

4 Operationalizing the health sector response

4.1 Operational management

HIV/AIDS programmes require regular review and update. A systematic review and update process should include: situation analysis, strategic re-planning at the national level every few years, annual or biannual implementation planning, ongoing management of implementation, and ongoing monitoring and evaluation.

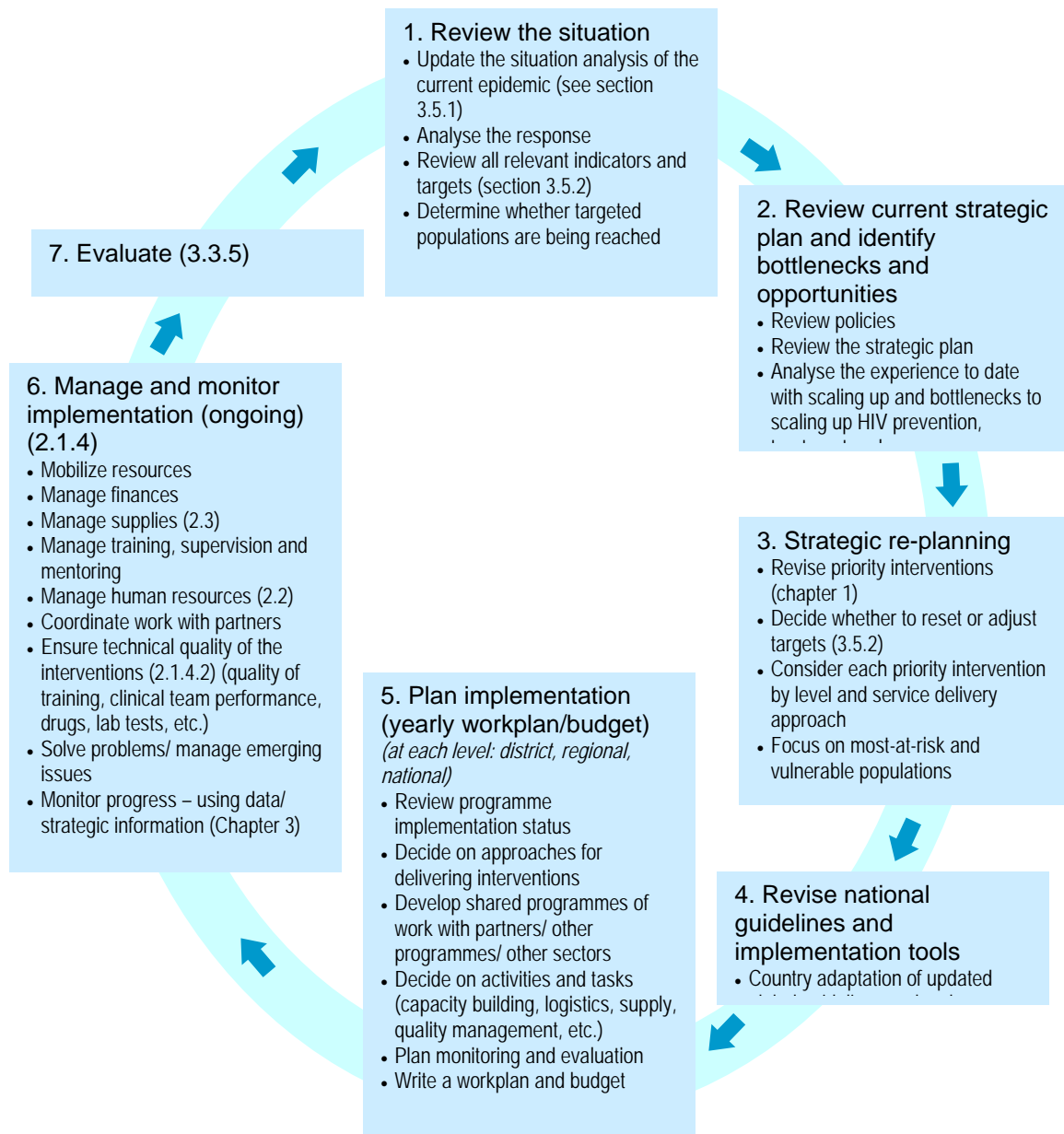
Figure 2 illustrates the cycle of review, strategic re-planning, and implementation planning and management. The content of most of these steps has already been outlined in the discussion in Chapters 2 and 3. This chapter focuses on some of the more critical aspects of the review and update cycle, including those that require careful attention as countries scale up their response to the HIV epidemic. In particular, it highlights the importance of: strategic re-planning; spotting bottlenecks to service delivery; and approaches to overcome these bottlenecks. Thereafter, the chapter addresses key factors in prioritizing interventions and in service delivery within specific epidemic settings.

4.2 Strategic review and re-planning

Twenty-five years of responding to HIV have yielded many lessons. Today, it is well-known that an effective response requires the cooperation of many levels of government and many sectors of society. At all levels and in all of sectors, there has been an impressive accumulation of experience. Lessons learned from these successes and failures have led to a better understanding of how to design and deliver services that achieve their intended results, while making efficient use of available resources. To build on this experience, partners in each country's health-sector response to HIV should collaborate on developing a coherent and realistic health-sector strategic plan and on strengthening management capacity to support its operationalization.

Decisions over which interventions to include in the national HIV/AIDS programme are usually made during strategic planning, as are decisions about how to prioritize the interventions so that available resources can be allocated accordingly. Most disease control programmes do this every five years or so. However, strategic re-planning of the HIV response often occurs more frequently in order to respond to the changing situation in a country, including the changing shape of the epidemic (see section 3.5.1 on situation analysis), and to take advantage of emerging knowledge about effective interventions and new funding opportunities. Regardless of how quickly the strategic planning review and update cycle evolve, they should involve all key service providers (in government, civil society and the private sector), and all key service recipients (people living with HIV, those most-at-risk of infection and those made vulnerable by gender, age or other characteristics).

Figure 2. Strategic and implementation planning and management cycle



4.2.1 Overcoming bottlenecks

Strategic re-planning requires the identification of any bottlenecks preventing scale-up of the HIV response, the analysis of these bottlenecks, and the formulation of strategies for overcoming them. In most countries where scale-up is occurring, critical and usually long-standing weaknesses in health care systems are the main bottlenecks. These bottlenecks commonly occur in the following areas:²⁴

- human resources: availability, skills, motivation, mobilization, effective and efficient use, payment levels, and management;
- managing and coordinating services: management capacity at all levels (local to national) for health-sector policy development, coordination of multiple partners, and handling relations with non-health-sector participants;
- laboratory capacity;
- physical infrastructure;
- information and monitoring systems;
- drug and diagnostic procurement and supply chain management;
- financing: adequacy of amounts, speed of disbursement, rules and procedures that may limit access or contribute to poverty;
- referral and coordination between different elements of the health system;
- guidelines and operating procedures;
- community capacity for care;
- transport and communications;
- legal, regulatory and policy frameworks;
- stigma and discrimination within health services.

The nature and severity of bottlenecks vary between and within countries, and from location to location. Bottlenecks in the areas of financing and human resources are often the root cause of many other obstacles.

The steps necessary to overcome bottlenecks are often inter-linked and mutually reinforcing, and they consist largely of the actions outlined in Chapter 2. Well-organized districts appear to perform better and adapt to constrained environments, underscoring the fundamental importance of leadership and management capacity at this level.²⁵ Lack of management and logistical capacity in health facilities and at national, regional and district levels are increasingly recognized as critical bottlenecks. Despite increasing availability of HIV funding, these bottlenecks often result in slow and irregular disbursement of funding to front-line service providers.

Remaining focused on priority interventions and on effective coordination of all health-sector activities can become even more challenging when increasing numbers of new partners become involved in delivering HIV services. Though new partners may have helped overcome old bottlenecks, they may also create new ones. For example, new partners may create parallel systems that introduce new inefficiencies, focus disproportionate shares of resources on interventions that are not of highest priority, or exacerbate weaknesses in health system management by offering better paid positions to good managers. These examples illustrate the importance of: strengthening coordination among all partners in the response to HIV; strengthening management throughout the health system; and responding to new circumstances during the strategic re-planning phase. At this time in the epidemic, strategic re-planning also requires moving from an emergency to a long-term perspective, while keeping abreast of emerging issues.

Attempts to scale up rapidly often result in substantial investment in training that is not adequately matched by post-training supervision, mentoring and quality management. Lack of standard operating procedures (e.g. in clinical care, laboratory services or supply management) is another common bottleneck during rapid scale-up, particularly as decentralization calls for preparation of hundreds of health-centre teams (compared to dozens of sites when ART stopped at hospital level). Without good

²⁴ Derived from several analyses of constraints to GFATM grant implementation (2006); country priorities in GFATM round 5 health system strengthening proposals; PEPFAR assessment reports.

²⁵ Alleviating system wide barriers to immunization: issues and conclusions from the second GAVI consultation with country representatives and global partners. Oslo, Norway, 7–8 October 2004. The Global Alliance for Vaccines and Immunization, Geneva, Switzerland. Available at: http://www.gavialliance.org/resources/14brd_allev_sys_barriers.pdf

coordination and standard operating procedures, there is a potential for many parallel systems and tools, duplication and waste, and poor sustainability.

Finally, restrictive policies, laws or regulations may be very serious bottlenecks limiting the types of services that can be delivered (e.g. harm reduction and outreach to most-at-risk populations), and preventing the optimal use of human and other resources (e.g. by task shifting).

Key resources:

230. Guidelines for conducting a review of the health sector response to HIV/AIDS
http://www.searo.who.int/LinkFiles/Publications_HealthSectorResponse-AIDS-2008.pdf
231. The Global Fund strategic approach to health systems strengthening: Report from WHO to the Global Fund secretariat
http://www.who.int/healthsystems/GF_strategic_approach_%20HS.pdf

4.2.2 Responding to controversial, sensitive and emerging issues

HIV/AIDS programmes operate in a dynamic environment that can present significant challenges to programme managers. For example:

- Their decisions have important, often wide ranging consequences for the health and welfare of populations.
- They often deal with controversial and sensitive topics, such as sex, drugs, morality and culture.
- They attract much interest from the media, and often trigger debate in communities.
- They rely on cooperation between a wide range of sectors and groups, not health alone, and need to actively engage affected communities.
- They have to deal with a wide range of competing interests and lobby groups that often have financial interests.
- They have to be aware of debates, nationally and internationally, about HIV/AIDS.
- In light of rapid and frequent advances in knowledge and evidence, they need to regularly review, reflect and change approaches or priorities.

This dynamic environment requires a range of leadership qualities, as well as good management and communication skills. It also requires being 'on top of things' with the latest strategic information, emerging knowledge, and best international practice. A review and update cycle should take into account changes in strategic direction, normative tools and guidelines, and the priority package of interventions.

Keeping on top of things requires appropriate consultation mechanisms, including technical and community advisory groups. WHO will continue to contribute by keeping this document up to date so that it presents the most recent normative guidelines and tools.

4.3 Planning and managing implementation

Implementation planning, or operational planning as it is more often called, needs to occur even more frequently than strategic planning, and it should be followed up with continuous monitoring to ensure activities take place as planned. Increasingly, operational planning and management are decentralized from national to sub-national levels, and may take place largely at a district level, but also reach down to the community and local facility levels. Operational plans should be closely linked to and aligned with national strategic plans, since they are the means for implementing them.

Operational plans should support consistent progress towards universal access, so that a comprehensive package of high quality HIV prevention, treatment and care reaches ever more people—in particular, the increasing numbers of people living with HIV, and those most-at-risk of infection or vulnerable because of gender, youth, poverty, ethnicity, imprisonment, or other characteristics and circumstances. Good operational planning will often involve combining several service delivery models, and active collaboration among service providers from government, NGOs, faith-based organizations and the private sector.

Good operational plans describe in detail how implementation will take place on the ground. This includes: identifying which service providers will offer which services, and to whom; determining how available resources will be allocated among all providers and services; covering each service and

integrated service package by level of care; and specifying plans and activities to ensure that appropriately skilled human resources, logistical support, and strategic information will be available.

4.4 Planning for low-level epidemics

In low-prevalence settings, it is particularly important to focus on implementing effective prevention programmes so that HIV incidence remains low, and then defining the minimum package of services that will be available at each level of the health system.

Serological and behavioural surveillance of HIV and sexually transmitted infections is particularly important. It provides the data on which to base estimates of size and geographical location of populations living with HIV, or those most at risk of infection. It also provides data on the behaviours that may have resulted in HIV infection or could result in new infection. This information should guide planning, with priority given to populations and geographical locations where people are most at risk of transmitting infection or becoming newly infected. Priority should also be given to interventions targeting particular behaviours.

In low-level epidemics, sexually transmitted infections are sensitive markers of high-risk sexual activity. Monitoring STI rates can help identify HIV vulnerability and also help evaluate the success of prevention programmes. In addition, early diagnosis and treatment of STIs will decrease their related morbidity and the likelihood of HIV transmission. STI services are a critical entry point for HIV prevention in low-level epidemics.

4.4.1 Prevention services

Targeting most-at-risk populations with HIV/AIDS programmes and services is an efficient way of responding to HIV in all epidemic situations, but it should be the key strategy for scaling up HIV prevention, treatment and care in low-level epidemics.

Targeted interventions are aimed at offering services to specific populations within the general population. They are also aimed at geographical locations where those specific populations are most likely to be found, so that they can be given the information, skills and tools (e.g. condoms, water based lubricants, safe injection equipment) that will minimize the risk of HIV transmission, as well as access to HIV treatment and care services. The best-designed HIV/AIDS programmes also improve sexual and reproductive health and well-being among these populations, and address general health concerns by reducing the harm associated with practices such as female and male sex work and injecting drug use.

Successful targeted interventions do not stigmatize populations at risk; they respect their rights and endeavour to protect them. In low-level epidemics, targeted interventions optimize the use of resources by focusing on the people and places where risk is greatest and where access to HIV prevention, treatment and care is most needed.

Even in low-level epidemics, interventions to prevent HIV transmission in health facilities must ensure safe blood transfusion, and provide infection control measures, standard precautions and safe injections. Client-initiated testing and counselling (CITC) should be available, and provider-initiated testing and counselling (PITC) may also be considered in STI and TB services, services for most-at-risk populations, and antenatal, childbirth and postpartum health. Essential interventions for HIV prevention and care, as well as antiretroviral therapy, should be provided for people living with HIV. However, some of these interventions can be offered in fewer facilities, depending on health system capacity and resources. **Table 9** outlines priority health-sector interventions by level of the health system appropriate for a low-level epidemic setting.

Key resource:

232. National AIDS programme management: A set of training modules
http://www.searo.who.int/en/Section10/Section18/Section356_13495.htm
Preliminary pages: http://www.searo.who.int/LinkFiles/Publications_Preliminary_pages.pdf
Introduction: http://www.searo.who.int/LinkFiles/Publications_Introduction.pdf
Module 1 – Situation analysis: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_1.pdf
Module 2 – Policy and planning: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_2.pdf
Module 3 – Determining programme priorities and approaches: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_3.pdf
Module 4 – Targeted HIV prevention and care interventions: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_4.pdf
Module 5 – Setting coverage targets and choosing key outcome indicators:
http://www.searo.who.int/LinkFiles/Publications_NAP_Module_5.pdf
Module 6.1 – Minimizing sexual transmission of HIV and other STIs: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.1.pdf

Module 6.2 – HIV prevention and care among drug users: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.2.pdf
 Module 6.3 – HIV counseling and testing: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.3.pdf
 Module 6.4 – The continuum of care for people living with HIV/AIDS and access to antiretroviral therapy: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.4.pdf
 Module 6.5 – Prevention of mother-to-child transmission: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.5.pdf
 Module 6.6 – Prevention of HIV transmission through blood: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.6.pdf
 Module 7 – Managing the AIDS programme: http://www.searo.who.int/LinkFiles/Publications_NAP_Module7.pdf
 Module 8 – Management systems for the AIDS programme: http://www.searo.who.int/LinkFiles/Publications_NAP_Module8.pdf
 Module 9 – Strategic information: http://www.searo.who.int/LinkFiles/Publications_NAP_Module9.pdf

4.4.2 Treatment and care services

In low-level epidemics, scale-up of HIV treatment and care services is more likely to be concentrated at provincial or regional hospitals, with some private service providers increasing access to these services. Developing special treatment and care facilities to cater to the particular needs of extremely marginalized high-risk groups—such as injecting drug users—may also be appropriate. In any case, when these services are provided in only a few facilities, a well performing system of referrals is critical. It is also important to create services that promote patient self-management, home- and community-based care, and mutual support by networks of people living with HIV.

Clinical teams that support self-management and involve expert patients on those teams are basic tenets of good chronic care in any epidemic setting. However, some community-based services may not be resource-efficient in low prevalence settings. Components of chronic HIV care may be decentralized to health centres over time, given the well-known advantages of an integrated primary care approach close to home for adherence, community support and quality of life.

Key resources:

136. IMAI general principles of good chronic care
 English: <http://www.who.int/hiv/pub/imai/generalprinciples082004.pdf>
 French: http://www.who.int/hiv/pub/imai/imai_general_2008_fr.pdf
232. National AIDS programme management: A set of training modules
http://www.searo.who.int/en/Section10/Section18/Section356_13495.htm
 Preliminary pages: http://www.searo.who.int/LinkFiles/Publications_Preliminary_pages.pdf
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 Module 3 – Determining programme priorities and approaches: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_3.pdf
 Module 4 – Targeted HIV prevention and care interventions: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_4.pdf
 Module 5 – Setting coverage targets and choosing key outcome indicators: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_5.pdf
 Module 6.1 – Minimizing sexual transmission of HIV and other STIs: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.1.pdf
 Module 6.2 – HIV prevention and care among drug users: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.2.pdf
 Module 6.3 – HIV counseling and testing: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.3.pdf
 Module 6.4 – The continuum of care for people living with HIV/AIDS and access to antiretroviral therapy: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.4.pdf
 Module 6.5 – Prevention of mother-to-child transmission: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.5.pdf
 Module 6.6 – Prevention of HIV transmission through blood: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.6.pdf
 Module 7 – Managing the AIDS programme: http://www.searo.who.int/LinkFiles/Publications_NAP_Module7.pdf
 Module 8 – Management systems for the AIDS programme: http://www.searo.who.int/LinkFiles/Publications_NAP_Module8.pdf
 Module 9 – Strategic information: http://www.searo.who.int/LinkFiles/Publications_NAP_Module9.pdf

4.4.3 Considerations for middle-income countries

In middle-income countries, determining the prioritized set of HIV interventions by level of the health system will involve significant emphasis on containing a rapid escalation in health- service costs. In these settings, it is important to 'stick to the essentials', emphasizing high quality delivery of the selected priority interventions.

Table 9. Example: priority health sector interventions by level of health system in low-level epidemic

	Outreach to most-at-risk populations (MARP)	Community and home-based delivery of interventions	Primary care: at health centre or outpatient clinics (at district hospital) or private providers	District hospital: second level referral care; inpatient care	Regional or central hospital/ specialist physicians, paediatricians
Increasing knowledge of HIV sero-status	Outreach HIV testing and counselling	CITC	CITC: at health facility PITC: • Antenatal PITC • Family and partner testing	<i>As to left, plus:</i> • Blood donor HIV testing and counselling • PITC for HIV-exposed infants • PITC before post-exposure prophylaxis (PEP) • Resolve discordant results	Perform virological tests on dried blood spot and send back results
Prevention of HIV transmission	HIV prevention outreach to most at-risk populations (e.g. sex workers, drug users, men who have sex with men), and vulnerable populations (e.g. migrants, mobile populations) including: • Peer-based information and education • Provision and exchange of sterile needles and syringes • Condom promotion and programming, including 100% condom promotion campaigns • Targeted STI and sexual and reproductive health services, particularly for vulnerable girls and women • Referral to specific prevention services	Community prevention literacy Peer support for prevention with people living with HIV. Pharmacy programmes for needle and syringe access • Community family planning If HIV-positive mothers in the community: • Mother-to-mother support for PMTCT • Infant feeding support, and replacement feeding if AFASS	Prevent sexual transmission of HIV • Condom promotion, provision to prevent STIs in MARP • Detect and manage STI • Safer sex, risk reduction counselling (as at hospital depending on people living with HIV client population) • Special, friendly clinical services for sex workers, men who have sex with men Prevent HIV infection through IDU: comprehensive harm reduction including: • Patient information, education • Sterile needle, syringe provision • Drug dependence treatment (including opioid substitution treatment) Prevent infection in infants, young children: • Family planning • ARV prophylaxis for PMTCT • Care, support for pregnant women • Infant feeding counselling and support Prevent transmission in health-care settings, including: • Infection control, standard precautions • Safe injections • Safe medical waste management • Occupational health of health workers • Post-exposure prophylaxis	<i>As to left, plus:</i> • Manage STI treatment failures Prevention with people living with HIV: • Discordant couples risk reduction • Counsel on continued possibility of HIV transmission on ART, • Condom promotion and provision • Counselling on sexual health, return to sexuality and fertility, reproductive choices • Counsel on substance use and relationship to risky behaviour • Brief interventions for harmful or hazardous alcohol use PMTCT: ART for eligible women; support for complications on ART/AZT prophylaxis Safe blood	Safe blood

HIV-AIDS treatment and care	Outreach to most-at-risk populations (MARP)	Community and home-based delivery of interventions	Primary care: at health centre or outpatient clinics (at district hospital) or private providers	District hospital: second level referral care; inpatient care	Regional or central hospital/ specialist physicians, paediatricians
	Interventions delivered through outreach to most-at-risk populations (in partnership with other sectors) Integration of treatment support for antiretroviral therapy, TB treatment and prophylaxis in outreach services	Home-based care: Palliative care	<p>Prevent illness:</p> <ul style="list-style-type: none"> • Cotrimoxazole prophylaxis • Vaccination • Nutritional care and support • Education: safe water, hygiene, sanitation <p>Clinical care/ manage opportunistic infections and co-morbidities:</p> <ul style="list-style-type: none"> • Primary care for pneumonia, fever/ malaria, diarrhoea, malnutrition, other common conditions • Mental health, psychosocial support • Back up palliative care at home, symptom management <p>TB prevention, diagnosis, treatment:</p> <ul style="list-style-type: none"> • Intensified casefinding TB • TB infection control • Isoniazid preventive therapy • Diagnose, start, follow TB treatment 	<p>As to left, plus:</p> <p>ART:</p> <ul style="list-style-type: none"> • Adherence preparation, support • Recommend or initiate first-line regimens • Monitor, adjust dose • Clinical, CD4, limited laboratory monitoring • Support patient self-management • Diagnose treatment failure (under supervision clinical mentor) • Manage serious complications of ART <p>HIV care:</p> <ul style="list-style-type: none"> • Assess and manage severe opportunistic infections • Inpatient care • Manage severe malnutrition • TB-ART co-treatment plan • TB-HIV co-management 	<p>Second-line ART</p> <p>Clinical mentor for district clinicians</p> <p>Management of uncommon and certain severe opportunistic infections, ART toxicities, oncology</p>
AFASS ART ARV	acceptable, feasible, affordable, sustainable and safe antiretroviral therapy antiretroviral	AZT CITC IDU	Azidothymidine, Zidovudine Client initiated testing and counselling injecting drug use	MARP PITC PMTCT STI	most at risk populations provider initiated testing and counselling prevention of mother to child transmission sexually transmitted infections

4.5 Planning for concentrated epidemics

4.5.1 Targeted interventions and service delivery models

See sections 1.2.1.6 and 4.4.1 for a discussion of targeted interventions. The discussion begins there, but targeted interventions are also the key strategy for scaling up HIV prevention, treatment and care in concentrated epidemic settings. Targeted interventions:

- are for people within the community who are most at risk of HIV infection;
- are located in settings where risk behaviours and HIV transmission are concentrated;
- are adapted to be culturally and socially appropriate for the target population;
- effectively use the language and culture of the people being targeted;
- focus on where limited resources can be used to best advantage;
- acknowledge that barriers to accessing health-care services exist for some populations within communities;
- recognize that people who are at risk of HIV transmission are often marginalized from the broader community, and are experiencing stigma and discrimination.

In many countries experiencing concentrated epidemics, a continuum-of-care network revolving around a range of linked services is the preferred model for implementing HIV treatment and care. Client-Initiated Testing and Counselling serves as an entry point, supplemented by PITC and entry from TB clinics, general health services, NGOs and outreach to most-at-risk populations. Private practitioners clearly linked with HIV care services often follow up all those identified as being HIV positive.

4.5.2 Understanding most-at-risk populations (MARPs)

It is important to remember that most-at-risk populations, such as sex workers and men who have sex with men, are not homogeneous. For example, there are many different types of sex workers with varying levels of HIV risk and of access to health services. The same can be said of other most-at-risk populations. Some men who have sex with men, for example, adopt a cultural identity associated with this behaviour, and join community groups and frequent venues where other men who have sex with men congregate. Others may not identify or socialize with this community and may have female partners on a long- or short-term basis. Having a detailed understanding of most-at-risk populations, especially those hardest to reach, is critical for programme planning purposes, and assists in the prioritizing of interventions for service delivery.

4.5.3 Priority focused interventions and delivery approaches

Targeted interventions take many forms; selecting the right intervention depends on the degree of marginalization of the group being targeted, the availability of other services, and the capacity of the focus population to participate in or lead the design and implementation of services. In many concentrated HIV epidemics, the populations that require priority interventions are sex workers, men who have sex with men, transgender people, drug users (particularly injecting drug users) and prisoners. Sometimes it is necessary to target other populations (such as minority, ethnic and displaced, mobile or migrant populations) that do not have the same access to health information and services as the general population.

Selecting the most appropriate service delivery models for promoting and distributing prevention commodities, and securing entry into care and treatment, involves ensuring that condoms, sterile needles and syringes are available through outreach workers and outlets in venues accessible and acceptable to the target population. The design of HIV messaging also needs to be relevant to a specific population, using language that they understand and that best suits their educational needs. Several suitable service delivery models exist.

Outreach: This approach involves peers or people who are trusted by the target population (or are making efforts to build this trust); outreach workers make direct contact with members of the community, providing them with information and the means of protection, as well as help in accessing services. Examples of outreach include:

- training sex workers or community health workers to visit brothels, to provide information and condoms, and to link sex workers with STI and HIV services;
- training men who have sex with men to go to bars and sex venues to talk to other men about HIV, distribute condoms, and help them access STI and HIV services;
- training current and ex-drug users to go into drug-user environments to distribute clean needles and syringes, provide information, assist in overdose prevention and abscess care, and to help people access drug dependence treatment and HIV services;
- arranging mobile vans to visit sex work, MSM or IDU settings at night to provide information, prevention commodities, clinical services and referrals.

Support for self-help and community groups: This involves facilitating self-help or community groups from target populations and providing them with resources and facilities where they can work together to address HIV and related issues in their communities. Building the capacity of target groups to create partnerships in prevention and care services has been successfully used in many settings.

Establish local clinics and link these to other services: This involves providing clinical services for particular populations—such as sex workers, MSM and clients of sex workers—in their own neighbourhoods, with links to other services. It may also include introducing HIV services within already existing health, social or welfare services targeting these populations (e.g. conducting regular clinics in drop-in centres for sex workers).

Table 10 outlines priority health-sector interventions appropriate for a concentrated epidemic setting.

Key resources:

232. National AIDS programme management: A set of training modules
http://www.searo.who.int/en/Section10/Section18/Section356_13495.htm
 Preliminary pages: http://www.searo.who.int/LinkFiles/Publications_Preliminar_pages.pdf
 Introduction: http://www.searo.who.int/LinkFiles/Publications_Introduction.pdf
 Module 1 – Situation analysis: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_1.pdf
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 Module 4 – Targeted HIV prevention and care interventions: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_4.pdf
 Module 5 – Setting coverage targets and choosing key outcome indicators:
http://www.searo.who.int/LinkFiles/Publications_NAP_Module_5.pdf
 Module 6.1 – Minimizing sexual transmission of HIV and other STIs: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.1.pdf
 Module 6.2 – HIV prevention and care among drug users: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.2.pdf
 Module 6.3 – HIV counseling and testing: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.3.pdf
 Module 6.4 – The continuum of care for people living with HIV/AIDS and access to antiretroviral therapy:
http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.4.pdf
 Module 6.5 – Prevention of mother-to-child transmission: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.5.pdf
 Module 6.6 – Prevention of HIV transmission through blood: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.6.pdf
 Module 7 – Managing the AIDS programme: http://www.searo.who.int/LinkFiles/Publications_NAP_Module7.pdf
 Module 8 – Management systems for the AIDS programme: http://www.searo.who.int/LinkFiles/Publications_NAP_Module8.pdf
 Module 9 – Strategic information: http://www.searo.who.int/LinkFiles/Publications_NAP_Module9.pdf

4.5.3.1 Services for sexually transmitted infections

See section 1.2.1.2.

Providing services for sexually transmitted infections (STI) requires policies, procedures and health-worker training to encourage sex workers, men who have sex with men, transgender people, clients of sex workers, vulnerable young people and other targeted groups to access STI services. Staff attitudes, opening times, confidentiality and cost of services are all factors that should be considered in designing these services.

STI services are often best located in environments of high STI incidence, such as within sex work districts, and sex worker and MSM organizations. The use of mobile clinics and reproductive health and primary care clinics should also be optimized. Engagement with the private sector can help increase the quality and reach of services.

For sex workers, it is important to modify and disseminate STI diagnosis and treatment guidelines that include special screening or presumptive treatment. In all sex-work settings (particularly male sex-work settings), it is important to ask sex workers and clients about anal sex practices. Guidance should be provided on managing proctitis and on water-soluble lubricants. Provider-initiated HIV testing and counselling protocols should be integrated within STI services.

4.5.3.2 Services for injecting drug users

Providing services for injecting drug users should be a high priority wherever injecting drug use occurs. Improved access to HIV prevention, treatment and care services should be a key concern for this population, particularly in closed settings such as prisons. A comprehensive harm reduction programme for injecting drug users should include:

- interventions for preventing HIV transmission associated with injecting drug use (see section 1.2.2);
- interventions for treatment and care of drug users living with HIV (including managing viral hepatitis and TB co-infection);
- models of service delivery that are able to reach marginalized and most-at-risk drug users (and involve them and people living with HIV in service delivery) and are able to ensure continuity of services (e.g. from prisons to community programmes);
- structural interventions that create supportive environments for harm-reduction programmes, including review of laws and policies, and addressing stigma and discrimination.

Drug-dependence treatment is an effective way of reducing both the demand for illicit drugs and the risks associated with drug use. Clients of such treatment programmes significantly decrease their illicit drug consumption, are less likely to become involved in crime, and gain greater stability in their lives. An integrated approach can work well, with an IDU/HIV clinic serving as a 'one-stop-shop' possibly placed in existing HIV clinics, detoxification/drug substitution centres, closed settings and other places with clinical services for IDUs. All drug-treatment services offer opportunities to provide HIV prevention and education services and to ensure access to condoms and clean needles and syringes. Similarly, drug-dependence treatment services can be integrated into HIV treatment and care services.

Non-injecting drug use should also be considered. Use of many psychoactive substances is associated with high-risk sexual behaviour, including sex work, multiple sexual partners and unprotected sex. The hazardous use of alcohol and stimulants is a particular concern, including amphetamine-type stimulants and cocaine. There is also the risk that non-injecting drug users may transition to drug injecting. For these reasons, HIV risk reduction information and counselling and provision of condoms should be included in drug dependence and harm reduction services targeting non-injectors. See also section 1.2.1.6.1.

Key resources:

70. HIV prevention, treatment and care for injecting drug user (IDU) and prisons (Webpage)
<http://www.who.int/hiv/topics/idu/en/index.html>
233. IMAI IDU modifications of acute care and chronic HIV care with ART guideline modules and training tools
<http://www.who.int/hiv/capacity/IMAIsharepoint/en/>
234. Scaling-up HIV prevention, care and treatment: Report of a regional meeting. Bangkok, Thailand, 31 October - 2 November 2006
http://www.searo.who.int/LinkFiles/Publications_scaling-up-HIV200307.pdf

4.5.3.3 Services for sex workers

Preventing HIV among sex workers is critical to preventing HIV in general populations, since sex workers can transmit their infections to their clients, who in turn transmit to their wives or other regular partners. Interventions in several countries, however, have demonstrated that sex workers and their clients have the potential of being effective partners in prevention. Evidence shows that positioning sex workers as proactive collaborators at the centre of HIV service provision can be highly effective.

Most sex work, however, takes place within an unhealthy and unregulated working environment, with little or no promotion of safer sex, scant control over client behaviour, and pressure for high client turnover. When sex workers are poorly organized and have few alternative sources of income, they are less able to refuse a client unwilling to use a condom.

Where possible, programmes for HIV prevention, care and treatment in sex-work settings should entail: national, and where applicable, cross-border coordination; involvement of the sex workers for whom the services are planned; mapping of the spatial dimensions of sex work and unmet needs for services; outreach services through peer sex workers, with high coverage and intensity; and documenting service delivery outcomes.

Providing HIV-related services in sex-work settings requires a clear description of the needs, practices and size of the sex work and client population. Surveillance can also be used to define sex workers' and clients' success at avoiding risk, and their health-seeking patterns. This information can inform the planning of flexible responses that are adapted to the local sex-work setting and the prevalent distribution of behavioural and societal factors. Repeating surveillance at regular intervals can monitor trends over time.

Effective outreach builds trust and lines of communication between the non-sex work and sex-work community. In some settings, outreach is the principal (and sometimes only) means of reaching sex workers and maintaining continual contact. It is also an opportunity for providing health services, materials and information to sex workers who do not or cannot attend clinics, and reducing sex workers' social isolation through referrals to social services.

Peer services (the provision of services by those for whom they are intended) and peer-support networks also promote positive cultural values. Peer education enables the sex-work community to gain control over its own health; some safe sex information is best taught by experienced sex workers. Given the necessary skills and tools, sex work community members can provide services for their own peers and support behaviour change, often more effectively than outsiders can. This empowers them and increases their self-esteem and self-reliance. It also helps to put services in place more quickly and more cost-effectively. Since they are part of the community, peers can maintain regular contact with sex workers during hours that are convenient for them. They can raise awareness of HIV and STIs, and can provide safe sex information and supplies. However, peer services should not be stand-alone; they should be part of an integrated package of interventions in clinics and the community.

Integrated approaches that combine services for sex workers with services for the general population are likely to be more sustainable in the long term. In the short and medium terms, rapid scale-up of access to HIV services requires special services for sex workers. In settings where sex work is common, special services for sex workers may also be the most cost-effective approach in the long term. Absence of disease is not always a priority for sex workers; this makes it necessary to reach out to them with services that are convenient in terms of location, opening hours, and so on.

Key resource:

48. Toolkit for targeted HIV/AIDS prevention and care in sex work settings
<http://whqlibdoc.who.int/publications/2005/9241592966.pdf>

4.5.3.4 Services for men who have sex with men

In some settings, there is official denial that men who have sex with men (MSM) exist. In other settings, the illegality of male-to-male sex and officially tolerated stigma and discrimination make it difficult to obtain official support for services that target this group. Even if there is such support, it is often half-hearted, and arrest or harassment of MSM and peer outreach workers by police may impede the delivery of services. Many MSM in these settings do not self-identify as such, and make every effort to hide the fact, often by marrying or having regular female partners.

For these reasons, services that target only MSM are often impractical; MSM are often best reached through services to broader populations (e.g. through STI services for males or services targeting youth). Transgender people and highly effeminate MSM constitute a special case, since they often face serious stigmatization and discrimination. Some form of outreach to them is almost always necessary, and it can usually be done through their own formal or informal organizations and networks. The special services needs of MSM and transgender people (e.g. for water-based lubricants to reduce risk of condom breakage during anal sex) are discussed in Chapter 1, section 1.2.1.6.2.

Key resources:

232. National AIDS programme management: A set of training modules
http://www.searo.who.int/en/Section10/Section18/Section356_13495.htm
Preliminary pages: http://www.searo.who.int/LinkFiles/Publications_Preliminar_pages.pdf
Introduction: http://www.searo.who.int/LinkFiles/Publications_Introduction.pdf
Module 1 – Situation analysis: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_1.pdf
Module 2 – Policy and planning: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_2.pdf
Module 3 – Determining programme priorities and approaches: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_3.pdf
Module 4 – Targeted HIV prevention and care interventions: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_4.pdf
Module 5 – Setting coverage targets and choosing key outcome indicators:
http://www.searo.who.int/LinkFiles/Publications_NAP_Module_5.pdf

Module 6.1 – Minimizing sexual transmission of HIV and other STIs: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.1.pdf
Module 6.2 – HIV prevention and care among drug users: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.2.pdf
Module 6.3 – HIV counseling and testing: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.3.pdf
Module 6.4 – The continuum of care for people living with HIV/AIDS and access to antiretroviral therapy: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.4.pdf
Module 6.5 – Prevention of mother-to-child transmission: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.5.pdf
Module 6.6 – Prevention of HIV transmission through blood: http://www.searo.who.int/LinkFiles/Publications_NAP_Module_6.6.pdf
Module 7 – Managing the AIDS programme: http://www.searo.who.int/LinkFiles/Publications_NAP_Module7.pdf
Module 8 – Management systems for the AIDS programme: http://www.searo.who.int/LinkFiles/Publications_NAP_Module8.pdf
Module 9 – Strategic information: http://www.searo.who.int/LinkFiles/Publications_NAP_Module9.pdf

235. **Clinical guidelines for sexual health care of men who have sex with men**
http://www.iusti.org/sti-information/pdf/IUSTI_AP_MSM_Nov_2006.pdf

Table 10. Example: priority health sector interventions by level of health system in concentrated epidemic

	Outreach to most-at-risk populations (MARP)	Community and home-based delivery of interventions	Primary care: at health centre or outpatient clinics or private providers	Second level care at district hospital; inpatient care	Tertiary care at regional or central hospital/ specialist physicians, paediatricians
Increasing knowledge of HIV sero-status	<p>Outreach HIV testing and counselling to MARP and bridge population and consider offering CITC and including sites with rapid tests</p> <p>Support for self-help and community groups</p>	CITC closest to MARP setting	<p>CITC at health centre PITC:</p> <ul style="list-style-type: none"> • Consider in health services targeting MARPs and prison health care • Sexual and injecting partners of index cases • Patients with TB, STI, hepatitis B and C, other blood-borne viruses • Patients at drug dependence setting • Bridge populations • Pregnant women • Infant testing and counselling • Prior to receiving post-exposure prophylaxis (PEP) 	<p><i>As to left, plus:</i></p> <ul style="list-style-type: none"> • Blood donor HIV testing and counselling • Resolve discordant HIV test results 	Perform virological tests on dried blood spot and send back results
Prevention of HIV transmission	<p>HIV prevention outreach to MARPs and 'bridge' populations such as mobile populations, migrants, border areas:</p> <ul style="list-style-type: none"> • Peer-mediated information and education, and distribution of prevention commodities • Condom promotion and programming, including 100% condom promotion campaigns • Provision of harm reduction including exchange of needles and syringes • Linkage/referral to prevention, care and treatment sites friendly and oriented to MARP 	<p>Advocacy to reduce stigma, discrimination and criminalization of MARP</p> <p>Peer support for prevention with MARP</p> <p>Support for self-help and community groups</p> <p>Condom promotion and provision</p> <p>Counselling to reduce risky behaviour</p> <p>Community prevention literacy including STI</p> <p>Harm reduction including needle-syringe programme</p> <p>PMTCT for women in MARP</p>	<p>Prevention in people living with HIV with emphasis on prevention in MARPs</p> <ul style="list-style-type: none"> • Targeted STI management and sexual and reproductive health services • Management of rape and sexual violence including PEP <p>Prevent HIV infection through injecting drug use: comprehensive harm reduction including:</p> <ul style="list-style-type: none"> • Patient information, education • Sterile needle, syringe provision • Drug dependence treatment (including opioid substitution treatment) <p>Special and tolerant clinical services for sex workers, MSM including mobile services to attend MARP sites</p> <p>HIV prevention among youth:</p> <ul style="list-style-type: none"> • Special attention to young MARP • Tolerant, adolescent-friendly services • Ensure access reproductive health, family planning <p>Prevent infection in infants, young children</p> <ul style="list-style-type: none"> • Family planning • ART or ARV prophylaxis • Treatment, care, support pregnant women • Infant feeding counselling and support <p>Prevent transmission in health-care settings, including:</p> <ul style="list-style-type: none"> • Infection control, standard precautions • Safe injections • Safe medical waste management • Occupational health of health workers; • Post-exposure prophylaxis 	<p><i>As to left, plus:</i></p> <p>Manage STI treatment failures</p> <p>PMTCT for complicated cases</p> <p>Safe blood</p>	

	Outreach to most-at-risk populations (MARP)	Community and home-based delivery of interventions	Primary care: at health centre or outpatient clinics or private providers	Second level care at district hospital; inpatient care	Tertiary care at regional or central hospital/ specialist physicians, paediatricians
HIV treatment and care (including prevention of illness in PLHIV)	<p>Integration of care and support in outreach services</p> <p>Use prevention outreach as entry point to HIV treatment and care services</p> <p>Referral to prevention, care and treatment sites friendly and oriented to MARP</p>	<p>Self help and community support groups</p> <p>Home-based:</p> <ul style="list-style-type: none"> • Care-seeking support • Social support • Nutritional support <p>Palliative care:</p> <ul style="list-style-type: none"> • Symptom management and end-of-life care in home by caregivers • Patient self-management 	<p>At prevention, care and treatment sites friendly and oriented to MARP</p> <p>Counselling of PLHIV on adherence, ART, opportunistic infections prevention and treatment</p> <p>ART</p> <p>Opportunistic infections prevention and treatment</p> <p>Management of hepatitis and other co-infections</p> <p>Management of non-infectious co-morbidities</p> <p>Patient monitoring (including lab follow up)</p> <ul style="list-style-type: none"> • Psychological support • Immunization • Opioid substitution treatment <p>TB prevention, diagnosis, treatment</p> <ul style="list-style-type: none"> • Intensified casefinding TB • TB infection control • Isoniazid preventive therapy • TB- HIV co-management • Diagnose, start, follow TB treatment with focus on MARP 	<p><i>As to left, plus:</i></p> <p>Management of complicated HIV cases</p> <p>ART including toxicities and treatment failure</p> <p>If resources available: manage severe comorbidities including oncology and opportunistic infections</p> <p>Supervise ART prescription at previous level of care</p> <p>Inpatient care</p>	<p><i>As to left, plus:</i></p> <p>Clinical mentor for previous level</p> <p>Referral for uncommon and certain severe opportunistic infections, ART toxicities, oncology</p>
AFASS ART ARV	acceptable, feasible, affordable, sustainable and safe antiretroviral therapy antiretroviral	AZT CITC IDU	Azidothymidine, Zidovudine Client initiated testing and counselling injecting drug use	MARP PITC PMTCT STI	most at risk populations provider initiated testing and counselling prevention of mother to child transmission sexually transmitted infections

4.6 Planning for generalized HIV epidemics

4.6.1 Prevention

Prevention efforts have led to declines in levels of HIV in some countries with generalized epidemics, but this has yet to take place in many others. Furthermore, in all countries the epidemic continues to disproportionately affect women.

Comprehensive prevention interventions, informed by evidence, could have broader success. Making better use of opportunities to integrate HIV prevention within health services is especially critical to this success. Providing Patient-Initiated Testing and Counselling, condoms and counselling for women who take their children for immunization and other child care services is one example. The female condom remains an under-exploited option, as does safer sex counselling, which should occur after HIV testing but also on many other occasions when health workers and patients interact. Safer sex counselling should reinforce the message that concurrent sexual partnership is very high risk.

The health sector can also play an important role in promoting progressive delay of the age of coital debut for young people, and in advocating for the control of alcohol use, since it is increasingly recognized as a significant contributor to risk-taking behaviour in countries with generalized epidemics. Hazardous or harmful patterns of alcohol use are associated with unsafe sex, high partner numbers and condom accidents. Addressing this problem is now recognized as an essential part of HIV prevention.

4.6.2 Decentralization of integrated prevention, treatment and care

In generalized epidemics with high HIV prevalence, the large numbers of people living with HIV mean that providing efficient and decentralized services is a key strategy in moving towards universal access. This requires a public-health approach to scaling up services with emphasis on achieving broader coverage with key interventions; simple, standardized regimens and formularies; algorithmic clinical decision-making; effective supervision and patient monitoring; and integrated delivery of primary health care through health centres and in the community, within a district health network.

Increasing evidence underscores the greater complexity and cost of caring for patients presenting with advanced HIV disease. Increasing the number of people who are tested and—for those who test positive—regularly following up with pre-antiretroviral care can prevent illness and ensure the timely initiation of antiretroviral therapy.

Good survival rates have been reported for patients on antiretroviral therapy, and the numbers of patients in chronic HIV care have increased steadily. This has led to development of 'mega-clinics' in some hospitals. Decentralizing chronic HIV care to the health centre and community level and integrating it with other priority health-sector interventions are challenges that must be met if universal access is to be achieved in an effective and cost-efficient way. People living with HIV require multiple interventions for TB, substance use, pregnancy, child health, and so on. In many countries, these interventions are delivered through a number of different facilities with specialized personnel. This is an inefficient use of resources and an increased burden on patients. Integration of these services in health facilities, together with standardized protocols and training for health workers, enables more effective co-management of patients, and promotes family-based care that addresses the needs of adults, adolescents and children.

To support scale-up and to avoid inefficient use of resources and increased burden on health workers and patients, coherent and integrated packages of essential interventions appropriate for each level of the health system are necessary. These should be developed and delivered through a shared programme of work. Operational collaboration is important, both internationally and between: national HIV/AIDS programmes, and those focusing on TB, maternal and newborn services, child health, STIs, mental health, and oral health; programmes organized around specific health cadres (such as nursing and midwifery); and those with a cross-cutting mandate such as human resources for health, health system strengthening, palliative care, chronic care, essential drugs and essential health technologies.

Successful programming requires negotiation of a shared programme of HIV/AIDS work at national level within a clear health-sector strategy. Cosponsorship of integrated implementation at facility and district level with co-supervision by several programmes (usually HIV, TB and maternal and child health) are essential to support integrated services. Cooperation within the district management team and at point of care is often substantially better (and easier) than at the national or international level.

Meanwhile, the kind of integration described above is already happening as those responsible for HIV and TB services recognize the advantages of working together on prevention, treatment and care for both diseases (see sections 1.3.2.4 and 2.1.1).

Most of the HIV interventions described in Chapter 1 can be decentralized to health centres by using simplified, operational guidelines. Nurse-led clinical teams in health centres (and in district hospital outpatient clinics) are able to deliver most of the clinical and prevention interventions listed in Chapter 1, provided they have backup from district hospital clinicians and periodic clinical mentoring. Nurse-led teams can initiate and monitor antiretroviral therapy, manage uncomplicated opportunistic infections, and provide primary mental health and neurological care.

Managing the broad range of opportunistic infections and other co-morbidities experienced by people living with HIV requires an integrated and coordinated response from a wide range of health services. Clinical teams at health-centre level are able to manage uncomplicated opportunistic infections, but need to be able to refer patients with severe or complicated conditions to a district hospital clinician for diagnosis and management. Cotrimoxazole prophylaxis should be started promptly for all eligible patients, in all clinical services.

Key resources:

47. IMAI-IMCI chronic HIV care with ARV therapy and prevention: Interim guidelines for health workers at health centre or district hospital outpatient clinic
English: http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf
French: http://www.who.int/hiv/pub/imai/imai_chronic_fr.pdf
112. IMAI-IMCI basic chronic HIV/ ART clinical training course
<http://www.who.int/hiv/capacity/IMAISHarepoint/en>
85. IMAI-IMPAC integrated PMTCT training course
<http://www.who.int/hiv/capacity/IMAISHarepoint/en/>
113. IMAI basic ART aid (lay counsellor) training modules
<http://www.who.int/hiv/capacity/IMAISHarepoint/en>
100. IMAI acute care
English: http://www.who.int/hiv/pub/imai/en/acutecarerev2_e.pdf
French: http://www.who.int/hiv/pub/imai/imai_acutecare_2008_fr.pdf
236. IMAI acute care/opportunistic infection training course
<http://www.who.int/hiv/capacity/IMAISHarepoint/en/>
136. IMAI general principles of good chronic care
English: <http://www.who.int/hiv/pub/imai/generalprinciples082004.pdf>
French: http://www.who.int/hiv/pub/imai/imai_general_2008_fr.pdf
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
Facilitator's guide: 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
148. IMAI TB infection control at health facilities
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
Participant's manual: http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_partman.pdf
237. Briefing package: Integrated approach to HIV prevention, care and treatment: Integrated management of Adult Illness (IMAI) and Childhood Illness (IMCI) tools
<http://www.who.int/hiv/capacity/ImaiBriefingStrategyAug2007Sm.pdf>
238. HIV prevention, treatment, care and support: a training package of 8 modules for community volunteers
<http://www.ifrc.org/what/health/tools/hiv-training.asp>
Facilitators guide: <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Facilitators-guide.pdf>
Introduction to training <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Intro-to-Training.pdf>
Module 1: Basic facts on HIV and AIDS <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-1.pdf>
Module 2: Treatment literacy <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-2.pdf>
Module 3: Treatment preparedness <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-3.pdf>
Module 4: Adherence <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-4.pdf>
Module 5: Community-based counselling <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-5.pdf>
Module 6: Nutrition <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-6.pdf>
Module 7: Palliative care - symptom management and end-of-life care <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-7.pdf>
Module 8: Caring for carers <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-8.pdf>

Evaluation tool <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Evaluation-Tool.pdf>
Participants handbook <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Participants-handbook-full.pdf>
Flipchart for client education <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/hiv-flipchart1.pdf>
124. Pocket book of hospital care for children: guidelines for the management of common illnesses with limited resources
English: <http://whqlibdoc.who.int/publications/2005/9241546700.pdf>
French: http://whqlibdoc.who.int/publications/2007/9789242546705_fre.pdf

Portuguese: http://whqlibdoc.who.int/publications/2005/9789248546709_por.pdf
Russian: http://whqlibdoc.who.int/publications/2005/9241546700_rus.pdf

	Outreach to most-at-risk populations and vulnerable groups	Outreach to most-at-risk populations and vulnerable groups	Primary care: at health centre or outpatient clinics of district hospital or private providers	Second level care at district hospital; inpatient care	Tertiary care at regional or central hospital/specialist physicians, paediatricians
HIV/AIDS treatment and care	<p>Interventions delivered through outreach to most-at-risk populations (in partnership with other sectors)</p> <p>Integration of treatment support for antiretroviral therapy, TB treatment and prophylaxis in outreach services</p>	<p>Treatment preparedness for both HIV and TB</p> <p>Patient self-management</p> <p>Peer support groups</p> <p>Home-based:</p> <ul style="list-style-type: none"> • Treatment support- ART, TB treatment, and prophylaxis • Drug refill delivery • Management diarrhoea, fever • Careseeking support • Psychosocial support • Nutritional support • Water treatment and safe storage • Hygiene • Insecticide-treated nets • Palliative care: pain and other symptom management and end-of-life care 	<p>First-line ART:</p> <ul style="list-style-type: none"> • Adherence preparation, support • Recommend or initiate first-line treatment • Monitor, adjust dose • Clinical, CD4, limited lab; patient monitoring systems for HIV care/ ART, TB-HIV, PMTCT • Support patient self-management <p>Prevent illness:</p> <ul style="list-style-type: none"> • Cotrimoxazole prophylaxis • Vaccination • Nutritional care and support • Education: safe water, hygiene, sanitation • Prevent malaria <p>Clinical care / manage opportunistic infections and comorbidities:</p> <ul style="list-style-type: none"> • Primary care for pneumonia, fever/malaria, diarrhoea, malnutrition, other common conditions • Mental health, psychosocial support • Back up palliative care at home, symptom management <p>TB prevention, diagnosis, treatment:</p> <ul style="list-style-type: none"> • Intensified casefinding TB • TB infection control • Isoniazid preventive therapy • Diagnose, start, follow TB treatment including, if referral difficult, suspected smear negative TB • TB-HIV co-management 	<p><i>As to left, plus:</i></p> <p>ART:</p> <ul style="list-style-type: none"> • Initiate ART in complicated patients; • Oversee initiation of first line ART in uncomplicated patients by primary care team • Diagnose treatment failure • Second-line ART (under supervision clinical mentor) • Manage serious complications of ART • Assess and manage severe opportunistic infections • Inpatient care • Manage severe malnutrition • TB-ART co-treatment plan 	<p>Clinical mentor for district clinicians:</p> <ul style="list-style-type: none"> • Reviews cases of suspected treatment failure • Makes decision on switching to second-line ART <p>Management of uncommon and certain severe opportunistic infections, ART toxicities, oncology</p>
AFASS	acceptable, feasible, affordable, sustainable and safe		AZT	MARP	
ART	antiretroviral therapy		CITC	PITC	most at risk populations
ARV	antiretroviral		IDU	PMTCT	provider initiated testing and counselling
				STI	prevention of mother to child transmission sexually transmitted infections

Table 12 How/who IMAI-IMCI-IMPAC tools relate to the priority interventions

IMAI-IMCI-IMPAC tools:

A	IMAI/IMCI district hospital learning programme	124, 133	E	IMAI/STB – TB care with TB-HIV co-management	147, 148
B	IMAI palliative care and community tools		F	IDU version of IMAI tools	230
		87, 116, 134, 138, 139	G	Reproductive choices and family planning tools	85
C	IMAI acute care adults/IMCI children	33, 93, 101, 121	H	IMAI/IMPAC integrated PMTCT tools	83, 84
D	IMAI-IMCI chronic HIV care with harmonized short courses	10, 88, 113, 114, 115, 116, 136, 190, 216	I	CAH infant feeding tools	92, 93
			J	Operations Manual	99

Priority interventions and related IMAI-IMCI-IMPAC tools	A	B	C	D	E	F	G	H	I	J
1.1 Enabling people to know their HIV status			X							
Client-initiated testing and counselling										
<i>Provider-initiated testing and counselling</i>										
Diagnosis of HIV in infants and young children	X		X	X						X
Family and partner testing and counselling	X			X						X
Laboratory recommendations for HIV diagnosis										X
1.2 Maximizing the health sector's contribution to HIV prevention										
<i>Prevention of sexual transmission of HIV</i>										
Condom promotion and provision	X	X	X	X	X	X	X	X		X
Detection and management of STI	X		X							
Safer sex and risk reduction counselling	X	X	X	X		X	X	X		
Male circumcision	X									
Prevention among people living with HIV	X	X		X			X			X
Interventions targeting sex workers			X							
Interventions targeting MSM and transgendered people	X		X							
Specific considerations for HIV prevention in young people			X	X						
Non-occupational post-exposure prophylaxis	X		X	X						X
<i>Interventions for injecting drug users (harm reduction)</i>										
Needle and syringe programmes						X				
Drug dependence treatment						X				
Information, education and communication for IDUs						X				
<i>Prevention of HIV in infants and young children</i>										
Family planning, counselling and contraception							X			
Antiretroviral medicines for preventing HIV infection in infants				X				X		
Treatment, care, support for pregnant PLHIV	X			X				X		
Infant feeding counselling and support				X					X	
<i>Prevention of HIV transmission in health care settings</i>										
Safe injections	X		X	X			X			X
Safe waste management disposal										X
Occupational health of healthcare workers	X			X			X			X
Occupational post-exposure prophylaxis (PEP)	X		X	X			X			X
1.3 Accelerating scale-up of HIV treatment and care										
<i>Prevention</i>										
Co-trimoxazole prophylaxis	X			X		X		X		X
Vaccinations	X			X		X		X		X
Nutritional care and support	X			X		X		X		X
Prevention of malaria	X			X		X		X		X
<i>Treatment and care interventions</i>										
Antiretroviral therapy for adults, adolescents, children	X			X		X		X		X
Treatment preparedness and adherence support	X			X		X		X		X
Patient monitoring	X			X		X		X		X
<i>Management of opportunistic infections and co-morbidities</i>										
Management of HIV-related conditions	X		X	X		X				
Management of pneumonia	X		X	X		X				
Management of diarrhoea	X		X	X		X				
Management of malnutrition	X		X	X		X				
Management of malaria	X		X	X		X				
Prevention and treatment of mental health disorders	X		X	X		X				
Counselling	X		X	X		X		X		X
Other common conditions	X		X			X				
Palliative care: symptom management and end-of-life care	X	X								X
<i>Tuberculosis prevention, diagnosis and treatment</i>										
Intensified casefinding, TB preventative therapy	X				X					
Treatment of HIV associated TB	X				X					

4.6.2.1 Community mobilization and involvement of people living with HIV

As discussed in section 2.5.1, community mobilization is critical for scaling up HIV prevention, testing and counselling, and for preparing communities to prevent and support adherence to drug regimens. Civil society organizations and networks, including those involving people living with HIV and people most-at-risk of infection, complement formal health services. They provide preventive information and supplies, create demand for formal health services, ensure that the services are acceptable and of good quality, prepare communities for treatment by providing relevant education and information, support adherence to drug regimens, and provide various care and support services, including palliative care. Moving towards universal access requires reinforcing support for civil society organizations and networks, as well as strengthening the links between them and formal health services. Strong civil society organizations and networks are especially important given the crisis in human resources for health that many countries are experiencing.

See section 2.5.1 for further discussion of this subject and for ways of involving people living with HIV in clinical teams, together with the need for providing them with training, supervision and pay, and overcoming policy constraints that may prevent the shifting of tasks from professional to lay health care workers.

Key resources:

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>
238. HIV prevention, treatment, care and support: a training package of 8 modules for community volunteers
<http://www.ifrc.org/what/health/tools/hiv-training.asp>
Facilitators guide: <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Facilitators-guide.pdf>
Introduction to training <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Intro-to-Training.pdf>
Module 1: Basic facts on HIV and AIDS <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-1.pdf>
Module 2: Treatment literacy <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-2.pdf>
Module 3: Treatment preparedness <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-3.pdf>
Module 4: Adherence <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-4.pdf>
Module 5: Community-based counselling <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-5.pdf>
Module 6: Nutrition <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-6.pdf>
Module 7: Palliative care - symptom management and end-of-life care <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-7.pdf>
Module 8: Caring for carers <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Module-8.pdf>

Evaluation tool <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Evaluation-Tool.pdf>
Participants handbook <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/Participants-handbook-full.pdf>
Flipchart for client education <http://www.ifrc.org/Docs/pubs/health/hivaids/hiv-training-package/hiv-flipchart1.pdf>

4.6.2.2 Most-at-risk groups in generalized epidemics

Even though an epidemic may be generalized, it is important to identify and reach marginalized or neglected populations who are at higher risk of HIV infection, or who have poor access to clinical and community-based services. These often-neglected groups include sex workers, men who have sex with men, injecting drug users and prisoners. Male-to-male sex is increasingly recognized as a major contributor to HIV infection, and injecting drug use is increasing in some cities and ports in Africa. Sections 1.2 and 4.5.3 provide guidance on how to reach these populations with prevention and other services.

HIV-negative people in sero-discordant relationships may be numerically the single largest group at risk in countries with generalized epidemics. Special efforts are required to identify and support them, both through facility- and community-based interventions. These interventions include partner and couples testing and counselling, and risk reduction counselling and support (see section 1.2.3.2).

Adolescent girls and young women are also at disproportionately high risk in countries with generalized epidemics. They require special attention through youth-friendly services and active support for interventions that may be delivered predominantly in other sectors, such as efforts to address transactional sex, intergenerational sex and rape.

Key resources:

22. Practical guidelines for intensifying HIV prevention: towards universal access
http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf

23. [Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)
http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf

4.6.2.3 Where to implement: health facility or community?

With high HIV prevalence and large numbers of people living with HIV, community- and home-based service delivery become increasingly important. Trained and paid community health workers, home-based caregivers, and a treatment supporter for each patient on antiretroviral therapy and TB treatment can play a crucial role in assisting patients in care (e.g. through adherence support and home-based refills) and in promoting methods to prevent HIV transmission. Community-based testing—based on outreach from an index case receiving facility-based care or on large scale ‘know your status’ campaigns—are important both for prevention (e.g. to identify discordant couples and support safer sex and risk reduction in both HIV-positive and HIV-negative persons) and to ensure early entry into HIV care and treatment.

To conclude this chapter, scale-up is not a linear process and can become more complex in successive phases. Initial challenges can differ from those in later phases and may vary in different settings. Also, there may be unintended consequences that call for corrective action. For example, with increasing levels of activity, economies of scale may improve, but quality may deteriorate. Providing strong and vigilant oversight is essential for scaling up an integrated package of HIV services. Monitoring and evaluation information available to programme managers helps them manage the cross-cutting support activities and systems that need to be in place.