

## 2 Strengthening and expanding health systems

### Background

WHO defines a health system as "the sum total of all the organizations, people and actions whose primary intent is to promote, restore or maintain health." A country's health system embraces those who try to influence the determinants of health, as well as those who deliver health-improving services.

So defined, a health system is more than the pyramid of facilities owned by government, private business and NGOs, and of the health workers and support personnel who staff those facilities. It includes a mother caring for an HIV-infected child at home; peer educators who deliver behaviour-change communications; organizations run by and for sex workers that distribute preventive literature and condoms; health insurance providers; legislators who adopt health and safety and anti-discrimination laws; those who enforce the laws; and so on. A health system's activities may include, for example, a multidisciplinary and multisectoral campaign to encourage the ministry of education to promote female education, which is a well-known determinant of good health, or to encourage the ministry of finance to approve sufficient funding for a programme to promote and support the sexual and reproductive health of out-of-school youth.

WHO believes that health systems should be founded on the principles enshrined in the Declaration of Alma-Ata: universal access, equity, participation and multisectoral action, all within a framework of gender equality and human rights (see Box 3). That is, health systems should have multiple goals, including improving health in ways that are equitable, responsive, financially fair, and make the best use of available resources. By expanding coverage so it reaches an increasing number of people with ever more effective health interventions, these goals can be attained.

#### Box 3. Key excerpts from the Declaration of Alma-Ata

- IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.
- V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.
- VI. Health care ... is made universally accessible to individuals and families through their full participation and at a cost that the community and country can afford.
- VII. Primary health care:
  2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services ...;
  3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
  4. involves, in addition to the health sector, all related sectors and aspects of national and community development ...;
  5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control ..., making fullest use of local, national and other available resources.

Source: Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Available at: [http://www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf)

In its framework for action on health-system strengthening, WHO notes that "the principles set out in the Declaration of Alma-Ata are more often observed in breach than in observance"<sup>18</sup>. However, it is clear that the response to the HIV pandemic has set precedents and has renewed momentum towards applying those principles. In response to vigorous civil action, with widespread involvement

<sup>18</sup> *Everybody's business: Strengthening health systems to improve health outcomes. WHO's framework for action.* Geneva, World Health Organization, 2007. Available at: [http://www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

by people living with HIV, the rapid scale-up of access to antiretroviral therapy (ART) has led to an internationally endorsed and increasingly strong commitment to universal access. The recognition that the pandemic requires commitment from all sectors, not just the health sector, has taken firm hold. Furthermore, the international community has come to realize that prevention, care, treatment and support should all be part of the response to the pandemic—as per the principles for primary health care set out in the Declaration of Alma-Ata.

This has become a tenet of the response to HIV and, in turn, the response to TB, malaria and ill health among mothers, infants and children.

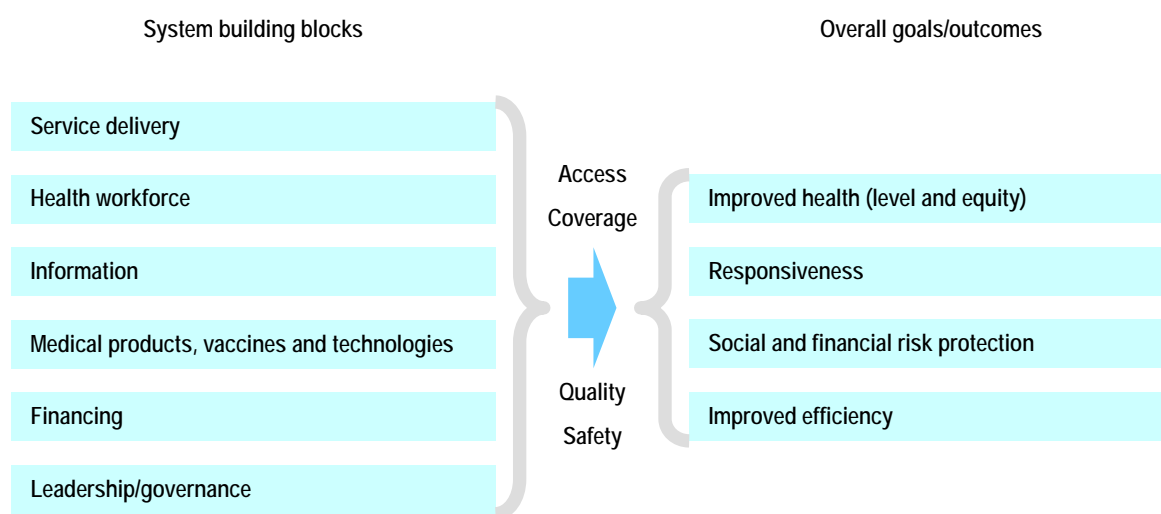
Despite those positive and encouraging achievements, the response to the HIV pandemic remains inadequate. Weak health systems—including organizations, people and actions intended to produce health outcomes, such as HIV prevention and treatment—remain a major barrier. This is true not only for low- and middle-income countries. High-income countries also face challenges—for example, in reaching most-at-risk and marginalized groups (e.g. sex workers, IDUs and MSM) with effective health system interventions that deploy resources efficiently. The biggest challenges of all lie in countries with generalized epidemics, where HIV undermines the capacity of the health sector to provide services by increasing its workload and decreasing its healthy and productive workforce.

While the structure and operations of health systems vary from country to country and from area to area within countries, WHO has identified six building blocks of all health systems. These are illustrated in **Figure 1** and include:

1. service delivery
2. health workforce
3. information
4. medical products, vaccines and technologies
5. financing
6. leadership and governance.

'Health-system strengthening' can be defined as improving these six building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. In this chapter, five of these building blocks will be discussed as they relate to scaling up the response to HIV and achieving the goal of universal access to HIV prevention, treatment, care and support. The chapter addresses the need for action under the fourth of the five strategic directions named in the introduction to this document: strengthening and expanding health systems. The remaining building block, strategic information (also the fifth strategic direction) is covered in Chapter 3.

**Figure 1. Health system building blocks, desirable attributes, goals and outcomes**



## 2.1 Service delivery

Good health services are those that deliver effective, safe, high quality health interventions to the people who need them, when and where they need them, and with minimum waste of resources. These interventions may target individuals or entire populations, whether defined by geography (e.g. national, district or local) or characteristics (e.g. gender, age, nature of illness, occupation, behaviour). In the case of HIV, health services should take into account that people living with HIV or most-at-risk of infection often face stigma and discrimination because of their infection, or because they may belong to groups with particular behavioural or disempowering characteristics, such as sex workers, injecting drug users, prisoners, youth and men who have sex with men. Reaching these groups with HIV prevention, treatment and care requires special interventions that are often best delivered through outreach, community groups, or their own organizations.

Those planning and implementing HIV-related service delivery programmes should consider the need for: integration and linkage of health services; infrastructure and logistics; demand for services; and management.

### 2.1.1 Integration and linkage of health services

There are no universal models for good service delivery. However, in the case of HIV-related services, it is agreed that services should be delivered across a continuum of care. This requires integrated and linked service provision at all levels of the health system, from primary to secondary to tertiary (specialist) care, embracing all elements of the health system, including home-based and community-based outreach care.

'Linkage' refers to a relationship—for example, between a local health centre and a district hospital. 'Integration' refers to delivering multiple services or interventions to the same patient by an individual health care worker or by a team of health care workers and, possibly, workers from other fields. Strong linkages (with referral and coordination between service providers) and integrated services are needed in particular areas of health care, such as family planning, care for mothers and newborn infants, mental health care, and care for people living with HIV. All of these may involve a range of services and service providers, including home-based and community-based ones.

A particularly strong case can be made for integrating HIV-related services into all maternal and newborn care and sexual and reproductive health care service delivery. Integrating HIV-related and TB-related services into one package of services is also recommended.

In many large health centres and hospitals, pregnant women with HIV are identified in the antenatal clinic and then referred for HIV-related services that are in another area of the facility, or in another facility altogether. This often results in a significant 'loss to follow-up'; many women do not appear at an HIV clinic, even if it is in the same facility. This is a reason why pregnant women who need ART often do not receive it.

To avoid this sequence of events, full integration of HIV intervention delivery within services for antenatal care, childbirth, newborn and postpartum care is a minimum requirement in any country, district or locality where HIV infection is common. Such integration should include HIV testing and counselling, assessment of whether antiretrovirals for treatment or prophylaxis are needed, initiation and monitoring of antiretrovirals in women and exposed infants, follow-up HIV testing for infants, clinical review, and cotrimoxazole prophylaxis when infants return for immunization.

Sexual and reproductive ill-health and HIV infection share the same driving forces, causes or contributors: poverty, limited access to information, gender inequality, cultural norms, and social marginalization of the most vulnerable and at-risk populations. This explains why there is international consensus around the need for effective linkages between responses to HIV and responses to sexual and reproductive health concerns, as well as consensus around the need for integration of related services whenever feasible. These integrated services should include: promoting condom use for preventing unintended pregnancy, sexually transmitted infections (STIs) and HIV; reproductive choice counselling and counselling for family planning and contraception; education on sexual health for people living with HIV; and youth-friendly health services covering sexual and reproductive health.

The high incidence of TB among people living with HIV and the frequent occurrence of HIV infection among people with TB provide the rationale for linkages between responses to TB and HIV, and integration of TB-related and HIV-related services. These linkages and integration have already resulted in substantial increases in the proportion of TB patients tested for HIV and then referred to HIV-care services (or provided with some HIV services on-site). In addition, HIV programmers are increasingly committed to TB control, intensified TB case finding among HIV-infected patients, and to offering Isoniazid prophylaxis after excluding active TB.

How exactly to go about linking and integrating services will depend on how the health service is organized, and also the characteristics of the HIV epidemic. For more on the latter, see Chapter 4.

### **Summary of recommendations**

Services for HIV should be linked or integrated with other services in the health sector, including those for TB, sexual and reproductive health, and maternal and newborn health. They should also be linked or integrated with services provided by other sectors, such as education and social welfare, and to those provided within homes and communities by families, international and national NGOs, community-based organizations, faith-based organizations and groups or networks of people living with HIV. All of these services should be provided as close to clients as possible.

However, when considering the integration of health services, planners should opt for a pragmatic approach that takes into account and balances the specific needs of target populations (that might be marginalized), the characteristics of the particular health system, and the aim of providing a comprehensive package of services.

### **Key resources:**

156. Integrated health services: What and why?  
[http://www.who.int/healthsystems/service\\_delivery\\_techbrief1.pdf](http://www.who.int/healthsystems/service_delivery_techbrief1.pdf)
157. WHO IMAI/IMCI/IMPAC tools (website)  
<http://www.who.int/hiv/topics/capacity/>  
[http://www.who.int/hiv/pub/imai/imai\\_publication\\_diagram.pdf](http://www.who.int/hiv/pub/imai/imai_publication_diagram.pdf)
158. Interim policy on collaborative TB/HIV activities  
English: [http://whqlibdoc.who.int/hq/2004/WHO\\_HTM\\_TB\\_2004.330\\_eng.pdf](http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330_eng.pdf)  
French: [http://whqlibdoc.who.int/hq/2004/WHO\\_HTM\\_TB\\_2004.330\\_fre.pdf](http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330_fre.pdf)  
Spanish: [http://whqlibdoc.who.int/hq/2004/WHO\\_HTM\\_TB\\_2004.330\\_spa.pdf](http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330_spa.pdf)  
Russian: [http://whqlibdoc.who.int/hq/2004/WHO\\_HTM\\_TB\\_2004.330\\_rus.pdf](http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330_rus.pdf)
25. Linkages between HIV and SRH: Technical documents and advocacy materials (web page)  
<http://www.who.int/reproductive-health/hiv/docs.html>
159. Ensuring the sexual and reproductive health of people living with HIV. *Reproductive Health Matters*. Volume 15, Issue 29, Supplement 1 pp. 1-135. May 2007.  
<http://www.who.int/reproductive-health/hiv/docs.html>
98. Operations manual for the delivery of HIV prevention, care and treatment at primary health centres in high-prevalence resource-constrained settings  
<http://www.who.int/hiv/capacity/IMAisharepoint/en>

## **2.1.2 Infrastructure and logistics**

Service delivery requires infrastructure and logistics, including physical space, equipment, utilities, waste management, transport, and communications.

Physical space is required for receiving clients, triage, waiting, clinical management, counselling, care delivery, surgery, pharmacy, storage, management and equipment. Space is also needed for laboratories, deliveries, communications, infection control, waste management, and so on.

For people living with HIV, particular attention should be paid to their needs for privacy and confidentiality, safe water, sanitation and hygiene, and infection control. The latter should take into account the need to reduce the risk of bloodborne infections, such as HIV and hepatitis, and of other infections, such as TB. Reducing the risk of TB infection is particularly important, given the high incidence of TB among people living with HIV and the emergence of multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB.

With the recent scale-up of treatment for HIV infection, the limitations of laboratory infrastructure are increasingly recognized as major obstacles to the roll-out of services. For follow-up on ART, it is important to have access to some laboratory support on the periphery of the health system (until recently not routinely available), as well as at higher levels of the system (see **Table 8** in Chapter 1). This means essential tests should be available on site at a local health centre or district hospital, as

should the capacity to transport specimens to higher levels. Laboratory support for antiretroviral therapy, early infant diagnosis and TB diagnosis are important priorities for HIV-related laboratory services.

Chapter 1 provides detailed guidance on the types of laboratory tests needed to support treatment of people living with HIV, and to manage conditions frequently found among them, such as TB. Providing the tests is a huge challenge, the dimensions of which can be understood best if laboratory support is considered as a health sub-system. When planning to scale up laboratory services, service delivery, health workforce and the other building blocks of a health system should be considered (see **Figure 1**).

Infection control in all facilities is also important. This includes safe medical waste management with separate containers and adequate disposal systems for sharps, other infectious or hazardous waste, and non-infectious and non-hazardous waste.

An emerging issue is the relatively low access to information technology in resource-limited settings. Computerization has the potential to markedly enhance efficiency of HIV service delivery, as computerized record keeping, monitoring and supply management can free up time for clinical tasks.

Communication between staff at local health centres and staff in health facilities and laboratories at higher levels of the health system is essential to provide HIV care of the highest quality. Facilitating this communication involves ensuring that telephone, radio or other communications infrastructure is adequate. Ideally, the infrastructure should include computers connected by intranet or internet.

### **Summary of recommendations**

The infrastructure and logistics of health-service delivery should be designed to last. They should be configured to enable delivery on demand of services to people who need them, wherever they may be located. For managing HIV infection, it is especially important that health facilities are designed for privacy and confidentiality, infection control and ready access to laboratories and imaging services.

Every effort should be made to limit the spread of nosocomial infections (resulting from treatment in health settings) and bloodborne infections (such as HIV and hepatitis). Support should be provided for comprehensive infection control, including specific consideration of the risk of the spread of TB.

### **Key resources:**

160. District health facilities: guidelines for development and operations.  
<http://www.wpro.who.int/NR/rdonlyres/C0DAA210-7425-4382-A171-2C0F6F77153F/0/DistHealth.pdf>
161. Management of resources and support systems: Equipment, vehicles and buildings (web page)  
<http://www.who.int/management/resources/equipment/en/index1.html>
151. WHO consultation on technical and operational recommendations for scale-up of laboratory services and monitoring HIV antiretroviral therapy in resource-limited settings: (Expert meeting, Geneva, 2004)  
<http://www.who.int/hiv/pub/meetingreports/labmeetingreport.pdf>
98. Operations manual for the delivery of HIV prevention, care and treatment at primary health centres in high-prevalence resource-constrained settings  
<http://www.who.int/hiv/capacity/IMAIsharepoint/en>
147. Tuberculosis care with TB-HIV co-management: Integrated Management of Adolescent and Adult Illness (IMAI)  
[http://whqlibdoc.who.int/publications/2007/9789241595452\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595452_eng.pdf)  
Facilitator's guide: [http://www.who.int/hiv/pub/imai/primary/tbhiv\\_comgt\\_fac.pdf](http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_fac.pdf)  
Participant's manual: [http://www.who.int/hiv/pub/imai/primary/tbhiv\\_comgt\\_partman.pdf](http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_partman.pdf)
148. IMAI TB infection control at health facilities  
[http://www.who.int/hiv/pub/imai/TB\\_HIVModule23.05.07.pdf](http://www.who.int/hiv/pub/imai/TB_HIVModule23.05.07.pdf)  
Facilitator's guide: [http://www.who.int/hiv/pub/imai/primary/tbhiv\\_comgt\\_fac.pdf](http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_fac.pdf)  
Participant's manual: [http://www.who.int/hiv/pub/imai/primary/tbhiv\\_comgt\\_partman.pdf](http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_partman.pdf)

### **2.1.3 Demand for services**

In health service planning, most attention usually goes to planning on the supply side of services. The question as to whether the services will be used is often neglected, even when it is clear there are factors that could limit demand. Denial, fear, stigma, discrimination, and high costs are among the factors that limit demand for and uptake of health services. This is especially the case for the uptake of services related to HIV and TB, conditions surrounded by fear, stigma and discrimination. Chapters 1 and 4 discuss interventions that can generate demand, such as outreach to people in most-at-risk populations.

### **Summary of recommendations**

Raising demand requires understanding the user's perspective, raising public awareness and overcoming cultural, social or financial obstacles. Overcoming such obstacles demands various forms of social engagement in planning, delivery and monitoring services. In the case of HIV-related services, people living with HIV and those vulnerable or most-at-risk should be involved in the design, management, delivery and monitoring of services. This can ensure that services meet their unique needs and concerns, such as fear of disapproval or open hostility on the part of staff, and fear of disclosure of their HIV status and the possible consequences.

#### **Key resources:**

162. Preparing for treatment programme (WHO website)  
<http://www.who.int/3by5/partners/ptp/en/>
163. Missing the target #5: Improving AIDS drug access and advancing health care for all  
<http://www.aidstreatmentaccess.org/>
164. Service delivery model on access to care and antiretroviral therapy for people living with HIV/AIDS  
[http://www.ifrc.org/cgi/pdf\\_pubshealth.pl?service-delivery-en.pdf](http://www.ifrc.org/cgi/pdf_pubshealth.pl?service-delivery-en.pdf)

## **2.1.4 Management**

Good leadership and management is about providing direction to and gaining commitment from partners and staff, facilitating change, and achieving better health services through efficient, creative and responsible deployment of people and other resources. Good leaders set the strategic vision and mobilize action towards that vision. Good managers ensure effective organization and use of resources to achieve results and meet goals and targets.

The health sector response to the HIV epidemic requires different types of management action. There is a need for strategic planning at the national and sub-national levels; for operational planning throughout the service delivery system; and for facility management.

At the highest level of a health system, good management requires situation analysis, review of the health sector response (including existing policies and strategies), setting programme priorities, selecting key indicators and setting targets. The next step is coordinating and managing the development and implementation of programmes; these issues are addressed in Chapter 4. Good management also requires strengthening management systems, and ensuring the technical quality of services, both of which are dealt with below.

Increasingly, the management of implementation occurs at district, facility and community level. The district management team, facility managers and community organizations need skills to plan the implementation, to mobilize resources, and to manage staff, finances and supplies. Training is usually organized and delivered at the regional or district level; it is then followed up by regular supportive supervision from the district team, and by mentoring from experienced managers from other districts, communities or facilities.

At health facility level, the aim of good management is to provide services to the community in an appropriate, efficient, equitable, and sustainable manner. This can only be achieved if key resources for service provision, including human input, information, finances, and the hardware and process aspects of care delivery are brought together at the point of service delivery and are carefully synchronized.

### **2.1.4.1 Strengthening management systems**

Deficiencies in health system management are well-recognized as obstacles to efficient service delivery.

#### **Summary of recommendations**

WHO recommends action to strengthen management capacity in the health sector. Such action should include ensuring an adequate number of managers at all levels of the health system, ensuring managers have appropriate competencies, creating better management support systems, and creating enabling working environments.

### **Key resources:**

165. Strengthening management in low income countries  
<http://www.who.int/management/general/overall/Strengthening%20Management%20in%20Low-Income%20Countries.pdf>
166. Managers taking action based on knowledge and effective use of resources to achieve results (MAKER) (WHO website)  
<http://www.who.int/management/en/>
167. Strengthening management capacity in the health sector (website)  
<http://www.who.int/management/strengthen/en/index.html>

### **2.1.4.2 Ensuring the technical quality of services**

Universal access to HIV prevention, treatment and care provided by the health sector requires that the package of interventions be accessible and affordable by the people who need those services and that interventions are of good quality, so that they achieve the intended results.

#### **Summary of recommendations**

Ensuring quality during scale-up of HIV-related services requires:

- Establishing external and internal quality management systems. These should address clinical care, laboratory testing, and workplace improvement. It is of critical importance to involve the community and beneficiaries (people living with HIV and those vulnerable and most-at-risk of infection) in assessing and improving the quality of care.
- Regularly updating of national normative guidelines and tools so they continue to reflect the best international practices and the latest recommendations. This requires convening technical advisory committees and working groups regularly, since HIV and AIDS are rapidly changing areas with new information constantly becoming available.
- Establishing standardized procedures to accredit health facilities and to certify health care providers in the delivery of HIV prevention, treatment and care. All facilities and providers, whether run by government, private business or NGOs, should be covered.
- Establishing national standards for HIV prevention, treatment and care.
- Ensuring quality of training through, for example, the use of experienced facilitators and attention to facilitator-trainee ratios.
- Establishing supervision and clinical mentoring systems, and a budget to prepare and deploy supervisors and mentors for post-training and on-the-job supervision.
- Establishing well functioning patient and programme monitoring systems that the clinical team is able to use to measure and improve the quality of care they provide.

### **Key resources:**

168. Standards for quality HIV care: a tool for quality assessment, improvement, and accreditation  
English: <http://whqlibdoc.who.int/hq/2004/9241592559.pdf>  
French: [http://www.who.int/entity/hiv/pub/prev\\_care/standardsquality\\_fr.pdf](http://www.who.int/entity/hiv/pub/prev_care/standardsquality_fr.pdf)
98. Operations manual for the delivery of HIV prevention, care and treatment at primary health centres in high-prevalence resource-constrained settings  
<http://www.who.int/hiv/capacity/IMA/sharepoint/en>
78. WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained settings  
[http://whqlibdoc.who.int/publications/2006/9789241594684\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/9789241594684_eng.pdf)
169. Guidelines for organising national external quality assessment schemes for HIV serological testing  
[http://www.who.int/diagnostics\\_laboratory/quality/en/EQAS96.pdf](http://www.who.int/diagnostics_laboratory/quality/en/EQAS96.pdf)
170. Guidelines on establishment of accreditation of health laboratories  
[http://www.searo.who.int/LinkFiles/Publications\\_SEA-HLM-394.pdf](http://www.searo.who.int/LinkFiles/Publications_SEA-HLM-394.pdf)

## **2.2 Health workforce**

Effective service provision requires trained service providers working with the right attitude, knowledge and skills, commodities (medicines, disposables, reagents) and equipment, and with adequate financing. It also requires an organizational environment that provides the right incentives to providers and users.

In many of the countries with the highest burden of HIV, international migration and domestic movement out of health sector employment contribute to the crisis in human resources. In some of these countries, the crisis is aggravated by civil service hiring caps.

HIV itself contributes to the crisis, as it increases the demand for services and infects and affects health workers. They may be disabled by illness, lost to death or required to spend less time at work and more at home taking care of HIV-infected family members, attending to those family members' usual chores, and attending funerals. Thus, the supply of healthy and productive health workers is reduced.

Working with people living with HIV is labour intensive and can also be emotionally stressful and draining. When there are many HIV-infected people, the demand for services increases. High workloads, poor pay and bad working conditions are added disincentives for health care workers to deal with HIV.

Working in the HIV field may also be unpopular with some health providers because they fear becoming infected with HIV or TB, or because they cannot relate easily to clients with risk behaviours of which they disapprove. The latter is a problem especially in countries with low or concentrated epidemics, where many people living with HIV come from marginalized groups, such as sex workers, injecting drug users, men who have sex with men and prisoners.

The combined results of the above are: first, it may be difficult to motivate health workers to take jobs providing HIV services unless they are provided with special incentives; and, second, there is a severe shortage of skilled health workers in areas with high HIV prevalence.

Despite those challenges, a defining feature of the response to the HIV pandemic has been the ability of communities to mobilize resources to address the impact of HIV and prevent its further spread. Groups of people living with HIV, community- and faith-based organizations, and many others have taken responsibility for advocacy and action. They have learned to play a wide range of roles in the response to HIV, serving as outreach workers, home carers, adherence supporters, providers of psychosocial support, counsellors, and managers. This has led to the creation of entirely new health professions in some countries. It has led to strong momentum in the direction of task shifting and to persuasive calls for recognition and payment for some of the essential services they provide. Their roles are increasingly recognized and institutionalized, and are beginning to transform the debate on universal primary health care from a distant dream to an achievable goal.

### **Summary of recommendations**

To counter difficulties in motivating and retaining health workers, WHO recommends the following actions:

- training additional health workers;
- sensitizing health workers for work with people living with HIV;
- ensuring health workers have access to prevention and other HIV- and TB-related services;
- considering task shifting as a way of retaining existing health workers for as long as possible.

A full package of HIV prevention, treatment and care services should be made available to health workers and their families on a priority basis and should be tailored specifically to their needs. Please also refer to Chapter 1, section 1.2.4.3 for additional information on programmes for health care workers.

In countries with generalized HIV epidemics and health worker shortages, efforts should be made to increase the number and the competence of health care workers. WHO recommends:

- recruiting and training additional health workers;
- ensuring relevant HIV content in pre-service curricula;
- shifting tasks from more- to less-specialized health workers;
- developing in-service training and support for continued learning (including mentoring and continuing medical education).

To retain existing health workers, the following policy changes should be considered:

- instituting codes of practice and ethical guidelines to minimize migration of health workers from low-income to high-income countries;

- reducing the draw of private and NGO-run programmes on workers in public health programmes;
- improving the quality of the workplace, including:
  - establishing occupational health and safety procedures to reduce the risk of contracting HIV and other blood-borne diseases;
  - addressing stress and burnout;
  - guaranteeing job security;
  - prohibiting HIV-related and other forms of discrimination;
  - providing social benefits;
  - adjusting work demands;
  - providing financial incentives;
  - providing non-financial incentives, such as career and training opportunities.

WHO also recommends recognition and support for the vital roles played by people living with HIV, community organizations and lay workers. It recommends that the recognition and support take tangible forms, such as certification of skills in service delivery, and pay. These measures should be integrated into national plans for developing human resources for health and HIV.

**Key resources:**

- 171. Tools for planning and developing human resources for HIV/AIDS and other health services  
[http://www.who.int/hrh/tools/tools\\_planning\\_hr\\_hiv-aids.pdf](http://www.who.int/hrh/tools/tools_planning_hr_hiv-aids.pdf)
- 172. Joint ILO/WHO guidelines on health services and HIV/AIDS  
English: [http://whqlibdoc.who.int/publications/2005/9221175537\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9221175537_eng.pdf)  
French: [http://www.who.int/entity/hiv/pub/prev\\_care/who\\_ilo\\_guidelines\\_fr.pdf](http://www.who.int/entity/hiv/pub/prev_care/who_ilo_guidelines_fr.pdf)  
Spanish: [http://www.who.int/entity/hiv/pub/prev\\_care/who\\_ilo\\_guidelines\\_sp.pdf](http://www.who.int/entity/hiv/pub/prev_care/who_ilo_guidelines_sp.pdf)  
Russian: [http://www.who.int/entity/hiv/pub/guidelines/ilowhoguidelines\\_ru.pdf](http://www.who.int/entity/hiv/pub/guidelines/ilowhoguidelines_ru.pdf)  
Arabic: [http://www.who.int/entity/hiv/pub/guidelines/who\\_ilo\\_guidelines\\_arabic.pdf](http://www.who.int/entity/hiv/pub/guidelines/who_ilo_guidelines_arabic.pdf)  
Chinese: <http://www.who.int/entity/hiv/pub/guidelines/ilowhoguidelineschinese-pdf.pdf>  
Indonesian: [http://www.who.int/entity/hiv/pub/guidelines/who\\_ilo\\_guidelines\\_indonesian.pdf](http://www.who.int/entity/hiv/pub/guidelines/who_ilo_guidelines_indonesian.pdf)  
Vietnamese: [http://www.who.int/entity/hiv/pub/guidelines/who\\_ilo\\_guidelines\\_vietnamese.PDF](http://www.who.int/entity/hiv/pub/guidelines/who_ilo_guidelines_vietnamese.PDF)
- 173. Task-shifting: Treat, train and retain, global recommendations and guidelines  
<http://www.who.int/healthsystems/TTR-TaskShifting.pdf>
- 98. Operations manual for the delivery of HIV prevention, care and treatment at primary health centres in high-prevalence resource-constrained settings  
<http://www.who.int/hiv/capacity/IMA/sharepoint/en>
- 174. IMAI-IMCI task-shifting implementation support brochure  
[http://www.who.int/hiv/pub/imai/IMA\\_IMCI\\_taskshifting\\_brochure.pdf](http://www.who.int/hiv/pub/imai/IMA_IMCI_taskshifting_brochure.pdf)

## 2.3 Medical products and technologies

Many health systems continue to have weak procurement and supply management systems, and the result is frequent stock-outs of antiretroviral drugs, medicines, and other essential commodities, including gloves, needles and testing reagents. Among 66 low- and middle-income countries reporting data on stock-outs of antiretroviral drugs in 2007, 25 experienced one or more stock-out episodes. Globally, 18% of all reporting treatment sites experienced at least one stock-out of antiretroviral drugs, with Africa and Latin America reporting higher stock-out rates than other regions.

Methadone and buprenorphine were added to the WHO list of essential medicines in 2005. These medicines, powerful opioid analgesics used to treat opioid addiction, are controlled substances under the international drug control conventions, and are not sufficiently available in many countries, mainly due to: (1) greatly exaggerated fears of dependence; (2) overly restrictive national drug control policies; and (3) problems in procurement, manufacture, storage and distribution of controlled substances. It is estimated that more than 80% of the world population has no proper access to controlled medications (including opioids and psychoactive substances) due to regulatory barriers, prejudice, and lack of proper information at national and international levels.

Another concern is for the quality, safety and efficacy of the medicines that are available. The supply of good antiretroviral medicines is reasonably well secured by the WHO prequalification scheme, by the US Federal Drug Administration's practice of giving provisional approval to generic medicines, and

by quality standards insisted on by the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, the same is not the case for other essential medicines brought in by a variety of suppliers under the oversight of national regulatory authorities, which face challenges in carrying out their duties.

### **Summary of recommendations**

A well-functioning health system should ensure equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, as well as access to their scientifically sound and cost-effective use. WHO recommends:

- establishing national policies, standards, guidelines and regulations for procurement of drugs and other commodities;
- providing health authorities with information on prices, international trade agreements and capacity to set and negotiate prices;
- ensuring reliable manufacturing practices and quality control for priority products;
- establishing procurement, supply, storage and distribution systems that minimize leakage and other waste;
- providing support for rational use of essential medicines, commodities and equipment through guidelines, strategies and training to ensure enforcement, reduce resistance and maximize patient safety;
- delivering on countries' obligations under UN Conventions to provide access to analgesics and opioids for substitution therapy.

### **Key resources:**

175. AIDS medicines and diagnostics service (AMDS) website  
<http://www.who.int/hiv/amds/>
176. Essential medicines and pharmaceutical policies (EMP) (WHO website)  
<http://www.who.int/medicines/en/>
111. Prequalification programme: A United Nations Programme managed by WHO (WHO website)  
<http://healthtech.who.int/pg/>
177. AIDS medicines and diagnostics service (AMDS): Treat 3 Million by 2005 Initiative technical briefs  
[http://whqlibdoc.who.int/hq/2003/WHO\\_HIV\\_2003.21.pdf](http://whqlibdoc.who.int/hq/2003/WHO_HIV_2003.21.pdf)
178. Global price reporting mechanism (GPRM)  
<http://www.who.int/hiv/amds/gprm/en/index.html>
179. A 'step-by-step' algorithm for the procurement of controlled substances for drug substitution treatment.  
<http://www.unodc.un.or.th/drugsandhiv/publications/2007/Step-by-Step.pdf>
180. Access to controlled medications programme: Framework  
[http://www.who.int/medicines/areas/quality\\_safety/Framework\\_ACMF\\_withcover.pdf](http://www.who.int/medicines/areas/quality_safety/Framework_ACMF_withcover.pdf)

## **2.4 Financing**

After the UN General Assembly's Declaration of Commitment on HIV/AIDS in 2001, funding for the response (including the health sector response) increased sharply each year until it reached an estimated US\$ 10 billion in 2007. However, WHO and UNAIDS estimated that there was still a US\$ 8 billion gap between what was available and what was actually needed to scale up the response to HIV at an acceptable pace. There is a similar gap between available resources and needs for other health priorities. In 2002, the WHO Commission on Macroeconomics and Health recommended that low- and middle-income countries spend a minimum of US\$ 40 per capita on essential health services, but many still spend far less than that amount.<sup>19</sup>

In many countries, the majority of people and governments cannot afford the costs of HIV treatment and care (particularly antiretroviral therapy). In most countries heavily burdened by HIV, sustainable provision of HIV treatment and care will require external funding for the foreseeable future. This would be true even if they increased their domestic funding for the health sector to 15% of national gross domestic product, as many African countries pledged to do in the 2001 Abuja Declaration.<sup>20</sup>

External and domestic government funding for the HIV response has increased considerably, but many people living with HIV still find it difficult to access essential services. Even when drugs are

<sup>19</sup> *Report of the WHO Commission on macroeconomics and health*. Geneva, Fifty-fifth World Health Assembly, 23 April 2002.

<sup>20</sup> Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Disease. Abuja, Nigeria, Organization for African Unity (OAU), 27 April 2001.

provided free of charge, they incur out of pocket expenditures for the treatment and prevention of concurrent diseases and opportunistic infections, laboratory diagnosis, and formal and informal fees. This limits their access to essential services when they are poor, or depend on others to cover their health care costs.

### **Summary of recommendations**

Health systems should raise and secure adequate funds for health in order to ensure people can use services they need and are protected from financial catastrophe or impoverishment because they have to pay for services. In 2005, the World Health Assembly urged its Member States to:<sup>21</sup>

- ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;
- ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that those insured receive equitable and good-quality health services according to their benefits package;
- ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole;
- plan the transition to universal coverage of their citizens in ways that contribute to: meeting the needs of the population for quality health care; reducing poverty; attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration; and achieving health for all.

With regard to access to services for HIV, WHO recommends that countries implement a public health approach to scale-up of services and, also, adopt a policy of free access at the point of service delivery to basic HIV services, including consultation fees, HIV testing and antiretroviral therapy.

### **Key resources:**

181. Costing guidelines for HIV/AIDS intervention strategies  
[http://data.unaids.org/publications/IRC-pub06/JC997-Costing-Guidelines\\_en.pdf](http://data.unaids.org/publications/IRC-pub06/JC997-Costing-Guidelines_en.pdf)
182. Achieving universal health coverage: developing the health financing system  
[http://www.who.int/health\\_financing/documents/pb\\_e\\_05\\_1-universal\\_coverage.pdf](http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf)
183. Health financing policy (WHO website)  
[http://www.who.int/health\\_financing/en/](http://www.who.int/health_financing/en/)
184. WHO discussion paper: The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care  
<http://www.who.int/hiv/pub/advocacy/promotingfreeaccess.pdf>

## **2.5 Leadership and governance**

Good leadership and governance can ensure that strategic policy frameworks exist and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability.

Leaders with consistent messages are needed to: counter stigma and discrimination; support the involvement of people living with HIV in the response to HIV; ensure equity in access to services; deal with the gender dimensions of the epidemic; speed progress towards reducing the gap between resources available and resources required to scale up the response; and achieve the universal access goal. Leaders with consistent messages are also needed to help people envision a better future, and to achieve that future through research and innovation that finds new tools, and new ways of putting them to effective use.

Calls for leadership often seem to be aimed at politicians and others in positions of great power. However, accelerating the response to HIV will also require leadership from business, industry, trade unions, and academic and research institutions. And it will require leadership within neighbourhoods and communities, from community councils, faith-based and other community-based organizations, formal and informal groups, networks of people living with HIV, people vulnerable or at high-risk of infection, youth, and so on. Health workers at all levels have opportunities to play leadership roles and

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<sup>21</sup> Sustainable financing, universal coverage and social health insurance. Geneva, Fifty-eighth World Health Assembly, ninth plenary meeting, 25 May 2005.

use their professional and personal connections to advance the cause of scaling up the response to HIV.

Governance of the response to HIV has evolved considerably over the last few years. It was once dominated by the health sector and led by national AIDS programmes within ministries of health. It then shifted to national AIDS commissions, with representatives from multiple sectors and HIV-related programmes in ministries and other organizations responsible for action in those sectors. In many low- and middle-income countries, UN Theme Groups on AIDS have been established. These groups were originally intended to coordinate the UN system's contribution to national responses to HIV, but they have expanded to include representatives from government, donors, civil society and the private sector, and now seek to harmonize and coordinate action by all of these stakeholders.

When the Global Fund to Fight AIDS, Tuberculosis and Malaria became operational in 2002, it introduced Country Coordinating Mechanisms (CCMs) to foster national ownership and engage government, donors, civil society and the private sector in the response to all three diseases.<sup>22</sup> CCMs are meant to build on already existing mechanisms, such as national AIDS commissions and Expanded UN Theme Groups on AIDS, while also increasing transparency and accountability of financing and implementation of the response to HIV. All of these mechanisms have the potential to make governance more complicated and difficult, and to increase rather than reduce duplication and waste if roles and responsibilities are not clearly defined.

The increasingly complicated governance of the response to HIV may call upon health sector stakeholders to participate in several multisectoral country coordinating mechanisms. Participating is vital to ensure their compliance with and their contributions to application of the 'Three Ones' principles: a) one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; b) one National AIDS Coordinating Authority with a broad based multisectoral mandate; and c) one agreed country level Monitoring and Evaluation System.

In addition, health sector stakeholders are called upon to ensure that health sector HIV interventions are included and given appropriate priority and weight in national AIDS plans and action frameworks, as well as in national health sector plans, medium term expenditure frameworks, and Poverty Reduction Strategy Papers. There are also calls for stakeholders working in other sectors to commit to collaborating with the health sector and to support health-sector HIV interventions.

While participating in all of these mechanisms and processes, health sector stakeholders need to maintain strong and coherent adherence to principles guiding the health sector in its contributions to the response to HIV, including commitment to universal access, respect for human rights, and community involvement in planning, governance, and delivering and monitoring HIV-related services.

These principles should be upheld within the health sector and through regular reviews of policies, legislation and regulations governing different aspects of the epidemic, and any appropriate actions that may arise from such reviews. For example, reviewing legislation that contributes to marginalization of most-at-risk populations might lead to advocating for legislative reform. Reviewing a ministry's workplace policies might lead to promoting and supporting improvement of those policies. Other areas calling for attention include legislation or government regulations pertaining to the confidentiality of medical records. Regulations governing the health workforce, for example shifting certain tasks, need also to be reviewed.

### **Summary of recommendations**

Effective leadership in HIV creates momentum for and provides oversight of the HIV response. It is defined both by its actions and by its outcomes. Leadership should create an environment that accelerates scale-up of the HIV response, defines the values and principles that should underlie the process, holds the different stakeholders accountable, and supports innovation to maximize the impact of the interventions.

Among the outputs that should be expected of leadership are development, implementation and adaptation of Strategic Policy Frameworks (discussed in Chapter 3), policies, legislation and regulations that create a favourable environment for an effective response to HIV, coalitions and partnerships that contribute to a better response, and new and more effective interventions.

To promote and support effective coordination, health sector stakeholders should participate in and liaise regularly with key country mechanisms that have a coordination function, such as National AIDS

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<sup>22</sup> More information available at: <http://www.theglobalfund.org/en/apply/mechanisms/>

Councils/Commissions, CCMs, UN Theme Groups and donor forums. They should also secure commitment of stakeholders from other sectors to actively participate in and commit to development and implementation of the response to HIV. For the health sector, establishing and strengthening coalitions and partnerships with a range of stakeholders (e.g. non-governmental, community-based and faith based organizations, people living with HIV, marginalized groups, academic institutions, and the private sector) are critical to scaling up to universal access.

Leadership should also support innovation and foster an environment that promotes human rights, including gender equality, women's empowerment, and the reduction of stigma and discrimination.

**Key resources:**

185. The Global Fund country coordinating mechanisms (CCMs) website  
<http://www.theglobalfund.org/en/apply/mechanisms/>
186. 'Three ones' key principles: Coordination of national responses to HIV/AIDS: Guiding principles for national authorities and their partners  
[http://data.unaids.org/UNA-docs/Three-Ones\\_KeyPrinciples\\_en.pdf](http://data.unaids.org/UNA-docs/Three-Ones_KeyPrinciples_en.pdf)
187. WHO's global health sector strategy for HIV/AIDS 2003-2007  
[http://www.who.int/hiv/pub/advocacy/GHSS\\_E.pdf](http://www.who.int/hiv/pub/advocacy/GHSS_E.pdf)
188. International guidelines on HIV/AIDS and human rights: 2006 consolidated version  
[http://whqlibdoc.who.int/unaid/2006/9211541689\\_eng.pdf](http://whqlibdoc.who.int/unaid/2006/9211541689_eng.pdf)
189. Ensuring equitable access to antiretroviral treatment for women: WHO/UNAIDS policy statement  
[http://www.who.int/hiv/pub/advocacy/en/policy%20statement\\_gwh.pdf](http://www.who.int/hiv/pub/advocacy/en/policy%20statement_gwh.pdf)
190. The Sydney Declaration: good research drives good policy and programming - a call to scale up research  
<http://www.iasociety.org/Default.aspx?pageld=63>

## 2.5.1 Coalition building and partnerships

For the health sector, building coalitions and partnerships with a range of stakeholders is critical to scaling up towards universal access.

### 2.5.1.1 Involving people living with HIV

People living with HIV (PLHIV) are a vital resource in the response to the epidemic. The involvement of PLHIV in advocacy efforts, in policy dialogue, in service delivery, and in the effort to reduce stigma and discrimination has already been documented extensively. Innovative mechanisms have been developed to involve them in HIV-related services, e.g. on clinical teams, as links with communities, and as community health workers. People living with HIV can also serve as expert patients and trainers.

Integrated Management of Adolescent and Adult Illness (IMAI), a WHO-organized initiative, provides tools to support the involvement of PLHIV in clinical teams; they serve as triage officers and lay counsellors who support HIV testing, adherence to ART and TB treatment, and infant feeding, as well as data clerks, laboratory assistants and links to community support services. To be effective in these roles, PLHIV require training, appropriate supervision and remuneration. In many countries, there are policy constraints that prevent PLHIV from taking on these roles, and these constraints need to be addressed.

**Summary of recommendations**

WHO and UNAIDS believe the **meaningful involvement of people living with HIV** is central to an effective, rights-based HIV response. They should be engaged in all aspects of planning, implementing, monitoring and evaluating health sector responses to HIV at global, regional, national and local levels; this includes the development and adaptation of normative policies, tools and guidelines, and the delivery of services.

**Key resources:**

162. Preparing for treatment programme (WHO website)  
<http://www.who.int/3by5/partners/ptp/en/>
191. The greater involvement of people living with HIV (GIPA): UNAIDS policy brief  
[http://data.unaids.org/pub/BriefingNote/2007/JC1299\\_Policy\\_Brief\\_GIPA.pdf](http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf)
192. IMAI expert patient-trainer curriculum  
<http://www.who.int/hiv/capacity/IMAISHarepoint/en>

### 2.5.1.2 Involving civil society and the private sector

Governments, particularly ministries of health, may take overall responsibility for health sector responses to HIV. However, an effective and comprehensive response that ensures equitable access to HIV services demands the active involvement of the private sector and civil society, as well as nongovernmental, faith-based and academic organizations.

Community mobilization is key to promoting HIV testing and counselling and prevention, to preparing people for treatment, and to providing adherence support. Civil society organizations complement and supplement formal health services by playing key roles in: HIV education and prevention, especially in reaching most-at-risk populations; creating demand for HIV services; ensuring that HIV/AIDS services are acceptable and of good quality; preparing people for treatment through information and education; supporting adherence to treatment; and providing other forms of prevention, care and support. These roles need to be reinforced as much as possible through providing adequate resources for community-health activities, and building strong links between health services and community organizations. Academic institutions have an important role in capacity-building, adapting guidelines and tools for local use, supporting operational research, and providing technical assistance.

In many countries, health services (including those related to HIV) are largely provided by faith-based organizations, NGOs and private businesses, rather than by governments. It is important to include them from any key mechanisms or processes for planning, coordinating, financing, monitoring and evaluating the overall response to HIV.

#### **Summary of recommendations**

National health sector strategies and plans should call for the active and meaningful engagement of civil society, NGOs, faith-based organizations, private businesses, and academic institutions in strategic planning, programme development, implementation, and monitoring and evaluation. These non-government players often constitute a significant portion of all health care providers, and can play critical roles in expanding access to services, particularly for most-at-risk, vulnerable and marginalized populations.

There should be country mechanisms to ensure that all providers of HIV-related services in the health sector meet minimum standards.

Appropriate referral and communication systems should be established or expanded and strengthened to ensure continuity of care and services across the different sectors and service providers.

#### **Key resources:**

193. WHO's stakeholder analysis tool  
<http://www.who.int/hac/techguidance/training/stakeholder%20analysis%20ppt.pdf>
194. Scaling up effective partnerships: A guide to working with faith-based organisations in the response to HIV and AIDS  
<http://www.e-alliance.ch/media/media-6695.pdf>
195. Partnership work: the health service–community interface for the prevention, care and treatment of HIV/AIDS  
[http://www.who.int/hiv/pub/prev\\_care/en/37564\\_OMS\\_interieur.pdf](http://www.who.int/hiv/pub/prev_care/en/37564_OMS_interieur.pdf)
196. Working with civil society (UNAIDS website)  
<http://www.unaids.org/en/Partnerships/Civil+society/default.asp>
197. Universal access targets and civil society organizations: a briefing for civil society organizations  
[http://www.unaids.org/unaidresources/images/Partnerships/061126\\_CSTargetsetting\\_en.pdf](http://www.unaids.org/unaidresources/images/Partnerships/061126_CSTargetsetting_en.pdf)

### 2.5.2 Addressing stigma and discrimination

HIV-related stigma and discrimination are often prevalent within health services and have been consistently identified as critical obstacles to provision and uptake of health sector interventions. Stigma or, more correctly, stigmatization devalues people because of their traits, behaviours or illnesses, and it is often followed by unfair and unjust treatment. Stigma results in lower uptake of HIV prevention, care and treatment services and makes people living with HIV reluctant to disclose their status to their sexual partners, family members and health care providers. It disproportionately affects women and girls (who are often devalued merely because of their gender), sex workers, men who have sex with men, injecting drug users and ethnic minorities, whose minority status may be due to the fact that they are displaced persons or migrants.

Though stigma and discrimination are often pervasive throughout societies, they are seldom adequately addressed in national responses to HIV. Both can be tackled through simple and practical

measures within a health system, such as providing people with accurate information that allays their fears and dispels their misconceptions about HIV and its transmission. The health sector can also advocate for and play its part in implementing a multifaceted national approach to combating stigma and discrimination. In order to reduce stigma and discrimination in health facilities, health workers' attitudes and practices need to be addressed, and they should be given information and supplies to prevent occupational exposure to HIV. These efforts will help countries reach targets for universal access while promoting respect for human rights, for vulnerable minorities, and for people living with HIV.

### **Summary of recommendations**

Strategic information about stigma and discrimination should be systematically collected using existing tools (e.g. questionnaires used in behavioural surveillance) to measure their prevalence and impact on the response to HIV.

Efforts to reduce stigma and discrimination should be included in national strategic planning and programming activities.

Health care workers should be provided with training on non-discrimination, and codes of conduct and oversight for service providers should be established.

As they scale up national responses to stigma and discrimination (and thus access to HIV prevention, treatment and care), planners should employ a range of approaches to prevent and reduce stigma and discrimination among different key groups (politicians, religious leaders, health authorities, law enforcers and so on). In this way, they can challenge stigma and discrimination in institutional settings and build capacity for recognizing human rights, including the establishment and enforcement of human-rights legislation.

### **Key resources:**

188. International guidelines on HIV/AIDS and human rights: 2006 consolidated version  
[http://whqlibdoc.who.int/unaid/2006/9211541689\\_eng.pdf](http://whqlibdoc.who.int/unaid/2006/9211541689_eng.pdf)
198. Reducing HIV stigma and discrimination: a critical part of national AIDS programmes  
[http://data.unaids.org/pub/Report/2008/jc1420-stigmadiscrimi\\_en.pdf](http://data.unaids.org/pub/Report/2008/jc1420-stigmadiscrimi_en.pdf)

## **2.5.3 Delivering gender-responsive HIV interventions**

Gender inequalities are a key driver of the HIV epidemic. Gender inequalities make women and girls especially, but also men, vulnerable to HIV in several ways. In sub-Saharan Africa, women constitute 60% of people living with HIV and in other parts of the world women continue to be disproportionately affected as sex workers, injecting drug users, and as partners of injecting drug users, men who have sex with men, and clients of sex workers. Harmful gender norms and practices such as violence against women, and denial of women's access to and control over resources, contribute to women and girls' vulnerability to HIV. Social norms related to masculinity encourage men to take sexual risks. These norms also contribute to homophobia, which stigmatizes men who have sex with men. Norms related to femininity discourage women, especially young women, from accessing sexual and reproductive health information and services.

In many settings, women and girls face barriers to HIV services because they lack the financial means to access care or they require permission from their husbands or other family members to go to a health care facility. In some cases, they may be afraid of being labelled as 'promiscuous' if they are seen to seek services for STIs or HIV. Health services can reinforce gender inequalities by stigmatizing those who seek HIV services, especially if they belong to marginalized groups. Violence or fear of violence prevents many women from negotiating safe sex and also from accessing HIV testing and counselling services or disclosing their status. For these reasons, achieving universal access to HIV prevention, treatment and care is contingent on the health sector taking action to reduce gender inequalities.<sup>23</sup>

### **Summary of recommendations**

'Know your epidemic in gender terms': Programme managers and policy-makers in the health sector should understand who is at risk for HIV in different epidemic settings, and the underlying sociocultural, economic and political factors that increase their vulnerability. Knowing your epidemic in gender terms requires disaggregating data, including figures from programme monitoring and

<sup>23</sup> United Nations. Scaling up HIV prevention, treatment, care and support. Note by the Secretary-General. 24 March 2006

evaluation (by sex, age and other appropriate equity parameters) in order to identify who is at risk, whether they are being reached equitably, and whether programmes are working for those most in need.

Build the capacity of programme managers, policy-makers and health care providers to understand and address the links between gender inequalities and HIV.

Ensure that national health sector HIV policies and programmes explicitly integrate gender and allocate financial and human resources to promote gender-responsive strategies.

Support prevention by promoting equality between women and men in sexual decision-making and building women's skills to negotiate safer sex including through use of female and male condoms.

Address women's fear of, or potential experience of, negative consequences of HIV testing and counselling, by incorporating safety planning as part of disclosure and risk-reduction counselling.

Reduce gender-related barriers to accessing services, including: non-affordability; the need for women to obtain permission from husbands or other family members to go to a health facility; stigma and discrimination against those most-at-risk for or living with HIV including marginalized groups; and providing an appropriate mix of male and female health care providers.

Support women care givers who provide the bulk of care for those living with and affected by HIV.

Advocate for gender equality in policies and laws related to women's rights, including those related to violence against women, property and inheritance rights for women, and access to education for girls.

**Key resources:**

199. Integrating gender into HIV/AIDS programmes: A review paper  
[http://www.who.int/hiv/pub/prev\\_care/en/IntegratingGender.pdf](http://www.who.int/hiv/pub/prev_care/en/IntegratingGender.pdf)  
Webpage: [http://www.who.int/gender/hiv\\_aids/en/](http://www.who.int/gender/hiv_aids/en/)
200. Integrating gender into HIV/AIDS programmes in the health sector: operational tool to improve responsiveness to women's needs  
Forthcoming in 2009
201. Addressing violence against women and HIV testing and counselling: a meeting report  
[http://www.who.int/gender/documents/VCT\\_addressing\\_violence.pdf](http://www.who.int/gender/documents/VCT_addressing_violence.pdf)
189. Ensuring equitable access to antiretroviral treatment for women: WHO/UNAIDS policy statement  
[http://www.who.int/hiv/pub/advocacy/en/policy%20statement\\_gwh.pdf](http://www.who.int/hiv/pub/advocacy/en/policy%20statement_gwh.pdf)