical interventions.

It is important to consider technical strategies needed for different levels — individual, family, community and societal — keeping in mind that at the center of all HIV/AIDS work are the individual and the family. Individual and family needs are not limited to one category of intervention. They require prevention, care and support programming, as well as strategies to mitigate the impact of the epidemic. Critical to all interventions is the need to integrate into and link with existing health and social services systems

and structures. It is crucial for community groups to be aware of the interlinkages among interventions and to be an important link in the referral network.

2.2 Method 2: Grouping Interventions for Targeted Prevention

Grouping technical interventions to meet the needs of individuals, families, communities and society around specific targeted populations has been successful over the past two decades of HIV work. Concepts of targeted prevention are described below.

Targeted Prevention Concepts

- HIV spreads faster among those with higher risk and vulnerability (e.g., IDUs, sex workers and clients, highly mobile workers).
- It is possible to prevent spread of HIV infection to lower-risk subpopulations by interrupting transmission among subpopulations at higher risk and bridge populations.
- It is important to focus prevention resources more strongly on those with higher risk or vulnerability.
- Targeting is a cost-effective use of limited prevention resources.
- Targeting is more effective in combination with programs to change social norms.

Increasing evidence indicates that the most efficient means for reducing HIV is to reduce transmission among those with the highest rates of partner change. Preventing infection among those with the highest rates of partner change, either sexual or drug injecting, has a multiplier effect of preventing many more subsequent, secondary infections.

As a result of targeted interventions, a decrease in infections has been observed not only in the targeted populations, but also in the bridge and general populations.

To apply the concept of targeted prevention, the subpopulations whose risk behavior is most concentrated, and who are most vulnerable, are determined on a country, state or provincial basis. Sex workers (SWs) and their clients, IDUs and men who have sex with men (MSM) are more likely to predominate, though target subpopulations must be selected based on local data.

The following chart highlights examples of how to combine technical strategies to meet specific program goals.

Program Goal	Intervention	Technical Strategies
Reduce HIV transmission in youth.	School-based HIV/AIDS program; outreach to out-of-school youth.	Behavior change communication (BCC), youth-friendly STI services, condom programming, VCT for HIV, policy with ministries of education, OVC activities.
Reduce transmission among mobile populations.	Comprehensive program at transport hubs to reach migrant workers, transport workers and sex workers.	BCC, STI services, condom programming, VCT, OVC, clinical management of opportunistic infections (OIs), workplace policies.

An urgent priority for countries, regardless of the state of the epidemic, is to rapidly expand and deliver prevention, care and support services to the majority of people at highest risk. Pilot projects have demonstrated the effectiveness of targeted interventions but, in most cases, coverage of the high-risk population has been low. High-risk populations exist in the community context; therefore, community assessment of risk and risk settings coupled with community advocacy for appropriate interventions is key.

Key Implementation Questions for Targeted Prevention

- Do targeted interventions for high-risk groups exist?
- What is the coverage of high-risk groups?
- What partners exist to extend coverage of high-risk groups?
- If targeted interventions exist, what services do they include?
- How are targeted interventions linked to existing systems and structures in the community?

2.3 Method 3: Integrating Targeted Prevention into Other Services and Sectors

The effectiveness of HIV/AIDS prevention efforts is enhanced when programs and activities are integrated into existing large-scale infrastructures that operate across a range of sectors. Delivering HIV/AIDS interventions through other services and sectors, rather than expanding HIV/AIDS interventions independently, yields greater economies of scope, including lower costs and greater efficiency and sustainability. But the potential for integrating HIV/AIDS programs into other services, such as

education, reproductive health, family planning or sex education, has not always been fully exploited by countries (Watts and Kumaranayake 1999). In addition to the public sector, integration is needed for civil society groups (e.g., trade unions and youth and women’s associations). The following chart demonstrates how HIV/AIDS can be integrated into existing programs, systems and structures.

Program/System	HIV/AIDS-related Activities
Education	HIV/AIDs in the curriculum, co-curricular activities, outreach to the community, AIDS clubs
Uniformed Services	Integration into basic and in-service training, peer education, STI services, condom distribution, outreach to the community, VCT
Agriculture	Integration into training of agricultural extension workers, revision of agriculture policy, peer education, food security issues
Unions/Associations	Peer education activities, referral to services
Workplace	Local BCC, policy, STI services, care and support services, VCT
Labor	Revised training programs, integration of HIV/AIDS into existing training initiatives, policy
Health	Reproductive health, primary health care system, training of health care providers
Women’s Organizations	BCC, training programs, care and support, VCT
Youth Organizations	BCC, training programs, care and support, referral to services

Key Implementation Questions for Integrating Targeted Populations Into Other Services and Structures

- What systems and structures exist to reach large numbers of people?
- How are these systems and structures linked to community initiatives?
- What mechanisms are in place to foster linkages between sectors?
- What tools are needed to support integration in each sector?
- What tools already exist?
- What human resources will be needed to integrate?
- How will HIV/AIDS be integrated into national and sectoral planning processes?

3. Implementing Technical Prevention Strategies

Ten technical prevention strategies comprising a comprehensive response are presented and discussed in this section: BCC; condom promotion; STI management; blood safety; VCT; prevention of mother-to-child transmission (PMTCT); safe motherhood; infant-feeding choice; harm reduction for IDUs; and stigma reduction.

3.1 Prevention Strategy 1: Behavior Change Communication (BCC)

Changing individual and community behaviors is key to HIV prevention. BCC plays five different but related roles in HIV/AIDS/STI programming: community dialogue, advocacy, provision of information and education, stigma alleviation and promotion of services and products (especially for care and support). For more information, please see *Behavior Change Communication (BCC) for HIV/AIDS: A Strategic Framework*, available on the FHI website (www.fhi.org/en/aids/impact/impactpdfs/bccstrategy.pdf).

Consistent messages from a variety of legitimate sources need to be disseminated in an interactive fashion to effect behavior change. HIV prevention interventions aim to change behavior at the individual level. Community- and societal-level interventions, however, have been developed to change norms and behaviors at the group level. It is critical to support and promote BCC at both the individual and group levels.

Experience has shown that while HIV risk may grow quickly in a community or country, attitudes favoring prevention and preventive behaviors are likely to lag far behind. Mass media play an important role in promoting attitudinal changes and popularizing safer behaviors. When behaviors lag behind knowledge, mass media can stimulate dialogue about risk behaviors and risk settings particular to a community. BCC campaigns are developed using behavior change methods and are tailored to address different stages, or times, of the epidemic. Population subgroups, or target audiences, may be at different stages in the behavior change continuum. It is essential that target audiences be segmented and that appropriate BCC campaigns be developed for each group.

Stigma is a critical issue to consider when developing BCC campaigns. Stigma is defined as a mark of shame or discredit on a person or group. In HIV/AIDS, stigma applies to PLHA, mothers who bottle-feed in public in breastfeeding cultures, MSM, SWs, IDUs, migrant populations and other marginalized groups.

Key Implementation Questions for BCC

- Is there a national BCC strategy for HIV/AIDS?
- Is BCC being implemented in the country based on audience research?
- What is the capacity to develop and deliver BCC in the country?
- What institutions/organizations/universities have the capacity to develop and train in state-of-the-art BCC?
- Is there consensus on the overall BCC approach for the country?
- Are there initiatives to develop community-level BCC strategies?
- Where mixed feeding is a cultural norm, what kind of programs can be developed to improve breastfeeding practices for all?
- If replacement feeding is an option, what kind of programs can help to remove stigma associated with public use of bottles?

3.2 Prevention Strategy 2: Condom Promotion

The male condom is the only widely available, effective method of protection against HIV and other STIs. Access to male condoms is essential to prevention strategies targeting SWs, their clients and non-client partners. Condom social marketing has been successfully deployed in developing countries and is one of the most effective HIV prevention interventions.

Social marketing and distribution of condoms to targeted populations can take place through multiple approaches, such as free targeted distribution, community-based distribution programs and dissemination via health facilities and other commercial outlets (e.g., pharmacies, village stores). The condom distribution strategy can be coordinated among the different outlets to achieve maximum availability.

For a comprehensive response, it is important to improve access to and availability of condoms in all communities, both urban and rural and for specific groups. A successful condom promotion program should ensure that condoms are used correctly and consistently in high-risk sexual encounters. A condom social marketing program that primarily reaches the lower-risk general population may not have a significant impact on reducing HIV transmission.

Over the last decade, the female condom has been the subject of extensive studies on effectiveness, acceptability, cost-effectiveness, training and gender dynamics. Study results have been positive. The World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have encouraged introduction of the female condom as a new method for preventing pregnancy and HIV infection. The female condom can be a vital component of reproductive health and HIV/AIDS programs. It needs to be introduced strategically to provide the greatest and most cost-effective public health impact. When attempting to expand the response to HIV/AIDS, it is important to utilize all potential methods in a strategic manner.

Key Implementation Questions for Condom Promotion

- Is there a national condom social marketing program?
- Is there a national condom logistics and dissemination system?
- Are condoms available in rural areas?
- Are condoms available in local communities?
- What is the role of community-based groups in the condom distribution system?
- Are condoms accessible and available to those at highest vulnerability and risk for HIV?
- Is there a defined system and structure for sampling and testing for quality assurance?
- Has an assessment been made of the potential for increased coverage of sex acts with the female condom?
- Are female condoms available?
- Is there a guaranteed supply of male and female condoms?

3.3 Prevention Strategy 3: STI Management

Several large-scale interventions have demonstrated the potential impact of STI control on HIV transmission. For additional information, please see the fact sheet *Control of Sexually Transmitted Infections*, available on the FHI website (www.fhi.org/en/aids/impact/briefs/controlsti.htm).

Experience in STI control programming shows that reducing high rates of STIs requires a comprehensive strategy for both prevention and treatment. This type of strategy includes well-known aspects of STI control programs, such as ensuring effective diagnosis and treatment, encouraging treatment adherence and partner treatment and avoiding re-infection. Equally important, however, is attention to who uses existing clinical services and who does not. Even the most technologically advanced services will have little impact on STI prevalence if access to those services is poor. One of the most important challenges in STI control is orienting effective services to reach the people who are most frequently exposed to infection and who have the most frequent opportunity to infect others.

While important, STI case management is not the sole component of an STI control approach. The syndromic approach endorsed by WHO/UNAIDS has become the standard of care in many countries for management of the most common STI syndromes. By directing treatment against the common causes of easily identified syndromes, high rates of cure can be achieved by primary health care workers without the delay and cost associated with laboratory workups. Syndrome algorithms serve to reduce treatment failures and re-infection by stressing treatment adherence, condom use and partner treatment. It must be noted that the syndromic management guidelines for vaginal discharge do not work well for low-risk women at family planning and antenatal clinics. Specialist advice should be sought when setting up STI services in these contexts, as local conditions will influence options.

Key Implementation Questions for STI Management

- Is there a national policy for STI case management?
- Are there communication strategies to promote STI services?
- Are services available at first point of contact?
- Does the majority of the high-risk population, especially youth, have access to acceptable services?
- Are non-stigmatizing services available in your community?
- Are STI services available through informal sector outlets, including traditional healers?
- Are STI services directed at the treatment of the most important core and bridging groups?
- Have staff received adequate training on syndromic management?
- Are treatment medications widely available and affordable?
- Are STI drugs on the essential drug list?
- Are institutions/organizations able to train in syndromic management?
- Are ongoing supplies of treatment drugs available in the country?
- Are STI services linked to counseling and other HIV/AIDS services?

3.4 Prevention Strategy 4: Blood Safety

Planners and program managers must consider many factors when designing strategies and interventions to promote blood safety in developing countries. These include:

- Level of awareness of basic principles and concepts, such as voluntary blood donation;
- Impact of HIV and the Hepatitis C Virus (HCV) on donor selection;
- Need for appropriate technology;
- Societal perceptions and behavior concerning blood donation;
- Political will;
- Organization of blood transfusion services;
- Behavior change within the delivery system (i.e., decreasing unnecessary blood transfusions);
- Need for new training methods;
- Need for system-wide health care training;
- Linking VCT to blood safety.

A reliable and safe blood supply is still out of reach in many countries. Blood-borne transmission of HIV accounts for up to 10 percent of HIV infections in countries with limited resources. The vast majority of these infections can be prevented by:

- Reducing unnecessary transfusions by effective clinical use of blood;
- Educating, motivating, recruiting and retaining blood donors with low risk;
- Screening all donated blood for infectious agents.

Many countries, often with limited resources, have made progress toward securing an adequate and safe blood supply. For additional information, please see the fact sheet *Ensuring Blood Safety*, available from FHI (contact Family Health International, 2101 Wilson Blvd., Suite 700, Arlington, VA 22201, telephone: 703-516-9779, fax: 703-516-9781).

Key Implementation Questions for Blood Safety

- Is there a national blood transfusion service?
- Are additional services available in the private and nongovernmental sectors?
- If there are additional services, are they coordinated under a guiding national policy?
- Do blood transfusion service staff have adequate capacity to deliver and maintain high quality?
- Is a quality assurance system in place?
- Does a voluntary blood donation program exist?
- Are there programs in place to decrease the number of “professional” blood donors?

3.5 Prevention Strategy 5: Voluntary Counseling and Testing (VCT) for HIV

Many people consider VCT to be a vehicle for behavior change, as well as an entry point to HIV care and support services. For a detailed discussion of VCT and its many benefits, please see Section 4.1.

3.6 Prevention Strategy 6: Prevention of Mother-to-Child Transmission (PMTCT) of HIV

Strategies to reduce MTCT include primary prevention of HIV infection among women, family planning, antiretroviral (ARV) interventions, restricted use of invasive obstetric procedures during vaginal delivery, provision of infant-feeding options, care for mothers who choose breastfeeding, prompt treatment of breast and nipple problems, support for exclusive breastfeeding, exploration of heat treatment of milk during weaning, and nutritional support for the mother. For additional information, please see the fact sheet *Reducing Mother-to-Child Transmission of HIV*, available on the FHI website (www.fhi.org/en/aids/impact/briefs/mtct.htm).

Some ARV regimens, including long- and short-course zidovudine and nevirapine, have been shown to be effective and safe in MTCT. UNAIDS, WHO and the United Nations Children's Fund (UNICEF) recommend that the prevention of MTCT be included in the minimum package of care for women living with HIV/AIDS, with the choice of ARV regimen determined according to local circumstances (UNAIDS 2000). Other elements of a minimum package include syphilis screening and treatment.

Determining whether to implement MTCT prevention on a large scale is complex. The following factors and considerations can help planners and program managers make decisions related to MTCT interventions:

- Cost-effectiveness of the intervention based on the prevalence level (cost-effectiveness has been questioned at HIV prevalence levels of less than 5-10 percent);
- State of the existing health system and maternal/child health services;
- Consideration of the risks associated with various infant-feeding options;
- Attitudes in the community regarding women who are living with HIV/AIDS;
- Cultural beliefs about childbearing, breastfeeding and family planning.

Key Implementation Questions for Preventing MTCT

- Is there an adequate and functioning antenatal care and maternity service in each district?
- Do women have access to these services?
- Is there access to confidential VCT?
- Are there follow-up provisions to provide quality clinical care and support services to infected mothers and children?
- Are services available where people will access them?
- Is there local capacity to implement VCT and MTCT?
- Is there laboratory support for MTCT?
- Is there a safeguarded and regular supply of drugs?
- Are community-based care and support services available?
- Is there a possibility of nevirapine (one dose antenatally, one dose postnatally and one dose for infant) where no real alternatives to breastfeeding exist?
- Are quality clinical skills available to support breastfeeding?
- Is nutritional support available to pregnant and lactating women?

3.7 Prevention Strategy 7: Safe Motherhood

There are important links between safe motherhood and HIV/AIDS programs. First, safe motherhood staff come into contact with many women at risk of HIV and other STIs, as well as women who are already HIV-positive and in need of care and support. If well trained in HIV/AIDS, safe motherhood staff can be important AIDS prevention educators and can make referrals for VCT and other relevant services. Second, safe motherhood programs can promote effective, voluntary family planning services for HIV-positive women. This can contribute in a substantial way to prevent MTCT. Third, learning and practicing safe obstetrical techniques can reduce the risk of MTCT from HIV-positive women to their newborns during delivery. This includes avoiding certain practices that unnecessarily expose the newborn to the mother's HIV-positive blood and amniotic fluid; avoiding the need for blood transfusions; and giving HIV-positive women access to cesarean section delivery, where safe, available and affordable. Fourth, midwives, traditional birth attendants (TBAs) and other health workers involved in conducting deliveries need to be trained in universal infection-control procedures, to be given necessary infection-control supplies such as gloves and soap and to be encouraged to practice these procedures at all times. This is essential to prevent HIV infection during delivery; it includes preventing health workers from being infected by HIV-positive pregnant clients, and preventing women who are delivering from being infected by HIV-positive health workers.

3.8 Prevention Strategy 8: Infant-Feeding Choice

Breastfeeding is crucial to child survival and early childhood development because of its health, nutrition, birth-spacing, emotional and psychological benefits for the infant. It also has significant health benefits for the mother. Given these benefits, the possibility of HIV transmission through breastfeeding has made safe infant-feeding counseling a special challenge for maternal and child health (MCH) services.

After extensive study, WHO determined that in environments where replacement feeding is safe, acceptable, feasible, affordable and sustainable, avoiding breastfeeding by women known to be HIV-positive is recommended from birth to avoid MTCT. But for many, if not most, HIV-positive women in resource-constrained settings, all of these conditions cannot be met. WHO has determined that, for mothers who cannot safely practice replacement feeding, exclusive breastfeeding is recommended for the first six months of life, followed by discontinuation of breastfeeding as soon as possible, once exclusive breastfeeding ends. This is based on the increased risks of diarrhea and other infectious diseases when exclusive breastfeeding is not practiced, as well as on the limited evidence of the increased risks of HIV transmission when other liquids and foods are introduced.

Finally, it is critical that the majority of women in any setting who are not HIV-positive continue to practice proper breastfeeding, since this is the optimal infant-feeding method for them.

3.9 Prevention Strategy 9: Harm Reduction for IDUs

There is evidence that HIV epidemics among IDUs can be prevented, slowed and even reversed in both developing and developed countries through implementation of specific harm-reduction strategies, including:

- Community-based peer outreach;
- Increasing access to sterile injecting equipment;
- Increasing access to drug dependence treatment, particularly methadone (Ball 1998).

For additional information, please see *Reducing HIV in Injection Drug Users*, available on the FHI website (<http://www.fhi.org/en/aids/impact/briefs/idu.htm>).

Key Implementation Questions for Harm Reduction

- What policies (law enforcement, public health) are in place for harm-reduction programs?
- What is the availability of needles and syringes?
- Are NGOs/CBOs providing outreach services for drug users?
- What programs/facilities (private/public sector) exist for drug rehabilitation, including drug substitution?
- What links exist between sex workers and IDUs?
- Are any IDU networks/groups providing services?
- Are networks of NGOs/CBOs working with IDUs?
- What links exist between drug treatment/rehabilitation facilities, outreach programs and general health services? Is a referral system in place?
- What drug-use prevention programs are in place?
- How does the general community perceive IDUs?

3.10 Prevention Strategy 10: Stigma Reduction

HIV/AIDS-related stigma continues to inform perceptions and shape the behavior of PLHA, which can affect the success of prevention interventions. Developing policies to combat discrimination is crucial to the success of any HIV prevention program. Stigma reduction is both a human rights and a public health issue. Stigma impacts at many different levels:

- **Prevention.** On the social level, stigma can cause target audiences to view those with or at risk of HIV/AIDS as *the other* or *them*, perpetuating notions that such an epidemic *could not happen to me*. BCC programs can inadvertently lead audiences to reject HIV/AIDS prevention messages when stigma is not addressed. On the individual level, not addressing stigma can cause people to decide not to seek VCT, medical or other care, including care regarding MTCT.
- **Quality of Care.** Stigma can perpetuate negative practices among health care providers, such as secrecy, neglect and poor treatment of PLHAs. A BCC campaign aimed at increasing demand for services at a facility might not be effective due in part to poor quality of care encountered by PLHAs.
- **Policy.** It is important to address stigma to facilitate the enforcement of existing laws and stop discriminatory laws or practices.

For more information on HIV/AIDS-related stigma, please see *Behavior Change Communication (BCC) for HIV/AIDS: A Strategic Framework*, available on the FHI website (<http://www.fhi.org/en/aids/impact/impactpdfs/bccstrategicframework.pdf>).

Key Implementation Questions for Stigma Reduction

- In what ways is stigma currently hindering effective prevention and care interventions?
- What roles can BCC, VCT and other prevention and care interventions play in alleviating the impact of stigma?
- What are the existing legal, political, human rights and policy contexts related to stigma?
- Are policies in place to enhance and protect the rights of PLHAs?
- Has high-profile disclosure occurred within the country?
- Does the hospital and health care setting play a role in perpetuating stigma?
- Is there community discussion about reducing stigma and discrimination?
- Tanzania has eliminated school fees to reduce stigmatization of AIDS orphans. What is the country or district doing in this respect?

4. Implementing Technical Care and Support Strategies

The needs of PLHA and their families have been identified in four related areas: 1) medical needs (e.g., treatment information and treatment); 2) psychological needs (e.g., emotional support); 3) socioeconomic needs (e.g., helping hands and orphan support); and 4) human rights and legal needs (e.g., access to care and protection against violence and discrimination). As HIV infection progresses, the types of services needed change. Provision of comprehensive care across a continuum — from home and community to institutional services and back — will ensure that the needs of clients and their families are met. As an individual enters the system for care, it is also essential that an active and effective referral system be in place. (For more information, please see *HIV Care and Support: A Strategic Framework*, available at www.fhi.org/en/aids/impact/impactpdfs/caresupportstrategy.pdf.)

Nine cost-effective care and support interventions are explored in this section: VCT; psychosocial support; palliative care; clinical management of OIs and HIV-related illnesses; tuberculosis (TB); home-based care; care for OVC; antiretroviral therapy (ART); and nutrition.

4.1 Care and Support Strategy 1: Voluntary Counseling and Testing (VCT) for HIV

Voluntary counseling and testing (VCT) is recognized internationally as an effective and pivotal strategy for HIV/AIDS prevention, care and support. Research conducted in Kenya, Tanzania and Trinidad by FHI in collaboration with UNAIDS, WHO and the Center for AIDS Prevention Studies at the University of California, San Francisco, provides strong evidence that VCT is an effective and cost-effective strategy for facilitating behavior change. VCT was also identified as an important entry point to care and support. These findings raised interest in and support for VCT as a valuable

component of comprehensive HIV/AIDS programs among international organizations, as well as the national AIDS programs of many countries.

The major barrier to VCT is fear of stigma. Women in particular can face violence and loss of security in the form of shelter, food and relationships. It is especially important with this population to ensure that testing is performed and results given without breaches in confidentiality. Other barriers are lack of available drug therapies, limited psychological support and clinical care for individuals who test HIV-positive, and personnel shortages at VCT sites (counseling is labor intensive and requires adequate training and supervision to assure high-quality services).

As an entry point for prevention, care and support services, VCT must be made available on a much larger scale. The use of simple, rapid HIV tests can decrease loss to follow-up in VCT.

For additional information on VCT, please see the following fact sheets, which are available on the FHI website: *Voluntary Counseling and Testing for HIV* (www.fhi.org/en/aids/impact/briefs/vctgeneral.html), *Issues in HIV Diagnostics for Voluntary Counseling and Testing* (<http://www.fhi.org/en/aids/impact/briefs/vcthidiagnostics.html>) and *Models of HIV Voluntary Counseling and Testing (VCT) Service Delivery* (www.fhi.org/en/aids/impact/briefs/vctmodels.html).

Key Implementation Questions for VCT

- What is the current level of VCT coverage and service provision?
- What are the current health-seeking behaviors of vulnerable people?
- How do people know that VCT services exist?
- Do people know the benefits of VCT services?
- Which models of VCT service delivery are best suited to the context?
- Are there enough trained counselors?
- What capacity exists to train counselors?
- Is there a standardized VCT training manual?
- Are facilities available to establish VCT services that ensure confidentiality?
- To what degree are basic care and support services available, to which VCT would serve as an entry point?
- Are faith-based organizations providing VCT?
- Are VCT services available in the community?
- Are community groups linked with VCT sites for follow-up support, post-test clubs, etc.?

4.2 Care and Support Strategy 2: Psychosocial Support

Ongoing counseling helps individuals to accept their HIV status and develop a positive attitude. It can facilitate information-sharing with partners or close family members, who may also participate in counseling. In Uganda, a study of 730 patients who received long-term counseling found that 90 percent revealed their sero-status to another person and 85.3 percent told relatives. But disclosure is still a very difficult process. Another study (Coates et al 2000) found a high level of acceptance of HIV-positive people in families (79 percent) and communities (76 percent). Psychosocial support can be provided at clinics, schools or community support groups.

Psychosocial support is also needed for caregivers. Caring for someone with a serious chronic illness is a physical and emotional challenge for even the most dedicated caregiver. This is particularly true for nurses, counselors and caregivers in the home, who provide the bulk of care for PLHAs. These caregivers also need support to help them do their jobs well, avoid “burnout” and remain free of HIV infection. For more information, please see *HIV Care and Support: A Strategic Framework*, available on the FHI website (www.fhi.org/en/aids/impact/impactpdfs/caresupportstrategy.pdf).

Key Implementation Questions for Psychosocial Support

- How many care providers are trained in counseling and actively using their skills?
- What structures exist through which psychosocial support can be offered?
- To what degree have PLHAs been actively engaged in peer support?
- Are communities being mobilized for support?
- Are faith-based organizations involved in providing psychosocial support?

4.3 Care and Support Strategy 3: Palliative Care

Palliative care is defined as the control of symptoms, relief of distress, promotion of quality of life and attention to the psychosocial aspects of illness. These aspects of care are appropriate in all stages of disease, not just during a terminal illness. In the case of HIV/AIDS, as the disease progresses, relief of symptoms, pain management and attention to psychosocial needs will require increased attention. Large numbers of infected persons currently lack access to palliative care and medications. Palliative care can be provided in hospitals and in the home environment. For additional information, please see *HIV Care and Support: A Strategic Framework*, available on the FHI website (www.fhi.org/en/aids/impact/impactpdfs/caresupportstrategy.pdf).

Key Implementation Questions for Palliative Care

- Do home-care programs exist to complement hospital-based care?
- Is there an active referral system with clinicians and palliative care providers in the community?
- Are faith-based organizations mobilized?

4.4 Care and Support Strategy 4: Clinical Management of Opportunistic Infections (OIs) and HIV-Related Illnesses

Most OIs are treatable with prompt recognition and appropriate management. TB is the leading HIV-associated opportunistic infection in developing countries and causes 30 to 40 percent of deaths in PLHAs. Other causes of AIDS-related mortality and morbidity include pneumonia, candidiasis, cyptococci infections, toxoplasmosis, herpes and common infections. Effective interventions against OIs require not only the appropriate drug and other medications, but also the infrastructure necessary to diagnose the condition, monitor the intervention and counsel PLHAs. For additional information, please see *HIV Care and Support: A Strategic Framework*, available at www.fhi.org/en/aids/impact/impactpdfs/caresupportstrategy.pdf, and visit www.aidsinfo.nih.gov/ed_resources/default.asp?REC_ID=35.

In addition to access to appropriate drugs, treating OIs requires clinic facilities for outpatient care and hospital facilities for serious illnesses. Laboratory facilities are needed for diagnosis and follow-up of certain OIs, such as TB and parasitic and bacterial infections. The potential to expand clinical management is heavily reliant on existing capacity constraints, both for inpatient and outpatient care. These capacity limits may already be reached in some countries, given that 50-70 percent of beds in some African countries are being used to treat HIV-related illnesses (World Bank 1997).

Interventions that prevent OIs can result in significant gains in life expectancy and quality of life for PLHAs. Cotrimoxazole has been recommended for preventive use in HIV-symptomatic persons as part of a minimum package of care (UNAIDS 2000). It is widely used in developing countries, listed as an essential drug and is inexpensive. In two randomized controlled trials in Cote d'Ivoire, cotrimoxazole prophylaxis resulted in fewer hospitalizations and fewer cases of enteritis, pneumonia, isosporiasis, non-typhoidal salmonella and septicemia, as compared with a placebo. In one of the studies, researchers observed decreased mortality (Anglaret et al 1999 and Wiktor et al 1999). While recommended, widespread TB treatment is still in the early stages in many countries, given the required intensive collaboration between TB and HIV clinical staff. VCT is seen as an entry point for TB prophylaxis, but few individuals have access to these services or the incentive to be tested. Highly active antiretroviral therapy (HAART) remains the most effective strategy for reducing OI-related

morbidity and mortality, but the treatment is complex and is not widely available in many countries.

WHO estimates that more than one-third of the world's population lacks access to essential drugs due to high prices or inadequate supply and distribution systems. Essential drugs are required to adequately treat a number of HIV-related OIs and malignancies. On a basic level, these drugs include anti-infective agents and palliative drugs. For more information, please see Module 7 of *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, available on the FHI website (<http://www.fhi.org/en/aids/impact/pubs/handbooks/ecrhndbk/ecrmod7.html>).

Key Implementation Questions for Clinical Management of OIs and HIV-Related Illnesses

- What is the capacity of the existing health system to provide this care?
- Is there capacity to deal with pediatric AIDS?
- Are training programs on clinical management of OIs available?
- Do the majority of those in need have access to this care?
- Is there a safeguarded supply of drugs for this care?

4.5 Care and Support Strategy 5: Tuberculosis

TB is a curable infectious disease strongly associated with HIV. Though fueled by the HIV/AIDS epidemic, TB does not remain confined to HIV-positive individuals. As one of the first opportunistic infections to appear in PLHAs, TB may be the earliest sign of HIV infection. It can also present an early opportunity for HIV interventions.

Studies in resource-scarce countries suggest that TB prophylaxis can be both cost-effective and operational (Brewer 1999). Preventive therapy with isoniazid is recommended as a health-preserving measure for HIV-positive persons at risk of TB, such as persons with a positive TB skin test or persons who are living in TB-endemic areas (WHO 1999). For additional information, please see *Tuberculosis Control in High HIV Prevalent Areas: A Strategic Framework*, available on the FHI website (www.fhi.org/en/aids/impact/impactpdfs/tbstrategy.pdf).

Coordinating TB and HIV services is important when targeting TB in countries with high HIV prevalence. This can be accomplished by fully implementing the directly observed treatment, short-course (DOTS) strategy, establishing HIV services at TB service points, integrating TB-control activities into HIV services and advocating for greater coordination of TB and HIV programs.

Key Implementation Questions for TB Programs

- Is the TB program linked to the HIV/AIDS program?
- Are TB programs targeted to reach prison and migrant populations?
- Does the TB program have links to VCT for HIV?
- Is the public aware of the relationship between TB and HIV?
- Are standard training guidelines for TB available at the clinic level?
- Are community programs facilitating discussion of TB and its link to HIV?
- Is the community promoting TB health-seeking behavior, TB services and adherence to therapy?

4.6 Care and Support Strategy 6: Home-Based Care

Home-based care, defined as any care given to PLHAs in the home or community environment, has emerged over the past decade as a valuable strategy to alleviate the strain on hospitals, families and communities and provide PLHAs with a better quality of life. Home-based care can reach people at different stages of HIV infection (e.g., when chronically ill at an early stage or at the terminal stage of illness). Family caregivers, trained volunteers and health and social/support workers can provide care.

Home-based care models are categorized into two approaches: 1) hospital/clinic-based outreach; and 2) community-based programs. PLHA and their families can benefit from both facility- and community-based components. Home-based care services are intended to provide comprehensive care for clients in the home while reducing the need for hospital admission.

While home-based care has many benefits, it can be time and resource intensive. As a result, outreach workers and family caregivers may not be fully trained and supported. Outreach workers may find it challenging to meet client needs as caseloads escalate, reducing the frequency and duration of visits. To alleviate this problem, community volunteers have been trained in some areas to link outreach staff and family caregivers. Other difficulties include traveling costs and time for outreach work.

For the family, caring for PLHA can be challenging. Families often must care for HIV-positive individuals in overcrowded and impoverished conditions. Alternatives to home-based care, such as hospice-based care or daycare centers, have not been explored in many countries. Faith-based organizations can also play a vital role in caring for PLHAs. For additional information, please see *HIV Care and Support: A Strategic Framework*, available on the FHI website (www.fhi.org/en/aids/impact/impactpdfs/caresupportstrategy.pdf).

Key Implementation Questions for Home-Based Care

- What delivery structures for community care are in place?
- What systems exist to identify and train caregivers?
- What linkages exist between health care providers and care and support services?
- Which models are best suited for home-based care?
- Are referral networks in place for nutritional support, basic food programs and other needed services?

4.7 Care and Support Strategy 7: Care for Orphans and Vulnerable Children (OVC)

Experience indicates that multisectoral, collaborative and coordinated responses are essential to effective OVC care. Some successful responses to OVC care have been developed, though they are relatively small and localized. Capacity building for NGOs and CBOs is still needed to develop a broader vision and engage additional organizations in OVC care.

To date, OVC care has been provided primarily by women who visit orphan households, establish income-generating projects and send children back to school. Adaptation and replication of many of these initiatives could protect and support greater numbers of vulnerable children.

While more resources are needed for OVC care, program planners and managers must consider carefully the timing and manner of resource provision. Funding should support community action undertaken with local resources. This type of targeted assistance goes hand in hand with community capacity building.

Efforts to strengthen the safety net for OVC require a complex set of social development interventions, which should increase access to and optimal use of resources. Interventions include social/support services, health services, education and food security. Target populations include child-headed households, widows, grandparents, orphans and youth. The goal is to foster self-support.

Recommendations for OVC Programming in Various Sectors

- **Labor.** As a preventive strategy, strengthen efforts to protect OVC without adequate family care from being economically exploited; train labor inspectors and revise national laws and policies in accordance with international conventions on child labor.

- **Education.** Accelerate action to ensure that universal primary education is available to all children, regardless of their social situation; assess the impact of the pandemic on the number and quality of teachers and the possible reduction in enrollment levels.
- **Health.** Build capacity to reach HIV-positive children with adequate medical care and provide adolescents with information about HIV prevention, care and support.
- **Agriculture.** Assess the impact of the pandemic on the productivity of farm families; develop outreach programs aimed at supporting young farmers; in cooperation with social welfare agencies, provide human resources and technical assistance to child- and adolescent-headed families that care for orphans.
- **Social Welfare/Community Development.** Identify vulnerable families, review material and other support needs and assess local and external resources with special attention to: abandoned newborns, child-headed households, families with young children headed by the elderly, and families with young children headed by adolescents; provide and support appropriate counseling services to encourage families to care for HIV/AIDS-affected children (in cooperation with the health sector).
- **Micro-finance.** Expand access to micro-finance services to improve the capacity of households and communities to support PLHAs.

Key Questions for Implementing OVC Care

- Is there untapped community or family capacity to accommodate the increase of orphans and vulnerable children?
- Are community leaders and community support groups, such as religious-affiliated organizations, youth and women’s groups and workplaces, sensitized and mobilized to address orphan issues?
- Is there a national or local policy or bylaws to exempt school fees for OVC?

4.8 Care and Support Strategy 8: Antiretroviral Therapy (ART)

With the introduction of ART into clinical HIV care, AIDS has become a manageable chronic illness. Antiretroviral (ARV) drugs have helped to restore economic productivity and social functioning, though this has only occurred in settings where resources are available to make the drugs affordable, and health service capacity exists to enable sustained, safe and effective use. Successful ART provision requires: 1) a consistent supply of affordable drugs; 2) client adherence; and 3) an adequate health care system.

Specific elements need to be in place before introducing ART into any setting, due to the high costs of the drugs, the complexity of drug regimens and the need for careful monitoring. These elements include:

- Access to VCT;
- Capacity to diagnose and monitor common HIV-related illnesses and infections;
- Laboratory monitoring services, including routine hematological and biochemical tests for detecting drug toxicity and monitoring immunologic and virologic parameters;
- Resources to pay for treatment on a long-term basis;
- Information and training for health professionals on safe and effective use of ART;
- Regulatory mechanisms to ensure that drugs are being used appropriately.

Lessons learned from large-scale programming include the following:

- HIV/AIDS care needs to be planned and implemented with significant involvement of PLHAs;
- Efforts to address stigma and discrimination are integral to successful mitigation;
- Community ownership of care and support is key;
- Successful responses are coordinated and planned across sectors.

For additional information, please see the fact sheet *Safe and Effective Introduction of Antiretroviral Drugs for HIV/AIDS*, available on the FHI website (<http://www.fhi.org/en/aids/impact/briefs/arv.htm>).

Key Implementation Questions for Provision of ART

- At the district and provincial levels, are there agreed-upon standards for ART provision? Whom to treat? When to treat? What regime?
- Is comprehensive HIV care and support in place and functional? (VCT, clinical management of HIV-related illnesses and preventive therapies, palliative care, home-based care and social support)
- Is the health system ready to embark on ART provision? (trained clinicians, functional laboratories with HIV testing, hematology, liver function laboratory, sputum acid fast bacilli, CD4 or alternatives, safe drug management system)
- Have community PLHAs, private doctors and pharmacists been involved in ART sensitization and training?

4.9 Care and Support Strategy 9: Nutrition

HIV/AIDS and malnutrition are closely interrelated. Studies indicate that malnutrition may increase the risks of MTCT and the progression from HIV to AIDS. In turn, HIV infection causes malnutrition through its attacks on the immune system and its negative impact on nutrient intake, absorption and utilization.

Nutrition counseling and interventions can slow or reverse the processes and outcomes of weight loss in PLHA. Practical nutrition recommendations are available for asymptomatic HIV-positive individuals, individuals who are HIV-positive and already experiencing weight loss, and adults and children who have AIDS.

Recommendations at the asymptomatic stage focus on counseling about good nutrition and a healthy diet, taking into account locally available foods and the need for increased energy intake. For HIV-positive persons who have begun to lose weight, recommendations center around maintaining food intake during the period of depressed appetite and avoidance of unhealthy lifestyles. In the later stages of AIDS, the emphasis shifts from preventing to mitigating the nutritional consequences of AIDS, and to preserving functional independence when possible. Food aid for the family may be indicated at this stage.

5. Further Reading

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National Latino/a Lesbian, Gay, Bisexual and Transgender Organisation (LLEGO), 1420 K St., NW, Suite 200, Washington, DC 20006. Phone 202-408-5380. (<http://www.llego.org>)

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6. The FANTA Project and HIV/AIDS

The FANTA Project's HIV/AIDS work is based on its unique strengths in food security and nutrition programming. FANTA's focus is on mitigating the impacts of HIV/AIDS at the community and household levels and on nutritional care and support including:

- Strengthening the design, implementation and performance reporting of USAID and partner programs to mitigate the impact of HIV/AIDS on communities and individuals;
- Improving nutrition care and support for HIV/AIDS-affected families in Sub-Saharan Africa;

- Providing technical assistance in defining monitoring and evaluation approaches to Title II PVOs and their local NGOs;
- Promoting practical approaches and strategies with partners, and strategies for addressing HIV/AIDS with Title II food aid resources.

Additional titles of interest:

HIV/AIDS: A Guide for Nutrition, Care and Support

Potential Uses of Food Aid to Support HIV/AIDS Mitigation Activities in Sub-Saharan Africa

Also see HIV-related material in: <http://www.enonline.net/ife/module1/Index.html> (infant feeding in emergencies).