

NATIONAL AIDS PROGRAMME MANAGEMENT

A SET OF TRAINING MODULES



**World Health
Organization**

Regional Office for South-East Asia

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World Health Organization, Regional Office for South-East Asia.
National AIDS programme management: a set of training modules.

1. HIV infections – prevention and control – transmission. 2. Acquired Immunodeficiency Syndrome – prevention and control – transmission. 3. Training programmes. 4. Teaching material. 5. Health status – indicators. 6. Policy-making. 7. Outcome and process assessment (health care) – methods. 8. Substance abuse, intravenous. 9. Counselling. 10. Breastfeeding – adverse effects. 11. Manuals.

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Module 2 – Policy and planning

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Module 5 – Setting coverage targets and choosing key outcome indicators

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Module 7 – Managing the AIDS programme

Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

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Foreword

The South-East Asia Region is at high risk for a massive spread of the HIV epidemic, not only because of the large size of the population and the high burden of sexually transmitted infections but also due to the prevailing risk behaviours and vulnerabilities. Explosive epidemics among injecting drug users, sex workers and men who have sex with men have occurred in India, Myanmar and Thailand, and more recently in Indonesia and Nepal.

The scaling up of HIV/AIDS prevention, care and treatment is rapidly evolving. HIV and AIDS issues have become more complex. Thus, it is important for the people working in AIDS programmes to have an updated knowledge and enhanced understanding of related issues and dimensions.

National AIDS programmes in many countries are overstretched in terms of skilled workforce and infrastructure. Moreover, there is also concern among countries regarding a high turnover rate of staff including senior staff and programme managers. Improving human resource capacity is therefore one of the persistent challenges faced by the countries. The term “human resources” refers not only to the number of staff, but also to their distribution, capacity and competence to effectively undertake multiple tasks at various levels and to respond to new needs.

The training modules on National AIDS Programme Management were developed by the WHO Global Programme on AIDS in the early 1990s to assist AIDS country programme managers at national and subnational levels in developing their capacity to manage the complex range of programmes and activities under their responsibility. Inter-country training courses using those modules were conducted by the WHO Regional Office for South-East Asia, followed by training at the national level during the 1990s. Those courses resulted in the development of the skills of many senior staff in the Region – and many of them are still playing critical roles as national programme managers or senior policy-makers today.

The new set of training modules was revised in 2006 by the WHO Regional Office for South-East Asia in collaboration with the AIDS Projects Management Group (APMG), Sydney, in line with advanced developments in HIV prevention, care and treatment. The modules were peer reviewed by experts and pre-tested at a training course in Bangkok, Thailand before finalization. The training course using these modules provides an opportunity to discuss and learn a systematic process for developing, managing and implementing a national AIDS prevention and control programme.

I am confident that AIDS programmes in all countries will find these modules relevant and useful.



Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director

Acknowledgements

The World Health Organization Regional Office for South-East Asia expresses its sincere gratitude to the AIDS Projects Management Group (APMG), Sydney, Australia for preparing the training modules.

We also wish to acknowledge the contributions of Supachai Rerks-ngarm, Anupong Chitwarakorn, Sombat Thanprasertsuk (Ministry of Public Health, Bangkok, Thailand); Purushottam Narayan Shrestha (Kathmandu, Nepal); Iyanthi Abeyewickreme (National STD/AIDS Control Programme, Colombo, Sri Lanka); Lou McCallum (APMG, Sydney, Australia); Shane Moore (Perth, Australia) and Clement Chan-Kam (WHO Headquarters, Geneva, Switzerland).

The modules are based on the WHO's Global Programme on AIDS Modules, which were developed in 1993, and evolved through an expert consultation process taking into consideration national AIDS programme experiences and the state of the art in prevention, care, support and treatment of HIV and sexually transmitted infections.

The work was coordinated by the HIV Unit staff, Department of Communicable Diseases, WHO Regional Office for South-East Asia.

Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
APM	AIDS programme manager
APMG	AIDS Projects Management Group
ART	antiretroviral therapy
CBO	community-based organization
CCM	Country Coordinating Mechanism
DG	director-general
EPP	Essential Prevention Package
ECR	expanded and comprehensive response
ELISA	enzyme-linked immunosorbent assay
FSW	female sex worker
GO	governmental organization
HIV	human immunodeficiency virus
IDU	injecting drug user
M&E	monitoring and evaluation
MCH	Maternal and Child Health
MoU	memoranda of understanding
MSM	men who have sex with men
MTCT	mother-to-child transmission
NAC	National AIDS committee
NAP	national AIDS programme
NASP	national AIDS strategic plan
NBTS	National Blood Transfusion Service
NCG	national core group
NGO	nongovernmental organization
OI	opportunistic infection
OVC	other vulnerable children
PEP	post-exposure prophylaxis
PLHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
RAR	rapid assessment and response
SHG	self-help group
SRH	sexual and reproductive health
SOP	standard operating procedure
STI	sexually transmitted infection
TB	tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
VCT	voluntary counselling and testing
WTO	World Trade Organization

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6.5– Prevention of mother-to-child transmission

6.6– Prevention of HIV transmission through blood

Module 7 – Managing the AIDS programme

Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

NATIONAL AIDS PROGRAMME MANAGEMENT

INTRODUCTION



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National AIDS Programme Management

A Training Course

Introduction



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Introduction

THE CHALLENGE OF HIV PREVENTION, CARE AND TREATMENT

Twenty-five years of responding to acquired immunodeficiency syndrome (AIDS) has provided many lessons. It is now clear that an effective AIDS response requires the cooperation of many levels of government and many sectors of society. It is also clear that there is no quick fix and that gains made in prevention and care can easily and quickly be lost if governments become complacent and wind down programmes.

All too often, several psychological, social, cultural and economic factors stand in the way of a rational approach to AIDS – the same factors that fuelled the pandemic in the first place. They include:

- denial by many individuals and societies that AIDS is relevant to them;
- complacency about the pandemic, especially where the problem is invisible;
- stigmatization of people who are infected with human immunodeficiency virus (HIV), or believed likely to become infected, which prevents them from seeking the help or information they need to protect themselves and others from infection;
- the inferior socioeconomic status of women which limits their ability to access education, to learn to protect themselves from sexual transmission and to act on this knowledge; and
- reluctance to discuss, or permit the discussion of, sexual matters.

This is a significant time in the global response to AIDS. The wider availability of affordable antiretroviral therapy (ART) and a significant increase in the global resources for AIDS, through the Global Fund, other multilateral and bilateral sources, and private foundations, provide an opportunity to gain control over the pandemic and reduce its impact. The “3 by 5” Initiative and the subsequent establishment of the goal of universal access to HIV prevention and care provide an opportunity for nations to set and achieve ambitious targets.

Responding to AIDS requires the following:

1. **Commitment** – Governments need to make HIV prevention, care and treatment a priority. Political leaders need to act on their commitment without delay and find

ways to accommodate clear prevention messages within the context of their country's social, cultural and religious norms.

2. **Involvement of all sectors of society** – AIDS programmes require action, support and resources not only from the Ministry of Health, but also from the Ministries of Youth, Women, Finance, Planning, Education, Information, Labour, Agriculture, and others. In addition, effective working relationships must be established with the private sector and community groups including nongovernmental organizations (NGOs).
3. **Giving priority to and providing resources for activities for the prevention of sexual transmission and transmission through injecting drug use** – This means promoting safer sex, including the use of condoms, especially among high-risk networks with frequent partner change. It also means providing early diagnosis and treatment of sexually transmitted infections (STIs) as these facilitate HIV transmission. It includes employing harm-reduction measures, increasing access to drug treatment and rehabilitation, and changing drug-using behaviours among injecting drug users (IDUs).
4. **Providing comprehensive care, support and treatment to people with HIV** – This includes expanded access to voluntary HIV counselling and testing, support for people living with HIV/AIDS (PLHA) and their partners and families, and access to the treatment of opportunistic infections (OIs) and ART for all who need these.
5. **Reinforcing efforts to counter discrimination against people with HIV** – All governments need to continue to find ways to ensure that responses of official authorities and individuals to AIDS are humanitarian and non-stigmatizing. Public health is undermined by mandatory HIV testing, by marginalization of people thought to be at greater risk of acquiring or transmitting HIV and by other discriminatory measures.
6. **Ensuring that people are well informed** – Clear prevention messages must reach all adolescents and adults so that they can protect themselves and others from HIV. Further, messages to counter misconceptions about HIV transmission need to be widely delivered and reinforced. Political leaders especially need to understand that action to strengthen the national AIDS programme cannot be delayed. Well-informed citizens and a well-planned and coordinated multisectoral response to AIDS are the keys to effective prevention, care and treatment.

AIMS OF THIS TRAINING COURSE

The purpose of this course is to improve the management of national AIDS programmes by:

- presenting a systematic process for developing and managing a comprehensive national AIDS prevention, care and treatment programme; and
- providing an opportunity to increase the knowledge and practice skills needed to implement such a process.

The primary audience for this training is AIDS programme managers – individuals who have the authority and primary responsibility for managing national AIDS programmes. The secondary audience includes people who can influence decision-making about the programme. Among these may be people in the office of the head of state responsible for interministerial coordination of AIDS activities; people in the Ministry of Health responsible for prevention, health education and health care; staff of other ministries such as education and planning; members of national and provincial AIDS coordinating committees including PLHA group representatives; and people working at the national level in international organizations that support national programmes. This training course will be repeated periodically to take account of the turnover of people in these key positions. The training course will initially be provided at the regional level, and may then be tailored to national needs and provided within countries, for state or provincial AIDS programme managers.

Upon completion of this training course, participants' ability to plan, manage and evaluate a comprehensive national AIDS programme will be strengthened. The curriculum attempts to cover the breadth of information required for effective AIDS programme management. This training provides an overview and may need to be complemented by more intensive, focused training in specific technical and management areas.

HOW THIS COURSE IS ORGANIZED

This is a working course that requires the active participation of the people who attend it. Rather than presenting a series of passive lectures, participants are required to work through a set of workbooks, individually and in groups, under the supervision and assistance of experienced facilitators. The curriculum is divided into modules that contain information on how to effectively plan and manage a national AIDS programme and exercises designed to give participants practice in applying that information. The modules are presented in plain language and during the course participants are given adequate time to work at their own pace. Participants read the information in the modules and complete the exercises, either individually or in small groups, according to the instructions in the module. Each small group is assisted by one or two experienced facilitators.

In the regional training course, participants from the same country are assigned to the same group while in the national training course, participants from the same province/district are assigned to the same group.

There are several ways to work through exercises with the facilitator. Participants in the regional training course are asked to work on some exercises individually. In others, participants are expected to work with other participants from the same country. Some

exercises require both individual and country group work. Facilitators will assist participants as needed in individual work and will facilitate small group discussions based on the modules and exercises.

The role of the facilitator in each small group is to spend time with individuals or with the groups, going through the content and assisting with the completion of the tables or questions in the exercises. A deliberate choice has been made in the design of this training course to move away from presentations and to focus on discussion, problem-solving, coaching and shared learning.

The content is balanced between programme management and technical information. The course is designed to cover around ten training days. The time allocated for each module can be adjusted to meet the needs of the participants. For a group that requires less technical updating, the time allocated for the modules on programme management can be extended and the technical modules can be used more as background resources.

COURSE MATERIALS

This course consists of an introduction and nine modules. Each module addresses a major aspect of AIDS programme development and contains exercises for the participants to practise what is learned. The list of the modules is as follows.

Introduction

- Module 1: Situation analysis
 - Module 2: Policy and planning
 - Module 3: Determining programme priorities and approaches
 - Module 4: Targeted HIV prevention and care interventions
 - Module 5: Setting coverage targets and choosing key outcome indicators
 - Module 6: Implementation of HIV prevention, care and treatment strategies
 - 6.1 Minimizing sexual transmission of HIV and other STIs
 - 6.2 HIV prevention and care among drug users
 - 6.3 HIV counselling and testing
 - 6.4 The continuum of care for people living with HIV/AIDS and access to antiretroviral therapy
 - 6.5 Prevention of mother-to-child transmission
 - 6.6 Prevention of HIV transmission through blood
 - Module 7: Managing the AIDS programme
 - Module 8: Management systems for the AIDS programme
 - Module 9: Strategic information
-

COURSE THEMES AND THE PROGRAMME MANAGEMENT FLOWCHART

The course modules are divided into three broad themes. The first three training days assist participants to examine the current AIDS situation in their country, using the data and information available to them, and to set priorities, targets and indicators for the programme. The next four days examine the range of prevention and care interventions that are available to programmes and assist participants to adapt what is known about successful interventions to their setting. The final three days focus on the skills and systems required to manage, monitor and evaluate the programme.

This logical sequence is set out in the AIDS programme management flowchart below, and the modules are derived from this flowchart.

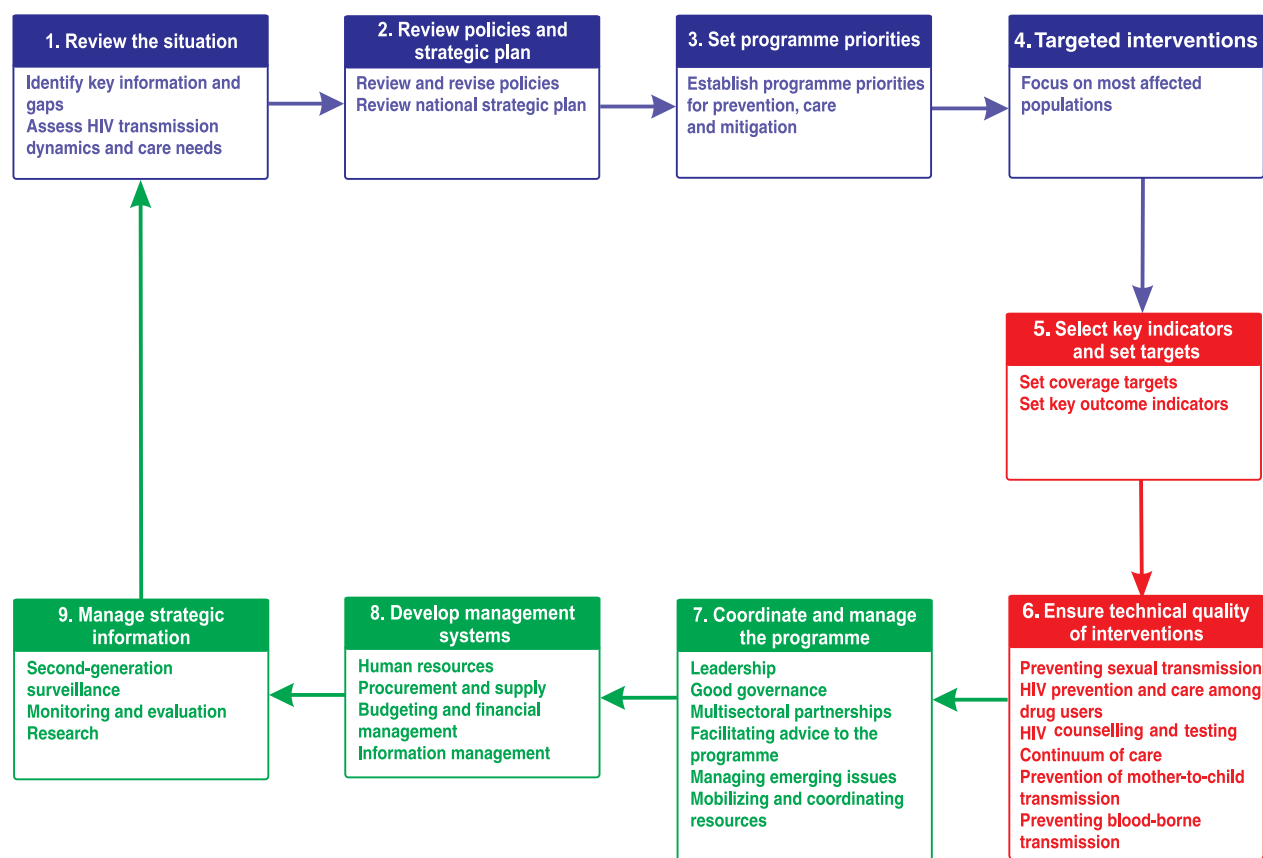


Figure 1. AIDS programme management flowchart

The AIDS programme management flowchart forms the backbone of the training. Each stage in the management of AIDS programmes is presented as a training module. The flowchart is a continuous cycle – strategic information informs planning policy development; this leads to priorities, approach and target setting, which guides

implementation. Systems are put in place to manage the programme. These assist in monitoring and evaluation, and in the generation of up-to-date information that is fed back into planning. In real life, AIDS programme management is not always in order and many of these processes are happening at the same time in different parts of the programme. This flowchart provides AIDS programme managers with an opportunity to see how these processes can fit together to improve the consistency, quality and effectiveness of programmes.

DRAFT PROGRAMME

This training course is designed to be delivered over ten training days. Time is set aside at the beginning for a briefing of the group facilitators, usually experienced programme managers from the Region, to familiarize themselves with the materials and to develop a consistent approach to the supervision and mentoring they will provide throughout the training.

Facilitator briefing

Prep Day 1

Prep Day 2

Prep Day 3

Week 1: Training

Day 1	08:30–11:00	Official opening Introduction of participants and facilitators Overview of the training
	11:30–01:00	Module: Introduction Establishment of intercountry groups Explanation of training process
	02:00–03:30	Module 1: Situation analysis
Day 2	04:00–05:30	
	08:30–11:00	Module 2: Policy and planning
	11:30–01:00	
	02:00–03:30	Module 3: Determining programme priorities and approaches
Day 3	04:00–05:30	
	08:30–11:00	Module 4: Targeted HIV prevention and care interventions
	11:30–01:00	
	02:00–03:30	Module 5: Setting coverage targets and choosing key outcome indicators
	04:00–05:30	

Day 4	08:30–11:00	Module 6.1: Minimizing sexual transmission of HIV and other STIs
	11:30–01:00	
	02:00–03:30	Module 6.2: HIV prevention and care among drug users
	04:00–05:30	Site visits
Day 5	08:30–11:00	Module 6.3: HIV counselling and testing
	11:30–01:00	
	02:00–03:30	Module 6.4: The continuum of care for people living with HIV/AIDS and ART
	04:00–05:30	
<hr/>		
Week 2:	Training	
Day 1	08:30–11:00	Module 6.4: The continuum of care for people living with HIV/AIDS and ART (cont.)
	11:30–1:00	
	02:00–03:30	Module 6.5: Prevention of mother-to-child transmission
	04:00–05:30	Module 6.6: Prevention of HIV through blood
Day 2	08:30–11:00	
	11:30–01:00	
	02:00–03:30	Module 7: Managing the AIDS programme
	04:00–05:30	
Day 3	08:30–11:00	
	11:30–01:00	
	02:00–03:30	Module 8: Management systems for the AIDS programme
	04:00–05:30	
Day 4	08:30–11:00	
	11:30–01:00	
	02:00–03:30	
	04:00–05:30	
Day 5	08:30–11:00	Module 9: Strategic information
	11:30–01:00	
	02:00–03:30	Evaluation, planning for country workshops, closing
	04:00–05:30	

Tea/coffee break: 10:30 am to 11:00 am and 3:30 pm to 4:00 pm

Lunch break : 12:30 pm to 1:30 pm



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 1 SITUATION ANALYSIS



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Module 1

Situation analysis



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Module 1: Situation analysis

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Situation analysis

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To describe the epidemiological features of HIV epidemics in Asia.
2. To summarize how to monitor prevalence and trends, analyse geographic patterns and estimate population sizes.
3. To describe the use of second-generation surveillance in guiding the response to HIV.
4. To review and summarize available data and information on HIV risk and vulnerability at the national/subnational level.

INTRODUCTION

The two overriding goals of national AIDS programmes are to reduce the transmission of HIV and to care for and mitigate the impact of HIV on those already infected. Achieving these goals requires an understanding of the extent of prevalence of HIV infection and also where it is spreading.

For example, to interrupt transmission, effective interventions must reach those geographic areas and populations where HIV is spreading most rapidly. Similarly, organizing services for HIV care, support and treatment requires an understanding of where people living with HIV/AIDS (PLHA) can be found. There may be considerable overlap in initiatives for prevention, care and treatment of HIV in terms of geographic and population focus. There may also be important differences because of the long lag time between HIV infection and AIDS.

AIDS programme managers are expected to utilize a great deal of information from a gamut of sources including:

- data from biological and behavioural surveillance;
- information from voluntary counselling and testing (VCT) centres, laboratories and other testing centres;

- data and information from sexually transmitted infection (STI) clinics;
- case reporting data from the health services;
- patient tracking data from care, support and treatment services;
- situation assessments, mapping studies and rapid assessments among target populations;
- population size estimation studies;
- social, cultural and behavioural research; and
- operational research.

Sometimes the challenge of tracking multiple sources of data – and analysing and applying such information to improve programmes – may seem daunting. Also, as AIDS programmes become more complex, it is increasingly challenging for programme managers to keep abreast of the many technical advances in HIV strategic information. Most national programmes now have technical advisory committees to oversee HIV and STI surveillance and research. The programme manager's role here is to oversee the technical advisory committee, manage the overall programme of strategic information, and apply analysed findings appropriately to improve the programmes.

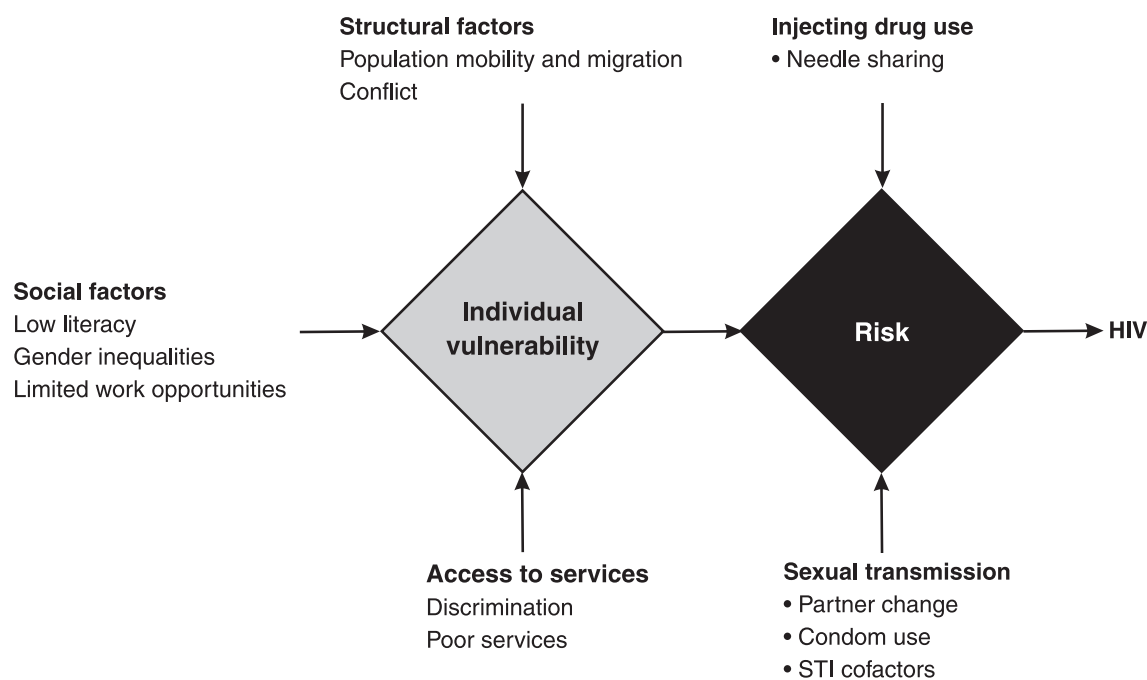
To do this, programme managers need to be familiar with the basic elements of surveillance, monitoring, evaluation and research that comprise the strategic information corpus. This module starts with a focus on key information relevant to the two main objectives of AIDS programmes. Later modules will look at targets and indicators (Module 6), systems for programme management (Modules 7 and 8) and an overall framework for strategic information (Module 9).

OBJECTIVE 1: To describe the epidemiological features of HIV epidemics in Asia

EXERCISE A

(Individual work followed by individual feedback)

Study the figure below, which summarizes some key factors of vulnerability and risk that contribute to HIV transmission.



These conditions of vulnerability and risk are not distributed equally across populations. To maximize the effectiveness of programmes, managers need to make strategic decisions about whom to target, what approaches to take, what services to provide in which settings, what resources are required, and how these should be distributed.

In many countries, for example, HIV epidemics are first reported in large cities, border towns or other locations where the elements of vulnerability and risk are very high. High population mobility tends to increase this vulnerability and also facilitates dissemination of HIV to new areas. Programme managers need to understand these geographic patterns to appropriately allocate prevention resources to areas where they will have the maximum impact on transmission.

Not everyone, however, is at equal risk even in areas of high HIV prevalence.

Answer the following questions:

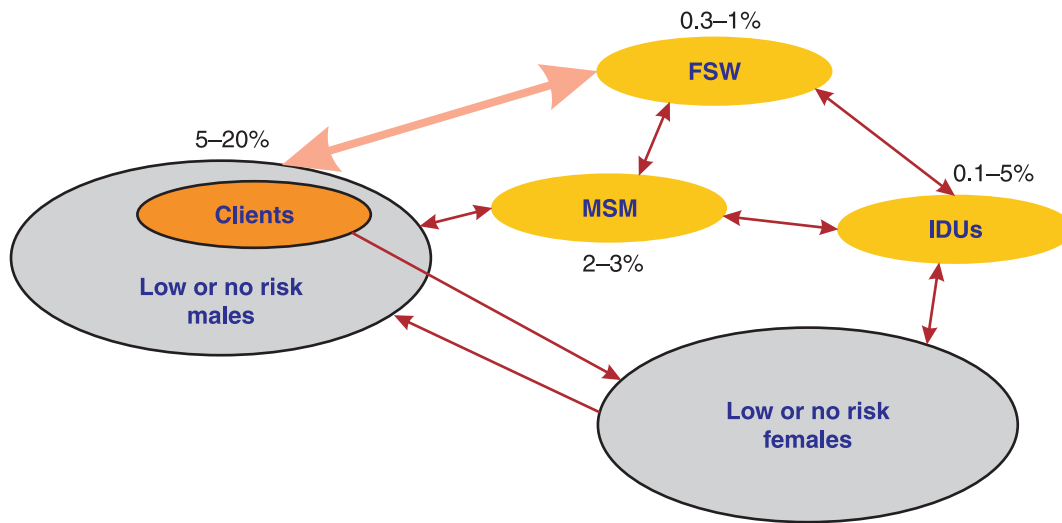
1. In which areas of risk and vulnerability can the programme that you manage most effectively intervene to reduce HIV transmission?
2. In which areas of vulnerability and risk can the programme that you manage work with other partners or sectors to improve conditions?

Inform your facilitator when you have finished the exercise.

EXERCISE B

(Individual work followed by country group discussion)

Study the figure on page 9 and discuss the questions that follow. In the figure, arrows represent potential HIV/STI transmission between high-risk groups – female sex workers (FSW), men who have sex with men (MSM) and injecting drug users (IDUs) – and bridging populations (male clients). Typical population size estimates for the Region are: FSW (0.3–1%), IDUs (0.1–5%), MSM (2–3%) and male clients (5–20%).



Source: A² —Analysis and Advocacy for Action (Thai Red Cross, East West Center)

Consider the information given above and answer the following questions:

1. It has been said that HIV epidemics in Asia frequently start with injecting drug use and then spread further into communities through sex work. Do you agree? Explain how HIV can spread between population groups as suggested in the figure above and how this is related to your country.
2. Do the estimated population sizes and network connections presented in the above diagram accurately describe the situation in your country? Where would you look for the information to answer this question?

Inform your facilitator when you are ready for country group discussions.

Next, we will look more closely at how to identify and interpret information that addresses such questions. It is important to understand not only who is getting infected but also why, and to know whether patterns of risk and vulnerability are changing over time. It is also important to comprehend the barriers that may prevent PLHA from accessing services and support, the changing patterns of use of these services and the outcomes at the individual and community level – of care, support and treatment. Managers also need to know whether or not their interventions are making any difference. Some of these information needs will be addressed in subsequent modules.

OBJECTIVE 2: To summarize how to monitor prevalence and trends, analyse geographic patterns and estimate population sizes

Programme managers clearly need some basic information to guide an effective response; but with dozens of indicators and multiple sources of data, it is essential to know which ones are the most important.

It is obviously necessary to monitor HIV infection itself and most countries have some systems in place to report cases (case reporting) and estimate prevalence (HIV surveillance). This alone would not be enough to guide programmes since HIV sentinel surveillance and case reporting only count people who are already infected. Surveillance should also help in identifying areas where people are at risk for HIV, preferably before HIV starts spreading.

This is where surveillance of risk behaviour and STI can be useful. Behavioural surveillance monitors key populations believed to be at risk because of behaviours that are known to facilitate transmission. STI surveillance provides an early warning system for potential HIV transmission as well as relatively short-term outcome data that can help evaluate the prevention response. By tracking rates and patterns of other STIs, programme managers can identify places and populations where HIV is most likely to spread, and where such programmes may need strengthening.

Three main areas thus form the basic building blocks for analysing HIV epidemics and planning an effective response. These are:

- HIV sentinel surveillance
- Behavioural surveillance
- STI surveillance

For Asian epidemics where transmission of HIV infection is largely linked to sex work, injecting drug use and sex between men, information on patterns and trends in these subpopulations is most important. Methods for collecting, analysing and using such information to improve programmes are described in guidelines and related materials on *second-generation surveillance*.

OBJECTIVE 3: To describe the use of second-generation surveillance in guiding the response to HIV

Second-generation surveillance permits programme managers to summarize the state of their epidemics in basic epidemiological terms of “person”, “place” and “time”.

- Affected populations such as sex workers, MSM, IDUs, men at high risk;
- Geographic distribution at subnational and local levels; and
- Trends over time to detect change.

HIV, STI, and related behaviours provide complementary information that helps programme managers determine where to focus resources.

The basic steps of data analysis include:

- Examining the data by site
- Examining the data by subpopulation
- Graphing the data to examine trends
- Mapping the data to analyse geographic patterns

In the next exercise, you will practise using some real second-generation surveillance data from the Region to describe epidemics and discuss the implications for programmes.

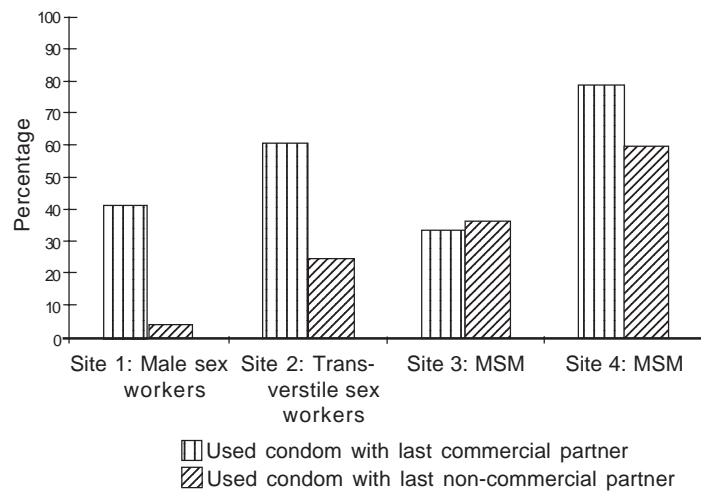
EXERCISE C

(Individual work followed by country group discussion)

Summarize the information presented in the graphs on pages 13–14 and discuss their implications for HIV programmes.

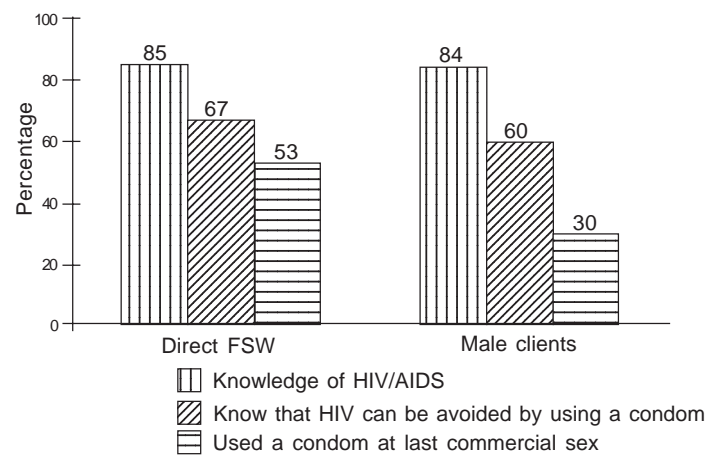
(1)

Proportion of men using condoms in last sex with another man, by type of partner, 1999–2000



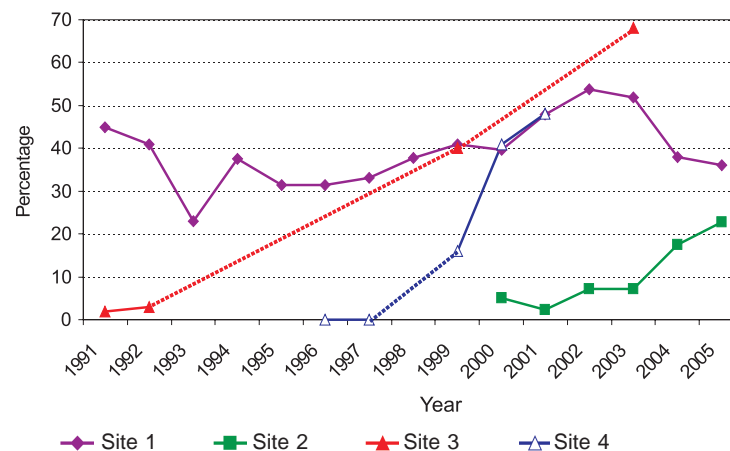
(2)

Knowledge and practice about HIV prevention among sex workers and their male clients, 2003



(3)

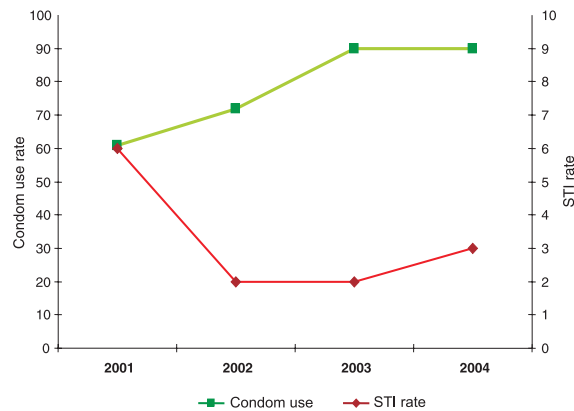
HIV prevalence among injecting drug users (IDUs), 1992–2005



Source: National AIDS Programme, 2005

(4)

Condom use and STI rates among sex workers



Inform your facilitator when you are ready for country group discussions.

Second-generation surveillance is also used to estimate the size of HIV epidemics. This information is important for purposes of advocacy and for planning interventions and service needs.

In most Asian epidemics where risk and vulnerability are highly concentrated among specific populations and their sexual partners, prevalence and population size figures from second-generation surveillance can be used to estimate the size of epidemics as follows:

Estimating HIV prevalence:

- Determine which subpopulations are potentially exposed to HIV.
- Estimate the size of each subpopulation.
- Examine surveillance data for the index subpopulations.
- Estimate HIV prevalence in exposed populations not included in the surveillance.
- Apply the HIV prevalence estimates to the population size estimates.
- Sum up all estimates to obtain a national HIV prevalence.

Source: *Guidelines for effective use of data from HIV surveillance systems*, WHO, UNAIDS, 2004

First, we need to estimate the sizes of different subpopulations affected by HIV. Several methods of estimation are described in Module 6.

It is important to remember that determining the patterns of HIV and STI and related behaviours in different populations is not a one-time exercise. The basic tasks described in this section should be repeated continually over time as epidemics evolve. The response to those epidemics is also a changing phenomenon.

EXERCISE D

(Country group work followed by intercountry group discussion)

In country groups, describe your country's current HIV surveillance system by completing the following table. Place a tick or cross in each box according to whether your surveillance system "currently provides data" on the areas described for the subpopulations indicated.

	HIV prevalence	STI prevalence	Risk behaviours	Population size
Sex workers				
IDUs				
MSM				
Men at high risk*				
General population				

* The choice of monitoring potentially high-risk male groups for surveillance purposes varies, but may include certain defined migrant workers, the military, police personnel, transport workers, etc.

Answer the following questions:

1. Which subpopulations are included in your country's surveillance system?

2. Which surveillance methods are used (singly and in combination)?

3. Where and when does the surveillance occur?

Inform your facilitator when you are ready for intercountry group discussions.

OBJECTIVE 4: To review and summarize available data and information on HIV risk and vulnerability at the national/subnational level

EXERCISE E

(Country group work followed by intercountry group discussion)

In country groups, review all the data and information available to you on HIV risk and vulnerability for your country.

1. Summarize what it tells you about the current state of the epidemic.

2. What are the “most important messages” that these data tell you?

3. What key information are you missing?

4. How would you obtain this missing information?

Inform your facilitator when you are ready for intercountry group discussions.

RESOURCES

1. *Guidelines for effective use of data from HIV surveillance systems*, WHO, UNAIDS, 2004 (<http://www.who.int/hiv/strategic/surveillance/en/useofdata.pdf>).
2. *UNAIDS/WHO AIDS epidemic update*, December 2006 (http://www.unaids.org/en/HIV_data/epi2006/default.asp).
3. *HIV surveillance modules*, New Delhi, WHO Regional Office for South-East Asia, 2007
 - (i) Module 1: Overview of HIV/AIDS epidemic with an introduction to public health surveillance
 - (ii) Module 2: HIV clinical staging and case reporting
 - (iii) Module 3: HIV serosurveillance
 - (iv) Module 4: Surveillance for sexually transmitted infections
 - (v) Module 5: Surveillance of HIV risk behaviours
 - (vi) Module 6: Surveillance of populations at high risk for HIV transmission
 - (vii) Facilitator training guide for the surveillance curriculum.



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 2 POLICY AND PLANNING



**World Health
Organization**

Regional Office for South-East Asia

National AIDS Programme Management

A Training Course

Module 2

Policy and planning

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Module 7 – Managing the AIDS programme

Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

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Module 2: Policy and planning

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Policy and planning

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To describe the contribution that policy makes to create an enabling environment for HIV/AIDS programmes and the role of policy to reinforce that environment.
2. To describe the principles that guide the development of AIDS policy.
3. To identify the major issues for which a national AIDS policy needs to be established.
4. To assess the national policy environment, and identify any gaps in policy or conflicts between policies.
5. To outline the steps for developing a national AIDS policy.
6. To outline the steps for developing a national AIDS strategic plan.

INTRODUCTION

Policy plays an essential role in guiding an effective response to HIV and AIDS. Governments use policy to state their views on a particular issue and declare the approach they will take to resolve or respond to that issue. Organizations use policy to explain to their employees the modalities of executing their work as well as norms of behaviour. Community groups use policy to advocate for what the community needs.

Policy is simply an expression of what a group or organization thinks or believes about a particular issue. Laws are a formal expression of policy for a nation. They set out what is permissible and what is not. Governments and organizations disseminate written policies which aim to prescribe, explain and outline how particular issues will be dealt with. A national policy on HIV counselling and testing, for instance, sets out how counselling and testing will be conducted, and, more importantly, how it will not be conducted.

Some policy is not written in stand-alone documents, but contained in reports or other papers. Governments accept the recommendations of a review report, for instance, and these are then viewed as the government's opinion about or approach to a subject.

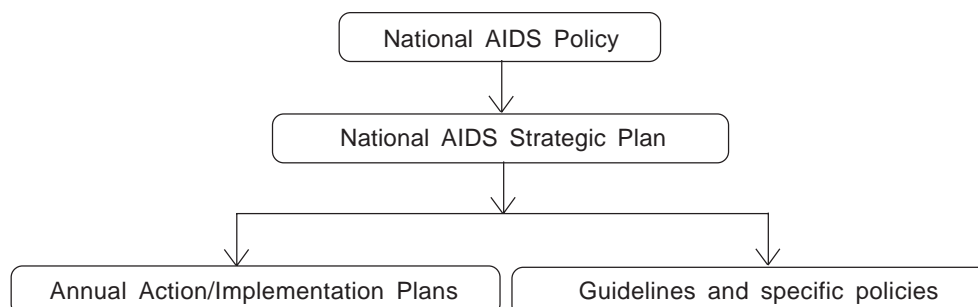
Sometimes governments find it difficult to express formal policy on a controversial issue or subject. In such cases, policies are “hidden” or implied in the manner the issue is dealt with in practice.

Although it is important to start developing policies early in the process of establishing or revising a national AIDS programme (NAP), not all policies are made at this stage. For example, some policies can only be developed after a programme has established its major priorities. Policy development and review is a dynamic process. Policies change according to the lessons learnt during the implementation of the programme. Sometimes policies set early in the development of a programme turn out to negatively affect implementation and need to be adjusted. Evidence and knowledge change over time. Policies, therefore, need to be able to respond to these changes.

This module examines the role of policy in creating and maintaining a supporting or enabling environment for AIDS programmes. It sets out some guiding principles for framing an AIDS policy and takes participants through the steps involved in developing policy. It provides an opportunity for participants to consider the range of HIV-related policies that are in place in their country, identify gaps and recognize opportunities for filling those gaps.

It also details the process for developing a national AIDS strategic plan (NASP) that can turn the policy into practice.

Different countries prepare their policy and strategy in different ways. The national AIDS policy is usually a single document that sets out how a country plans to respond to AIDS. It usually contains a set of guiding principles and a description of the context and extent of HIV and AIDS in the country. It describes how the response will be coordinated, who will be involved and what their respective roles will be. It summarizes the approaches to be adopted and the government's position on key issues such as HIV counselling and testing, access to care, support and treatment and the rights of people living with HIV/AIDS (PLHA). It is usually complemented by a NASP that contains details about priorities, objectives, strategies and resources. This is sometimes further supported by an annual action plan.



OBJECTIVE 1: To describe the contribution that policy makes to create an enabling environment for HIV/AIDS programmes and the role of policy to reinforce that environment

THE CONTRIBUTION OF POLICY TO THE ENABLING ENVIRONMENT

AIDS programmes do not exist in isolation. Policies and strategies may look good on paper but may be undermined or rendered ineffective by a range of external factors. For instance, a policy that aims to provide access to HIV counselling and testing for all who need it will be undermined by the prevalence of stigma and discrimination against PLHA. An outreach programme that seeks to target sex workers will find it difficult to reach the target population if, for example, police policies or practices keep sex workers on the move. Laws, policies and practices can work in tandem to create an enabling environment for AIDS programmes. Policy helps to establish and support this enabling environment.

Expressing the country's approach to HIV and AIDS, through a national AIDS policy, or through detailed policies on specific areas such as counselling and testing and antiretroviral therapy (ART) access, and through the inclusion of attention to HIV in non-discriminatory and public health legislation can assist in creating stability and consistency across sectors and jurisdictions.

Policy makes the following contributions to create an enabling environment for AIDS programmes:

Authority, legitimacy and permission	The existence of a national AIDS policy, endorsed by the national government, gives the NAP a legitimate role and provides it with the power it needs to negotiate with other government departments and sectors. A multisectoral policy that identifies the need for all government departments and sectors to respond to HIV gives people working in those departments and sectors the legitimacy to raise HIV issues and to mobilize support and resources.
Stability	National and provincial governments change every few years. Ministers and senior bureaucrats come and go. A clear bipartisan policy can insulate the programme and protect it to some extent during periods of change when new personnel or governments bring new ideas and approaches.

Consistency	There is often considerable debate about the approach to be adopted to minimize HIV transmission. Having a clear policy in place that sets out the strategies to be used in HIV prevention, care and treatment can result in consistent approaches being taken from one jurisdiction to another. This minimizes to some degree the possibility of one province or one service adopting approaches or strategies that work against the goals of the entire programme.
Good practice	Services base their operating procedures on policy. Policy tells services what approach to take towards a particular group. An HIV counselling and testing policy, for example, shapes the practice that occurs in services that provide HIV testing. Anti-discriminatory laws and policies shape the practices of health workers and other service providers towards the people protected by these laws and policies.
Knowledge	Policy documents do not need to be merely lists of rules. They can also inform and educate people. A good infection control policy teaches the health staff how to keep their patients healthy and keep themselves safe. An organization's AIDS policy can teach people how HIV is transmitted, what they need to do to avoid HIV infection and what the organization is able to offer them if they test HIV-positive.
Consensus	The policy development process can provide an opportunity for all groups to come together to put forward their different views about the approaches that should be taken to reduce HIV transmission and improve care, and to reach a consensus on how to move forward. The process allows different groups to present their perspectives and learn from each other's knowledge and experience.
Collaboration and partnership	Having a common goal and approach, set out in policy, can provide an opportunity for different groups to work together in partnership. A policy that clearly sets out roles and allocates responsibilities and resources can increase collaboration between groups and sectors and reduce the competition for resources. AIDS policies that establish a clear role and resources for PLHA groups, for example, provide an opportunity for health services to work with PLHA groups to improve prevention and care.
Permission to speak	Having in place a national AIDS policy that raises and deals with difficult or taboo issues such as sex work, drug use and sex between men creates opportunities for these issues to be discussed and addressed in services and in communities. A policy that calls for communities to provide care and support for families affected by HIV acknowledges the fact that these families live within communities and need support. Having a President, a Prime Minister or a senior politician launch a national AIDS policy can help place the issue of AIDS on the agenda of a range of groups and organizations.

What priority elements of the programme should be addressed in policies? One way to identify these major issues is to think of how they will be used and when they will be useful. Some of the cases where policies prove to be useful are:

- when a clear statement of political commitment to priority elements of the programme will increase the likelihood of achieving the programme's objectives. For example, a policy statement recognizing HIV/AIDS as a critical public health problem with development consequences that deserve financial and political support will greatly improve the programme's ability to achieve its objectives.
- when there are options, and the most effective or practical choice is not obvious, a policy statement should make the programme's position clear. For example, a policy statement could state which level of health worker can provide ART for PLHA.
- when basic practices need to be described so that guidelines and activities can be developed to implement various interventions. For example, a policy on the need to increase condom use might make it clear that condoms will be promoted among all those who are sexually active, including youth.

OBJECTIVE 2: To describe the principles that guide the development of AIDS policy

GUIDING PRINCIPLES

The guiding principles of an AIDS policy are an important declaration of the basic desires that the country believes should be consistently reflected in all AIDS policies. These are important because they tell the organizations and individuals involved in responding to HIV as to how they are expected to behave, what their approach to HIV should be based on, and what their policies and procedures should comply with. They are also important to PLHA and people affected by HIV as they are often used as key advocacy tools to assist them to fight stigma and discrimination and to access the services and support they need.

Each country formulates a different set of guiding principles that are particular to their needs. Some common themes that appear in guiding principles are:

- the need for leadership from politicians and religious and community leaders;
- the need to grant PLHA the same rights and access to services as to all other citizens;
- the premise that people will be encouraged to know their HIV status, protected from discrimination and provided with the information and means to protect themselves and others;
- the need for a multisectoral approach;
- the need to address issues of gender as a core part of the response so that the burden of disease and care on women will be reduced;
- that the approach will be based on evidence and will be sensitive to the culture of the country;
- that resources will be set aside to implement the response;
- that the communities will be encouraged and supported to take up a role in prevention and care.

OBJECTIVE 3: To identify the major issues for which a national AIDS policy needs to be established

Some of the key areas in which policy can guide the AIDS programme include

- Setting out how HIV counselling and testing will be conducted and promoted
- Access to treatment to prevent mother-to-child HIV transmission
- Access to ART for PLHA
- Condom promotion
- Involvement of nongovernmental organizations (NGOs) in the national AIDS policy
- Increasing the avenues of primary and secondary education for women
- Decriminalization of sex work or registration of sex work venues
- Determining the level of health-care providers who provide treatment for individuals with sexually transmitted infection (STI) and AIDS
- Availability of appropriate drugs
- Availability of STI services for youth
- AIDS and the workplace (employment)
- Insurance and HIV testing
- Refugees and HIV status
- Visa regulations for short-term entry and HIV status
- Securing the blood supply system

Study the list above and reflect on the policies that guide your national response.

OBJECTIVE 4: To assess the policy environment and identify any gaps in policy or conflicts between policies

Sometimes the country's approach to AIDS is presented in a specific policy, such as the HIV counselling and testing policy. In other cases, a specific reference to the needs of PLHA is included in general policies. For example:

- A general policy in India that covers the establishment and funding of women's self-help groups (SHGs) contains a clause that permits the establishment of such groups by women with HIV and guarantees them access to the funding which is available to other SHGs.
- Maternal and child health policies can contain specific reference to access to prevention of mother-to-child transmission (PMTCT) services and to ART for mothers and children with HIV.

EXERCISE A

(Country group work followed by intercountry group discussion)

In country groups, answer the following questions to assess the current policy environment in your country, and identify any gaps or policy conflicts.

1. List the current specific policies that guide the response to AIDS in your country.

2. List the major issues that are not covered adequately by the AIDS policies?

3. List some general policies that encompass various AIDS issues.
4. Identify some general policies that should make a reference to AIDS but currently do not.
5. Identify some policies that appear to be counterproductive or to weaken the enabling environment for the AIDS programme.

Inform your facilitator when you are ready for intercountry group discussions.

OBJECTIVE 5: To outline the steps for developing a national AIDS policy

STEPS FOR DEVELOPING A POLICY

Different policies require different processes depending on the level of complexity and controversy associated with them. It is relatively easy to formulate and promote policy on issues where there is broad agreement. In other areas, a complex process of participation and consultation is required to evolve policy. The complexity of the process depends to some extent on the change you are trying to bring about through the policy. If the people who are required to implement the policy are likely to resist the change – either because of ignorance or because they believe that the way they are currently doing things is better – then the policy process may not succeed unless you involve them from the start.

Gather information needed for studying policy options

Before setting national policy in an area of HIV prevention, care and treatment, it is important to know as much as possible about the problem that the policy is trying to solve, the people who will be affected by it and the efforts that have been made so far to address the issue. For each issue that the national AIDS policy will deal with, information is needed regarding:

- the target populations, if any, that will be affected by the policy and their characteristics, such as risk behaviours or geographical distribution, as well as existing policies on this issue.
- social, religious and cultural norms that affect the issue.

Information can be obtained from many sources, such as a review of records, a survey of the people directly affected by the policy, consultation with community or health workers, and operational research.

Assess existing policies

Before developing a new policy, it is important to determine whether the issue can be addressed by modification or better implementation of existing policies. People working at the ground level can get disillusioned if the national programme produces a set of policies that contradict each other, or cannot be practically implemented at the ground level. It is important to ascertain the exact nature of the problem that you are trying to

solve and to determine whether setting a policy is the most effective approach to solving it.

Develop a clear policy that addresses the issue

The policy developed needs to be clear and focused on solving the problem identified. Make sure that the people for whom the policy is intended can understand the exact meaning of the policy and will be able to apply it to the practical reality of their work.

Policy statements allow the public and other interested parties to understand how the NAP proposes to address the AIDS epidemic. The following examples suggest the kind of statement a programme might develop to summarize important policy decisions.

Examples

Increasing the avenues of primary and secondary education for women

Recognizing that women are extremely vulnerable to HIV infection, the NAP advocates for increasing the avenues of primary and secondary education for women. Education is a particularly critical and effective way of improving the ability of women to provide for their families, understand their own health needs, know how and when to seek appropriate health care, and make informed choices in their sexual activities that can protect themselves and their children from HIV. Existing laws requiring full primary schooling for all children will be enforced. The ratio of girls to boys attending school will be monitored and corrective action taken as needed.

Promote human rights of PLHA and avoid discrimination against them

Recognizing the dangers to the health of everyone posed by discriminatory behaviour against PLHA, the national AIDS policy calls for a broad multisectoral response to promote the human rights of PLHA and avoid discrimination against them. The national AIDS policy encourages those in a position of authority in the health, legal, welfare and social sectors to coordinate efforts and mobilize political support and action to limit discriminatory laws, regulations and practices. The national AIDS policy will first focus on laws regarding housing, employment and insurance. The national AIDS policy is committed to educating the public about HIV to remove unfounded fears about HIV and AIDS.

Access to treatment and prophylaxis for opportunistic infections and to ART

All PLHA who need it will have free access to opportunistic infection (OI) treatment and ART through primary health-care clinics.

Obtain formal approval for proposed policies

In most countries, the National AIDS Committee (NAC) is responsible for *drafting* proposed policies. These policies are then *approved* by higher levels (that is, the executive or legislative levels) of the government. Although the procedures for obtaining formal approval will vary in each country, here are some suggestions.

- First, policies are submitted to the relevant multisectoral national committee for its review, and are revised as needed. Committee members may make useful suggestions about issues that they know are important to the policy-makers who will approve the policies, or they may have a different perspective because of their familiarity with how another sector intends to deal with HIV.
- Next, rationales are developed to convince key policy-makers of the need for the policies. The reasons for suggesting certain policies will not always be clear to others, especially those without public health training. It is useful to explain why certain policies are recommended and how adoption of these policies will benefit the initiative to prevent HIV and/or treat PLHA. This is especially important for potentially controversial subjects such as condom promotion among youth, confidential testing, discrimination, commercial sex, homosexuality, and injecting drug use.
- Proposed policies are submitted to policy-makers who are responsible for granting formal approval. Policy-makers include both executive or administrative and legislative or parliamentary members of the government.
- Perhaps, most importantly, the process should be monitored to ensure that the policy is approved, implemented and evaluated.

EXERCISE B

(Individual work followed by country group discussion)

In this exercise you will develop a policy for your country in a particular area of HIV prevention or care, then consider difficulties you may have to face in getting the policy approved. Follow these steps:

1. Meet with the other participants from your country and share with them the lists of major issues you have developed for Question 2 of Exercise A in this module. Each participant in your group should select a different issue from these lists. This could be one for which a current policy does not exist, or one for which the current policy needs to be revised. Write your selected issue below.
2. List the factors that need to be considered when developing a policy for the issue you have selected (such as impact of the policy and conflict with other policies, people or groups that might support or oppose it).
3. Write your new policy statement to summarize the government's position or approach in this area.

4. Briefly describe any difficulties you may encounter in your attempt to get this policy approved in your country.

Inform your facilitator when you are ready for country group discussions.

OBJECTIVE 6: To outline the steps for developing a national AIDS strategic plan

The national policy is usually complemented by a national strategic plan that sets out the goal, objectives and strategies that will bring about the desired changes. The strategic plan generally identifies the priorities for action and allocates time frames, targets and indicators. Sometimes the national policy and strategic plan are contained in a single document. The national strategic plan is often backed by detailed annual action or implementation plans that set out exactly what is to be done, by whom, and in what time frame. Guidelines and policies on specific issues – such as policies on HIV counselling and testing and access to ART and guidelines on how and when to use ART, how to prevent nosocomial infections, and so on – back up the main policy and strategic plan. Different countries have different approaches to this, but the main elements generally remain the same.

The strategic planning process begins with obtaining a consensus and commitment from all the concerned sectors including donors. The role of programme management staff is to stimulate and coordinate multisectoral involvement in the development of NAP activities and to ensure that the plans meet the objectives of the NAP and emphasize on priority interventions.

The process of assembling relevant information for preparing and revising the draft of the national strategic plan provides an opportunity for the NAP and the multisectoral NAC to review and coordinate all the activities planned for reducing the spread of HIV infection, and for providing care and support for PLHA. During the drafting of the strategic plan, other plans for major activities can be assessed for their consistency with overall programme policies and objectives. Programme and activity targets can be assessed to determine whether sufficient resources will be available to meet them. If not, modifications can be made or additional funding sought for those parts of the plan that have not yet been funded.

When the final draft of the strategic plan is completed, all those involved in the planning process will have a unified view of the NAP's response to AIDS. The plan can be reviewed by the NAC for its approval and endorsement. The completed document is used to communicate to the general public the NAP's planned response to AIDS in order to enlist its support and confidence.

Purpose of a national AIDS strategic plan

The purpose of an NASP is to provide a framework so that programme management staff will know what will be done, when, and by whom. The plan also serves as a basis for funding. Multisectoral participation is essential throughout the planning process. One outcome of the process is a written document, or national plan.

The written document should provide a broad outline of priority interventions and activities for the NAP. It should present a summary of the current AIDS situation, and the planned multisectoral response to the problem. While the NAP is usually responsible for preparing the final written plan, those funding and implementing the plan will have an opportunity to review and endorse the written document when it is presented to the NAC. The following sections describe how to assemble and prepare a national strategic plan.

Steps suggested for developing a national AIDS strategic plan

1. Preparation phase:

- (a) project proposal for formulating a national strategy to be developed in consultation with key partners, identifying the objectives, conceptual framework, methodology, activities, time frames, budgetary requirements and sources of funds, responsible agencies and their respective roles;
- (b) informal consultation with governmental organizations (GOs) and NGOs, PLHA groups, United Nations (UN) and international agencies;
- (c) project proposal submitted to a national authority for approval;
- (d) NAP to set up a steering committee to provide direction and to oversee the development process of the strategic plan. The committee should be multisectoral in nature and chaired by the director-general (DG) or a person of higher position;
- (e) the NAP manager plays a leadership role and coordinates the entire process with the support of the UN system. He/she will act as secretary of the steering committee and convener of the national core group (NCG);
- (f) NAP to appoint an NCG comprising a team of one local expert, one international expert and writer(s) to prepare the background paper including introduction, vision, goals and objectives of the HIV/AIDS prevention and control medium-term programme. Other members can include: focal point from NAP and focal point from UN (with secretarial and office assistance) with regular consultation with others as and when necessary (Terms of reference for the NCG, local and international experts to be set up);
- (g) appoint preparatory working groups to develop background papers on different areas, e.g.:

- epidemiology (provide estimated prevention and care needs based on status and trends of HIV and related epidemics, and provide recommendation on the surveillance system)
- prevention among most at-risk populations (sex workers, men who have sex with men (MSM), IDUs and other groups; define a specific package of interventions and mechanisms for scaling up)
- other means of prevention (awareness, school education, condom promotion, mass media)
- care and treatment – ART, other vulnerable children (OVC), community-based centres (CBC)
- health services (STIs, blood safety, voluntary counselling and testing [VCT], PMTCT, TB/HIV)
- institutional arrangements and structures (coordination, human resources, capacity building, budgeting, planning, monitoring and evaluation).

These groups prepare background papers for brainstorming workshops. The papers should include a brief review of the current work, achievements, major gaps, weaknesses and challenges along with possible solutions, alternative options and new approaches. They should also address the issues of policy advocacy, capacity building, monitoring and coordination.

2. Brainstorming workshops to draft national strategies for HIV prevention, care and treatment
 - NAP to conduct a three-day brainstorming workshop for participants from within and outside the government and from various fields of work such as behavioural science, epidemiology, education, social welfare, uniformed personnel, medicine and the other disciplines required to address the HIV epidemic, including community-based organizations (CBOs), state and local health departments, members of infected and affected groups and international agencies (non-health departments). These participants will examine a situation analysis of the current epidemic, as well as a response analysis of current activities. They will then discuss and develop prioritized objectives and strategies to address each of the goals identified for HIV prevention, care and treatment.
3. Drafting of the NASP completed by the NCG
 - The NCG drafts the NASP using information from the national workshops and small groups.
4. National seminar held to receive feedback (public opinion) on the draft plan
 - Participants from various sectors throughout the country are invited to attend a seminar to consider the draft NASP and provide feedback for the revision and finalization of the draft NASP.

5. Submission of the final strategic plan to the NAC for endorsement
 - The NCG finalizes the draft NASP and submits it to the national authority for concurrence. The NASP is then to be submitted to the NAC for endorsement. In some cases, it will be further submitted to the National Health Committee to be included in the National Health Plan.
6. Dissemination of the NASP
 - The NASP is published and copies disseminated to all GOs, NGOs and other partners.

Sample chapter headings of a national AIDS strategic plan

A. Introduction

1. Country demographic data: population size, age distribution, etc.
2. Overall health situation: infant mortality rates, etc.
3. NAP management
 - Staffing and lines of responsibility for the NAP
 - Organizational structure of NAC
 - Technical Advisory Committees
 - NAP management structure including
 - organizational relationship within NAP and with other sectors
 - collaboration with other sectors
 - research activities
 - reporting and information-gathering procedures
 - how the programme will be funded

B. HIV/AIDS problem, control activities and target populations

1. Current HIV prevalence including plans for surveillance
2. Number of current and future PLHA needing care
3. Current STI prevalence and incidence
4. Number of current and projected deaths from HIV/AIDS
5. Number of current and future AIDS orphans
6. Current activities for HIV prevention, care and treatment
7. Description of populations at risk

C. Objectives, strategies and interventions

D. Programme policies and guidelines

1. List of programme policies, for example, policies about promoting human rights of PLHA and avoiding discrimination against them, about promoting condom use and

ensuring their availability, ensuring availability of adequate quantities of appropriate drugs, etc.

2. List of topics on which standard guidelines will be developed, for example, clinical management of STI, ART, rational use of blood, universal precautions, etc.

E. Programme prevention priorities and targets

1. Major prevention priorities of NAP (target populations and interventions)
2. Programme targets

F. Plans for activities

1. List of major activities, activity indicators and targets, and individuals or organizations responsible for following through each major activity
2. Plans for monitoring key performances and outputs

G. Plans for evaluating the programme

1. Priority programme indicators, programme and activity targets
2. Plans for surveillance of the incidence and prevalence of HIV and STI
3. Plans for a comprehensive programme review

H. Timetable: Summary timetable of major activities. For detailed workplan timetables for each activity and task, refer to Item J.

I. Budget

J. Detailed workplans: Include the detailed workplans – such as those developed for the NASP. For each task and its related steps, include information such as who is responsible for the task, its time frame and output indicators.

RESOURCES

1. *Towards universal access by 2010*, WHO 2006 (<http://www.who.int/hiv/pub/advocacy/towardsuniversalaccess.pdf>).
2. *UNAIDS policy positions* (<http://www.unaids.org/en/Policies/>).
3. *Ensuring equitable access to ART for women*, WHO/ UNAIDS Policy Statement, 2004.



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 3 DETERMINING PROGRAMME PRIORITIES AND APPROACHES



**World Health
Organization**

Regional Office for South-East Asia

National AIDS Programme Management

A Training Course

Module 3

Determining programme priorities and approaches

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Module 5 – Setting coverage targets and choosing key outcome indicators

Module 6 – Implementation of HIV prevention, care and treatment strategies

Module 7 – Managing the AIDS programme

Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

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Module 3: Determining programme priorities and approaches

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Determining programme priorities and approaches

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To assess the current range of HIV prevention, care and treatment activities against the broad objectives of a comprehensive HIV prevention, care and treatment programme.
2. To review and select target populations for HIV prevention, care and treatment.

INTRODUCTION

An essential part of HIV programme planning and management is to determine the programme's priorities and the approaches it will adopt to achieve its outcomes of HIV prevention, care and treatment.

In Module 1, participants were asked to summarize the information available to them on HIV risk and vulnerability in their country. In this module, they will be asked to set out their current and planned prevention and care interventions and assess these against the broad outcomes of a comprehensive prevention-to-care continuum.

Participants will then review target populations for prevention and care, and determine priorities for the programme.

OBJECTIVE 1: To assess the current range of HIV prevention, care and treatment activities against the broad objectives of a comprehensive HIV prevention, care and treatment programme

The goals of national AIDS programmes are to minimize HIV transmission and to reduce the impact of HIV on individuals, families and communities. To achieve these goals, the programme sets a number of broad objectives. These are generally:

- preventing sexual transmission;
- preventing transmission through injecting drug use;
- preventing transmission through blood, blood products and invasive procedures;
- preventing transmission from mother to child;
- promoting maximum improvement in the health of people living with HIV/AIDS (PLHA) through access to HIV counselling and testing, and to a continuum of care, support and treatment; and
- minimizing the impact of HIV on families and communities affected by it by reducing stigma and discrimination, and by increasing access to community care and support.

EXERCISE A

(Country group work followed by intercountry group discussion)

In this exercise, country groups will assess the current range of HIV interventions in their respective countries against these broad objectives. This will provide a baseline of information from which to work towards examining programme priorities, targets and indicators.

Groups will take up each broad objective area in turn and summarize the programmes and interventions that are currently in place to achieve that objective.

This is not meant to be an exhaustive exercise, but should provide a quick summary of where countries currently stand in their response to AIDS.

Objective	Examples of intervention areas	List current interventions
Preventing sexual transmission	<ul style="list-style-type: none"> • 100% condom use programmes in sex work settings • Outreach to sex workers, men who have sex with men (MSM) and other groups at risk • Expansion of access to sexually transmitted infection (STI) prevention and treatment – generally and for groups most at risk • Condom access and promotion • Media campaigns on safer sex 	
Preventing transmission through injecting drug use	<ul style="list-style-type: none"> • Outreach to drug users • Access to needles and syringes • Increased access to drug treatment services • Condom promotion and access 	
Preventing transmission through blood, blood products and invasive procedures	<ul style="list-style-type: none"> • HIV testing of all donated blood and blood products • Promotion of safe, voluntary, non-remunerated blood donation • Standard infection control guidelines for health services and skin piercing 	

Objective	Examples of intervention areas	List current interventions
Preventing transmission from mother to child	<ul style="list-style-type: none"> • HIV counselling and testing in Maternal and Child Health (MCH) clinics • prevention of mother-to-child transmission (PMTCT) treatment/ antiretroviral therapy (ART) for pregnant women with HIV 	
Promoting maximum improvement in the health of PLHA through access to HIV counselling and testing and to a continuum of care, treatment and support	<ul style="list-style-type: none"> • Increased access to HIV counselling and testing • Collaboration between HIV and TB programmes • Clinical care, opportunistic infection (OI) treatment and prophylaxis and access to ART • Community care and support • Training of health workers 	
Minimizing the impact of HIV on families and communities affected by it by reducing stigma and discrimination, and by increasing access to community care and support	<ul style="list-style-type: none"> • Promoting community care and support efforts • Introducing initiatives to reduce stigma and discrimination • Strengthening PLHA groups and networks • Involving churches, religious groups, community leaders 	

Inform your facilitator when you are ready for intercountry group discussions.

OBJECTIVE 2: To review and select target populations for HIV prevention, care and treatment

THE PREVENTION-TO-CARE CONTINUUM

It is important for programmes to focus on HIV prevention, care and treatment as part of a continuum rather than as separate initiatives. For individuals, families and communities affected by HIV, prevention, care and treatment needs are connected. PLHA are generally as concerned about avoiding transmission to others as they are about improving their health through care, support and treatment. The wife of a migrant worker with HIV is as concerned about protecting herself and her future child from HIV as she is about providing care and support for her husband.

Care and support outcomes can, and should, be derived from programmes that have traditionally focused on prevention. People involved in outreach to drug users have traditionally focused on distributing needles and syringes, condoms and information. They need to be just as focused on helping their clients access HIV counselling and testing and, if a client is HIV-positive, on care, support and treatment services.

People working in HIV care and treatment services also have a role to play in prevention. They can help the PLHA, they care for, to disclose their status to their sexual or drug-using partners, and then encourage the latter to be counselled and tested. PLHA can be helped to maintain safer behaviours.

DETERMINING PRIORITY POPULATIONS

The selection of priority populations for the AIDS programme needs to be based on a clear understanding of the “current context” of HIV in the country – who is HIV-infected and why, who is at risk and why – coupled with an analysis of the “most effective interventions” to bring about change. These two considerations need to inform the choice of priority populations.

Choosing priority populations is more than just generating a list. For example, it is too simplistic to just say that the programme will target sex workers, MSM, injecting drug users (IDUs), young people, truckers and migrant workers. Certainly some people in all these populations are at risk, but some people who do not fit into these populations are also at risk, and there are people within these populations who do not require priority targeting. Many countries identify “young people” as a priority population, without carefully

considering which group of young people, in which settings and by which methods they are to be targeted? This has resulted in the implementation of broad-based, youth-oriented HIV awareness campaigns in some countries with concentrated epidemics; these programmes have done little to reduce risk behaviour.

Remember that targeting the groups most at risk also means targeting young people, as the latter are highly represented in these groups.

Identifying and determining target populations

It is important for a programme manager to identify and describe the populations to be targeted for prevention interventions in the country. Possible target populations will be listed and described in terms of their size, their risk behaviours, the possible factors influencing risk of infection, the likelihood of their becoming infected and infecting others. This information will be entered step by step in a *Matrix for describing the target populations* and can also be used later when planning interventions.

Step 1: List populations at risk (Column A of the “Matrix for describing the target populations” on page 11)

The first step is to write a list of populations at risk of becoming infected or infecting others.

- (a) Review the definition of target populations. Target populations are groups of people who are at risk of HIV infection. They can be described by considering common behaviours, practices and/or situations that place them at risk of acquiring HIV or transmitting it to others. Demographic features, such as age, sex, education, occupation and geographical location, can also be used to describe them.

To identify target populations, first consider behaviours and/or practices that put people at risk of acquiring HIV infection or infecting others.

- (b) Next, review this list of examples of potential target populations.

Potential target populations

1. Sex workers
2. Clients of sex workers
3. Sexually active young people
4. People with STI

5. IDUs
6. Prisoners
7. Sexual partners of IDUs
8. MSM
9. Special occupational groups: For example, migrant workers, truck drivers, military personnel and industrial workers
10. Women of childbearing age

(c) From what is known about the risk behaviours and populations in a country, you can develop a list of potential target populations which may be important for the national AIDS programme (NAP) to address.

The matrix for describing the target populations follows. Column A lists some target populations at risk as an example.

Example

Matrix for describing the target populations

A	B	C	D	E	F
Population at risk of becoming infected and infecting others	Estimated population size	Risk behaviours	Possible factors influencing risk of HIV infection	(C+D) Likelihood of population becoming infected or infecting others (H/M/L)	(B+E) Relative importance (primary or secondary)
Sex workers					
Clients of sex workers					
IDUs					
Prisoners					

H: high; M: medium; L: low

EXERCISE B

(Individual work followed by country group discussion)

In this exercise, you will begin to fill in a matrix on page 22 to describe some target populations in your country. Use what you now know about the target populations and any data available to you. This and the following exercises will provide you with an opportunity to practise the process of identifying and prioritizing populations and interventions. The NAP would later follow this process to describe all target populations when the relevant information can be obtained.

Refer to the process described in step 1 above. List three or four target populations at risk in your country in Column A of the matrix.

Inform your facilitator when you are ready for country group discussions.

Step 2: Estimate the size of each target population (Column B)

The population size is useful for (i) determining the level of importance of each target population, (ii) deciding priority interventions for the NAP, and (iii) planning specific activities for each intervention.

It is necessary to use the best available information for estimating the size of a selected population. Enter the estimated size in Column B of the matrix.

In the example on page 13, the estimated size of each target population has been filled in the matrix (Column B).

Example

Matrix for describing the target populations

A	B	C	D	E	F
Population at risk of becoming infected and infecting others	Estimated population size	Risk behaviours	Possible factors influencing risk of HIV infection	(C+D) Likelihood of population becoming infected or infecting others (H/M/L)	(B+E) Relative importance (primary or secondary)
Sex workers	1 00 000				
Clients of sex workers	3 000 000				
IDUs	40 000				
Prisoners	40 000				

EXERCISE C

(Individual work followed by country group discussion)

In this exercise, the country will allocate a separate target population to each participant. Then, estimate the size of each population at risk in your matrix. Make the best estimate on the basis of your own knowledge, as well as that of your colleagues. Enter each number in Column B of the matrix on page 22.

Inform your facilitator when you are ready for country group discussions.

Step 3: Specify risk behaviours (Column C)

Specific behaviours that place people at an increased risk of acquiring HIV infection or infecting others need to be identified. To do this, it will be necessary to:

- review the available information on the behaviours and practices of each target population from various sources, including surveys, focus group discussions and key informant interviews; and

- (b) identify the behaviours and/or practices that put people in each selected target population at increased risk by considering the following chart and country-specific information. This information on behaviours is to be recorded in Column C of the matrix.

Probable risk of HIV infection associated with different behaviours

Degree of risk	Sexual	MTCT	Blood
No risk	<ul style="list-style-type: none"> –Complete avoidance of sexual behaviours (abstinence) –Non-penetrative sex acts: fantasy, hugging, body rubbing, masturbation 	Avoidance of pregnancy and/or breastfeeding if self or partner has HIV infection	<ul style="list-style-type: none"> –Abstaining from injecting drug use –Abstaining from injection with used equipment –Abstaining from sharing injection equipment –Avoiding blood transfusion
Less risk	<ul style="list-style-type: none"> –Vaginal intercourse with correct and consistent use of condom –Cunnilingus –Oral sex without ejaculation in the mouth –Oral sex with ejaculation in the mouth –Anal intercourse with a condom 	Infection of a woman prior to pregnancy (conception when the woman has HIV infection)	<ul style="list-style-type: none"> –Disinfecting shared injection equipment with bleach
Most risk	<ul style="list-style-type: none"> –Vaginal intercourse without a condom –Anal intercourse without a condom 	Infection during pregnancy or breastfeeding	<ul style="list-style-type: none"> –Using contaminated skin-piercing equipment, invasive equipment –Sharing unsterilized injection equipment –Any contact involving blood –Transfusion of contaminated blood

The following is a sample matrix. The risk behaviours of the target populations have been listed in Column C.

Example

Matrix for describing the target populations

A	B	C	D	E	F
Population at risk of becoming infected and infecting others	Estimated population size	Risk behaviours	Possible factors influencing risk of HIV infection	(C+D) Likelihood of population becoming infected or infecting others (H/M/L)	(B+E) Relative importance (primary or secondary)
Sex workers	1 00 000	–Vaginal intercourse without a condom –Anal intercourse without a condom			
Clients of sex workers	3 000 000	–Vaginal intercourse without a condom			
IDUs	40 000	–Using unsterilized injection equipment –Vaginal intercourse without a condom			
Prisoners	40 000	–Unprotected male-to-male sex –Injecting drug use			

EXERCISE D

(Individual work followed by country group discussion)

In Column C of the matrix on page 22, write the risk behaviours of each of your above listed target populations. Follow the steps described to identify the risk behaviours.

Inform your facilitator when you are ready for country group discussions.

Example

Matrix for describing the target populations

A	B	C	D	E	F
Population at risk of becoming infected and infecting others	Estimated population size	Risk behaviours	Possible factors influencing risk of HIV infection	(C+D) Likelihood of population becoming infected or infecting others (H/M/L)	(B+E) Relative importance (primary or secondary)
Sex workers	1 00 000	<ul style="list-style-type: none"> –Vaginal intercourse without a condom –Anal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple sex partners –Presence of STI –Limited access to condoms –Limited access to STI care 		
Clients of sex workers	3 000 000	<ul style="list-style-type: none"> –Vaginal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple sex partners –Anal intercourse is accepted –First sexual intercourse at age of 12–15 years –Social non-acceptance of condoms 		
IDUs	40 000	<ul style="list-style-type: none"> –Using unsterilized injection equipment –Vaginal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple partners –Urbanization, increased drug trafficking –High prevalence of HIV –High mobility –Lack of access to health-care services (stigmatization, fear of police) –Lack of access to rehabilitation and drug use treatment services –Lack of availability of condoms –Drug and alcohol use: judgement impairment –Rituals of drug injection group reinforcing sharing injection equipment 		
Prisoners	40 000	<ul style="list-style-type: none"> –Unprotected male-to-male sex –Injecting drug use 	<ul style="list-style-type: none"> –Lack of access to condoms, clean injecting equipment –Lack of access to drug treatment 		

Step 4: Identify possible factors that may influence the risk of HIV infection
(Column D)

In order to describe the target populations in detail, it is necessary to have a more complete understanding of the important factors that influence the risk of HIV infection.

Examples of the possible factors are listed below.

- Epidemiological and demographic factors
- Factors linked with support services
- Political and cultural factors
- Social and economic factors

More detailed information on the factors influencing risk and vulnerability is contained in an appendix at the end of this module.

EXERCISE E

(Individual work followed by country group discussion)

Review Column D in the preceding chart. In Column D of the matrix on page 22, write all the possible factors that you believe might contribute to the risk of infection for each target population.

Inform your facilitator when you are ready for country group discussions.

Step 5: Determine the likelihood of becoming infected or infecting others
(Column E)

A combination of the risk behaviours in Column C and the possible factors influencing the risk of infection in Column D can be used to decide if a target population has a high, medium or low likelihood of becoming infected or infecting others. You would need to consider the probable risk of the behaviours and the seriousness or the impact of the other factors. Review the following example.

Example

Matrix for describing the target populations

A	B	C	D	E	F
Population at risk of becoming infected and infecting others	Estimated population size	Risk behaviours	Possible factors influencing risk of HIV infection	(C+D) Likelihood of population becoming infected or infecting others (H/M/L)	(B+E) Relative importance (primary or secondary)
Sex workers	1 00 000	<ul style="list-style-type: none"> –Vaginal intercourse without a condom –Anal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple sex partners –Presence of STI –Limited access to condoms –Limited access to STI care 	High	
Clients of sex workers	3 000 000	<ul style="list-style-type: none"> –Vaginal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple sex partners –Anal intercourse is accepted –First sexual intercourse at age of 12–15 years –Social non-acceptance of condoms 	High	
IDUs	40 000	<ul style="list-style-type: none"> –Using unsterilized injection equipment –Vaginal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple partners –Urbanization, increased drug trafficking –High prevalence of HIV –High mobility –Lack of access to health-care services (stigmatization, fear of police) –Lack of access to rehabilitation and drug use treatment services –Lack of availability of condoms –Drug and alcohol use: judgement impairment –Rituals of drug injection group reinforcing sharing injection equipment 	High	
Prisoners	40 000	<ul style="list-style-type: none"> –Unprotected male-to-male sex –Injecting drug use 	<ul style="list-style-type: none"> –Lack of access to condoms, clean injecting equipment –Lack of access to drug treatment 	High	

EXERCISE F

(Individual work followed by country group discussion)

Review the entries you have made in Columns A–D in the matrix on page 22. Then decide whether each target population has a high, medium or low likelihood of becoming infected or infecting others. Record H (High), M (Medium), or L (Low) in Column E for each population.

Inform your facilitator when you are ready for country group discussions.

Step 6: Determine the relative importance (Column F)

In order to plan prevention activities, it is necessary to decide the relative importance of each target population. The relative importance will be a guide for planning the amount of programme effort and resources that need to be devoted to the target population.

To assess whether a target population is of primary or secondary importance, consider the size of the target population (Column B) and the likelihood of the target population becoming infected or infecting others (Column E).

Decide which of the following definitions best fits each target population.

DEFINITIONS

Primary importance

A target population is of primary importance when its significance for immediate planning purposes is high. Because of its estimated size, identified risk behaviours and other factors contributing to the risk of infection and infecting others, this population needs a relatively greater amount of attention when planning programme interventions and activities.

Secondary importance

A target population is said to be of secondary importance when it needs relatively less attention. The NAP may deal with this target population at a later time and with less focus than in the case of a target population of primary importance.

Example

Matrix for describing the target populations

A	B	C	D	E	F
Population at risk of becoming infected and infecting others	Estimated population size	Risk behaviours	Possible factors influencing risk of HIV infection	(C+D) Likelihood of population becoming infected or infecting others (H/M/L)	(B+E) Relative importance (primary or secondary)
Sex workers	1 00 000	<ul style="list-style-type: none"> –Vaginal intercourse without a condom –Anal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple sex partners –Presence of STI –Limited access to condoms –Limited access to STI care 	High	Primary importance
Clients of sex workers	3 000 000	<ul style="list-style-type: none"> –Vaginal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple sex partners –Anal intercourse is accepted –First sexual intercourse at age of 12–15 years –Social non-acceptance of condoms 	High	Primary importance
IDUs	40 000	<ul style="list-style-type: none"> –Using unsterilized injection equipment –Vaginal intercourse without a condom 	<ul style="list-style-type: none"> –Multiple partners –Urbanization, increased drug trafficking –High prevalence of HIV –High mobility –Lack of access to health-care services (stigmatization, fear of police) –Lack of access to rehabilitation and drug use treatment services –Lack of availability of condoms –Drug and alcohol use: judgement impairment –Rituals of drug injection group reinforcing sharing injection equipment 	High	Primary importance
Prisoners	40 000	<ul style="list-style-type: none"> –Unprotected male-to-male sex –Injecting drug use 	<ul style="list-style-type: none"> –Lack of access to condoms, clean injecting equipment –Lack of access to drug treatment 	High	Primary importance

EXERCISE G

(Individual work followed by country group discussion)

Review the entries you recorded in Columns B and E in the matrix on page 22 for each target population. Determine the relative importance (primary or secondary) of these populations. Record your assessments in Column F.

Inform your facilitator when you are ready for country group discussions.

EXERCISE H

(Country group work followed by intercountry group discussion)

In this exercise you will complete the matrix on page 22 by filling column G.

Look back at your strategic information and at the table you completed on current and planned activities. For each of the target populations which you have rated as being of “primary importance” in the matrix on page 22, identify the approaches that need to be taken to strengthen HIV prevention, care and treatment.

Remember to consider care along with prevention, as you have already recognized that there are people with HIV within these populations.

A full analysis of the approaches to prevention and care is contained in Module 5. For the moment, just identify, as precisely as you can, the broad approaches that need to be taken. Use the examples of the interventions set out in Exercise A as a guide.

Inform your facilitator when you are ready for intercountry group discussions.

Example

Matrix for describing the target populations

A	B	C	D	E	F	G
Population at risk of becoming infected and infecting others	Estimated population size	Risk behaviours	Possible factors influencing risk of HIV infection	(C+D) Likelihood of population becoming infected or infecting others (H/M/L)	(B+E) Relative importance (primary or secondary)	Approaches to be taken to strengthen HIV prevention and care

Appendix 1: Factors influencing HIV risk and vulnerability

Epidemiological and demographic factors	Factors linked with support services	Political and cultural factors	Social and economic factors
<ul style="list-style-type: none"> –HIV prevalence levels –Presence of STI –Frequency of exposure, e.g. multiple partners, multiple injections –Mixing patterns of populations –Bridge populations –Others 	<ul style="list-style-type: none"> –Limited access to and availability of condoms –Limited access to trained health-care professionals –Limited access to risk-reduction information –Limited access to STI diagnosis and treatment –Limited access to antenatal care –Limited access to HIV testing and counselling –Limited access to drug treatment and rehabilitation –Limited availability of needles and syringes –Limited screening available for blood supply –Poor attitude of health workers 	<ul style="list-style-type: none"> –War/civil disturbance –Limitations on interventions, e.g. condom distribution is illegal –Social non-acceptance of condoms –Opposition from religious groups to interventions –Low status of women –National policies –Norms and practices (e.g. needle sharing, numbers and types of sexual partners, military or police expecting sexual favours, age at first intercourse, young girls expected to do sex work) –Cultural/ethnic practices (dry sex, circumcision, tattooing, scarification) –Marginalized populations –Others 	<ul style="list-style-type: none"> –Literacy rates –Urbanization –Imprisonment –High mobility –Migration and separation of families –Drug use: judgement impairment –Alcohol use: judgement impairment –Others

Appendix 1: (cont.)

Examples of situations in which these factors may influence the risk of HIV infection in a target population are given below.

EPIDEMIOLOGICAL AND DEMOGRAPHIC FACTORS

HIV prevalence level

The prevalence level in a population is an important factor in determining the target populations on which the programme's efforts and resources should focus. If the estimated level of infection in a target population is very low, transmission of infection from this to other populations is less likely. If the prevalence is high in a target population such as IDUs, it is more likely that HIV will be transmitted within the population and to the sexual partners.

Presence of STI

There is strong evidence that men and women with genital ulcerative disease or other STIs are at increased risk for acquiring and transmitting HIV. Thus, a high prevalence of STI in a population would be an influencing factor for increased risk of HIV infection.

Frequency of exposure (e.g. multiple partners, multiple injections)

The probability of a person becoming infected with HIV sexually is, in general, proportional to the number or frequency of unprotected acts and the number of high-risk partners with whom the person has had sexual contact in recent years.

Mixing patterns of populations

Risk behaviours may be mixed and there may be a bridge population. For example, IDUs might not only share injecting equipment within their own population group, but may also have sexual partners who are outside their group.

FACTORS LINKED WITH SUPPORT SERVICES

Access to and availability of support services

These factors may serve as additional determinants of the risk of infection. Particularly important examples include access to and availability of condoms, access to information on the reduction of risk, and to facilities for the diagnosis and treatment of STI.

Attitude of health workers

The attitude of health workers towards a target population can play an important role in determining if the population will use the health services. For example, sex workers may not use STI treatment services if they are badly treated by the health workers.

POLITICAL/CULTURAL FACTORS

War and civil disturbance or natural disaster

These impose limitations on the regular importation of commodities, such as antiretroviral drugs, drugs for the treatment of STIs, condoms and HIV test kits. Messages through the mass media, such as those promoting safer sex and the use of condoms, might not be disseminated as planned. An increase in violence and lawlessness can also lead to an increased incidence of rape.

Limitations on interventions

Limitations, such as an arrest while carrying condoms or a crackdown on drug users, can hinder the progress of interventions aimed at prevention.

Social non-acceptance of condoms

This may be a determinant of risk in certain populations. For example, it may be unacceptable for the youth or unmarried women to be seen obtaining or purchasing condoms, or it may be unacceptable for them to use a condom.

Opposition from religious groups

Religious groups sometimes oppose promotional messages. Thus, they may influence the population's health practices, such as the decision to use or not use condoms.

Status of women

The status of women may be low and this may limit their ability to practise safer sex. For example, women might not be in a position to make decisions about the use of condoms, or to question their partners about extramarital sex.

National policies

Some national policies serve as barriers to the implementation of an intervention aimed at prevention. For example, restrictions on the availability of needles and syringes would limit the usefulness of an intervention to promote safer drug-injecting practices. Similarly,

legal restrictions on the availability of condoms to certain populations, for example, the youth, may have an impact on interventions for promoting safer sex.

Norms and practices

Some populations may face an increased risk of infection due to certain norms and practices, which need to be considered before designing prevention interventions. For example, sharing needles to “belong” to a group of IDUs might be a common ritual. Young people might be under peer pressure to have many sexual partners. The military or police might expect free sex from sex workers. It may not be culturally acceptable to discuss homosexuality.

Cultural and ethnic practices

Circumcision in males and females, tattooing and scarification may be accepted practices, but can contribute to the risk of infection because of the use of poorly sterilized skin-piercing equipment.

Marginalized populations

Economically deprived populations may never be able to benefit from prevention efforts because the social system refuses to recognize them. Some examples of such populations are sex workers and IDUs.

SOCIAL AND ECONOMIC FACTORS

Literacy rates

Low literacy rates may limit access to written information on risk reduction.

Urbanization

Many people may move to larger cities when they cannot find work in the rural areas. Sex work and increased drug use may be possible outcomes of urbanization.

Imprisonment

There may be increased same-sex activity among male prisoners due to the denial of access to women.

High mobility

The high level of mobility of certain target populations increases the geographical spread

of HIV transmission. For example, truck drivers may engage in sex with sex workers at several truck stops, thus increasing the spread of HIV.

Migration and separation from the family

People may have to travel to another country or region of the country to find work. The resulting separation from the family brings about an increase in the use of the services of sex workers and of sex with non-regular partners.

Alcohol and drug use

The use of alcohol and drugs impairs judgement and limits the ability to consistently practise safer sex.

When the information is reviewed and the target population described more fully, it may become apparent that the list of selected target populations needs a reappraisal. For example, information on risk behaviours or other factors influencing the risk of HIV infection of one target population may indicate that another target population is also important. In this case, the additional target population should be added to the list of target populations to be further described.



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 4 TARGETED HIV PREVENTION AND CARE INTERVENTIONS



**World Health
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National AIDS Programme Management

A Training Course

Module 4

Targeted HIV prevention and care interventions

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Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

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Module 4: Targeted HIV prevention and care interventions

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Targeted HIV prevention and care interventions

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To describe the rationale for using a targeted interventions approach.
2. To identify the populations to be primarily targeted.
3. To describe the key principles and characteristics of targeted interventions.
4. To describe the components of targeted interventions that have been used in the response to HIV.
5. To identify the dynamics that operates in one key environment of HIV risk and vulnerability.
6. To describe the steps required to design and implement targeted interventions.

INTRODUCTION

Different HIV epidemics require different approaches. However, regardless of the epidemic stage, it is usually more efficient to target specific populations with HIV prevention and care programmes and services. This does not mean that the impact of the epidemic is restricted to these populations.

Successful targeted interventions do not attempt to stigmatize populations at risk from the general population. They focus energy, resources and services on populations at risk, as the most efficient and effective way to reach people affected by HIV.

This module explains the rationale for targeted interventions and the key characteristics of these interventions. It assists participants to understand the environments of risk and vulnerability and to take steps to design and implement successful targeted interventions.

OBJECTIVE 1: To describe the rationale for using a targeted interventions approach

Targeted interventions are a resource-effective way to implement HIV prevention and care programmes in settings with low-level and concentrated HIV epidemics. They are also a cost-effective method of reaching people who are most at risk in more generalized epidemics. Targeted interventions are aimed at offering prevention and care services to specific populations within communities by providing them with the information, means and skills they need to minimize HIV transmission and improving their access to care, support and treatment services. The best-designed programmes also improve sexual and reproductive health (SRH) among these populations and improve general health by helping them reduce the harm associated with behaviours such as sex work and injecting drug use.

Implementing targeted interventions does not negate the need for broader interventions in the community. In many settings, it optimizes the use of resources by focusing on the environments and populations in which the risk of HIV infection is the greatest.

Targeted interventions:

- are for people within the community who are most at risk of HIV infection.
- are adapted to be culturally and socially appropriate to the target audience.
- focus on limited resources and where they can be used to the best benefit.
- effectively use the language and culture of the people being targeted.
- acknowledge that barriers to accessing health-care services exist for some populations within communities.
- acknowledge that people who are at risk of HIV infection are often marginalized from the broader community, stigmatized and discriminated against.

OBJECTIVE 2: To identify the populations to be primarily targeted

COLLECT AND ANALYSE DATA AND INFORMATION

Targeted interventions focus on the populations most at risk of HIV infection and most in need of HIV care, support and treatment. Good surveillance and research data provide national programmes with information about the nature, size and location of these populations. The criteria for identifying these populations are the presence of risk behaviours along with the presence of, or potential for, HIV infection in the population. In some cases, where data about a particular population are lacking, the presence of reliable information about risk behaviours might be sufficient to justify targeting it for prevention and care programmes.

TARGET THE BEHAVIOUR, NOT THE IDENTITY

In many HIV epidemics in Asia, the populations that require priority targeting are sex workers, injecting drug users (IDUs), men who have sex with men (MSM) and mobile populations. Sometimes minority ethnic populations who do not have the same access to health information and services as the general population, also require targeting.

It is important to remember that these broad groups are not homogeneous – that there are many different types of sex workers, for example, with different levels of HIV risk and different levels of access to health services. The same can be said of other target populations. Some MSM, for example, adopt an identity associated with this behaviour. They socialize with other MSM, they join community groups and they attend bars and clubs with other MSM. On the other hand, some MSM do not. They may be married to women and not identify in any way with other MSM. This information is important for programme purposes and helps to determine the effective strategies for targeting.

REMEMBER THAT PEOPLE CAN BELONG TO MORE THAN ONE TARGET GROUP

Simply stating that a population is to be targeted is not sufficient. People at risk may also belong to different populations and have a range of identities. Sex workers may also use injecting drugs. IDUs may sell sex or have sexual partners who sell sex. MSM may also sell sex or use drugs. Sex workers are often a mobile population, moving in and out of sex work environments or setting up services where mobile populations, such as migrant workers or truckers, are present.

INVOLVE THE COMMUNITY YOU WANT TO TARGET

Information, particularly from people within these populations, as well as nongovernmental organizations (NGOs) and community groups working with these populations, is required for effective planning of services and programmes. In most cases, the most important information about what places a particular population at risk of HIV infection and what can be done to reduce that risk comes from the population itself.

OBJECTIVE 3: To describe the key principles and characteristics of targeted interventions

The key characteristics of targeted interventions are as follows.

- **Place:** Targeted interventions are generally implemented at the places where the population concerned lives, works or congregates. This is an important element of targeted interventions. The population being targeted is usually cut off from mainstream services, either because it is marginalized due to stigma and discrimination, or because it is mobile. Making services available to the population is the most effective way of removing these barriers.
- **Relevance:** Reaching marginalized populations requires strategies and messages which are directly relevant to their needs, and which are provided in a language that they understand. Simply telling people to engage in safer sex and to use safer means of injecting is not enough. To ensure that the messages and strategies are appropriate, relevant and practical, they need to be developed by the population.
- **Continuity:** The populations being targeted are generally mobile or fluid. People enter and leave the environments concerned every day. The turnover of women in sex work environments, for example, is often very high. It is not possible to say at any particular point that an intervention has reached the population and that the population is protected from HIV infection. Programmes need to operate continuously or be regularly repeated in these environments to ensure that new members of the population have access to HIV prevention and care.
- **Credibility:** The populations at risk of HIV infection are often marginalized and sometimes engaged in illegal behaviours, such as selling sex, sex between men and illicit drug use, or in behaviours that they fear will be judged illegal, such as purchasing sex outside marriage. This makes them suspicious of public health and government officials. Establishing the trust of marginalized populations is an essential element of successful programmes. This usually involves the use of peer outreach workers (people from the population to be targeted), or of other outreach workers, including committed health-care workers, who can develop the trust of the population.
- **Link to mainstream services and programmes:** The aim of many targeted interventions is to ensure that marginalized populations have the access they need to HIV prevention and care. This does not always mean that services have to be population-specific. The targeted interventions may act as a bridge to bring members of the targeted populations into mainstream services, such as sexually transmitted

infection (STI) services, HIV care, support and treatment services and prevention of mother-to-child transmission (PMTCT) services. People working for targeted programmes generally need to link with mainstream services to ensure that these services are designed with the needs of the particular population in mind, and that the stigma and discrimination experienced by this population is minimized.

- **Linking prevention and care:** Bringing messages pertaining to HIV prevention alone to a target population is rarely enough. Many people in these groups are already living with HIV and successful programmes need to take this into account. Prevention-alone programmes can further marginalize people living with HIV/AIDS (PLHA) within these populations by focusing solely on protecting the population from HIV. Programmes that work across the prevention-to-care continuum assist all population members to adopt and sustain safer behaviours. They also help the people access a full range of health services, including STI diagnosis and treatment, maternal and child health, drug substitution and treatment, HIV counselling and testing services, and HIV care, support and treatment.

OBJECTIVE 4: To describe the components of targeted interventions that have been used in the response to HIV

Targeted interventions take many forms. The choice of interventions depends on the degree of marginalization of the group being targeted, the availability of other services and programmes, and the capacity of the population to participate in or lead the implementation. Here are some examples of targeted interventions currently being used in HIV.

- **Outreach:** Sending peers or people who will be trusted by the target population into the environment to make direct contact with people, to provide them with information and the means of protection, and to help them access services. Examples 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 MSM to go to bars and sex sites to talk to other men about HIV, distribute condoms among them, 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 bleach, provide information, assist in overdose prevention and abscess care, and help people access drug treatment and HIV services.
 - Arranging mobile vans to visit sex work, MSM or IDU sites at night to provide information, prevention commodities, clinical services and referrals.
- **Promotion and distribution of means of protection:** Ensuring condom, bleach and needle/syringe distribution through outreach workers and outlets in specific areas. HIV information should be designed to be relevant to a specific population, using language that is used by them and best suits their educational needs.
- **Support for the setting up of self-help and community groups:** Facilitating self-help or community groups from within target populations and providing them with resources, drop-in centres, to work on HIV and related issues in their communities.
- **Providing clinics and linkage to other services:** Providing clinical services for particular populations – such as sex workers, MSM, clients of sex workers – in their own neighbourhoods, with links to other services.

OBJECTIVE 5: To identify the dynamics that operates in one key environment of HIV risk and vulnerability

Implementing successful targeted interventions requires specific knowledge about the environment in which the risk behaviour takes place. It is not enough to target the individual at risk, the sex worker, for instance. One must also consider how the factors in the environment affect that person's ability to absorb the prevention message, change their behaviour, opt for testing, and access care, support and treatment services. A good programme that targets individuals might fail if there is no support in the environment for the behaviours that you are trying to inspire.

Here are some examples of the barriers that individuals in the primary target groups face in the context of long-term prevention and care.

For sex workers

- For sex workers living in poverty, the client has the power to purchase unsafe sex and the sex worker may be under economic pressure to comply.
- Sexual assault by police, brothel owners and others is commonplace in many sex work environments.
- Some local laws lead to the arrest of women who carry condoms on the assumption that they are sex workers. This puts pressure on sex workers not to carry condoms and, therefore, reduces their access to the means of protection.
- Brothel owners may insist that they need to offer unprotected sex to attract clients, or may do little to support safer sex.
- Clinic hours, charges or discriminatory practices might limit sex workers' access to STI and HIV care, support and treatment services.

For IDUs

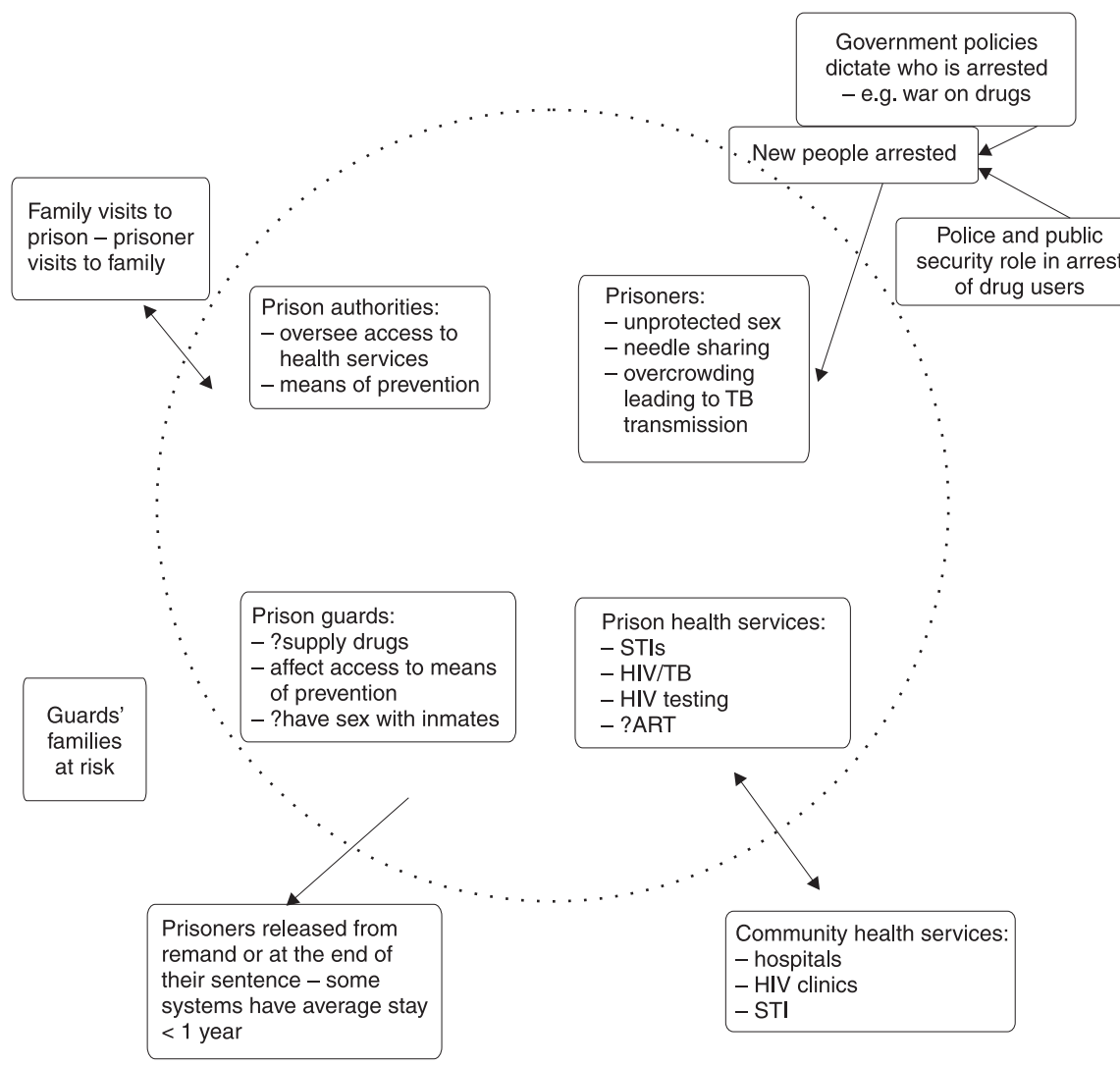
- Carrying clean injecting equipment can lead to arrest.
- The absence of non-injection alternatives (for example, drug substitution programmes) leads to an increased incidence of injecting.
- Stereotyping of drug users by medical personnel as unreliable may cut them off from HIV treatment programmes and services.
- The absence of HIV prevention and care programmes in prisons and drug rehabilitation centres, or poor links between prison and rehabilitation services, and services in the community may limit drug users' access to ongoing programmes for prevention and care.

For MSM

- Arrest or harassment of MSM and peer outreach workers by police makes it difficult to target MSM.
- Programmes that target only MSM who are identified by the fact that they join community groups may miss non-identified MSM.
- The lack of access to a lubricant (i.e., if it is not available or is too expensive) may lead to increased risk through condom breakage in anal sex.
- The stigma and discrimination experienced by feminized MSM and trans-gendered people cuts them off from programmes and services.

For prisoners

Environment of risk and vulnerability for prisoners, their families and the community



EXERCISE A

(Country group work followed by intercountry group discussion)

In country groups, choose a population at particular risk of HIV infection and in need of prevention and care services.

Describe the environment in which that population lives, using the diagram for prison environments as an example. Choose the environment of sex work, injecting drug use, male-to-male sex, or any other high-risk environment. Consider the following questions as you draw the diagram.

- Who are the people at risk of HIV infection in this environment?
- How do people flow through the environment – who comes in, who leaves?
- What are the different subpopulations within the environment?
- Who has the power to facilitate or block HIV prevention and care initiatives?
- What structures support safer behaviours or access to care, support and treatment?
- What structures work against this?

Use the diagram to explain the dynamic nature of the environment of risk.

Inform the facilitator when your country group is ready for intercountry group discussions.

EXERCISE B

(Country group work followed by intercountry group discussion)

In country groups, using the population your group chose for Exercise A, assess current interventions in your country against the criteria set out in the table below and identify and prioritize steps to strengthen the programme.

Element	Present situation	Steps to strengthen the programme
1. Strategic information		
What were the sources of information for designing this programme?		
What sources of data and information exist now?		
What are the gaps in knowledge, data and information?		
2. Participation of target population		
How have target populations been involved in the designing, implementation and evaluation of the programme?		
3. Range of strategies adopted		
Describe the range of strategies and services aimed at helping this population respond to HIV?		

Element	Present situation	Steps to strengthen the programme
4. Link to mainstream services		
	In what ways does the programme for this population link to mainstream services?	
	How is the access of the target population to mainstream services enhanced by the programme?	
5. Focus on the environment		
	How have the barriers to successful implementation been reduced?	
	What other players in the environment of risk are involved?	
6. Prevention-to-care continuum		
	Do the interventions focus on the continuum of prevention and care?	
Inform your facilitator when you are ready for intercountry group discussions.		

OBJECTIVE 6: To describe the steps required to design and implement targeted interventions

Putting all these elements together, it is possible, under the national programme, to design and implement a set of targeted interventions to reduce HIV transmission, both among the specific population and outside it, and to improve the population's access to HIV care, support and treatment.

In summary, the steps that will make these interventions work include the following.

Conduct initial mapping and make contact with the population

Complement behavioural surveillance information with information from the population, from groups which work within the population and from services that support it.

Involve the target population in the design, implementation and evaluation of the interventions, messages and services

This will maximize relevance, sustainability and ownership. Your priorities may not be the same as theirs. Listen to the target population and incorporate its needs into programme design. For example, your priority might be that female sex workers should use condoms, while theirs might be that their children should have access to education. Gaining their long-term trust and participation may depend on providing them with the things that they consider their highest priority.

Identify and support implementing partners who either have the trust of the population or can demonstrate that they can gain this trust

The prospect of HIV funding attracts many different groups. Make sure that the groups you fund have established links with the population that you wish to target, or will be acceptable to that population.

Obtain high-level support

Try to involve national or local leaders. Endorsement by a Minister, Governor or Mayor can ensure the collaboration of sectors other than health. Support the development of local implementing committees (for example, condom core group in 100% Condom Use Programme).

Involve the groups in the environment that have the power to affect the success of the interventions

Venue owners, police and security, local government officials, religious and community leaders, health service providers, clients of sex workers, drug suppliers, employers of migrant or mobile workers all have the power to “make or break” your programme. Make sure that they are also targeted.

Support long-term programming

It takes time to build a successful programme among a marginalized population. Interventions need to be sustained over time for the most effective long-term results.

RESOURCES

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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 5 SETTING COVERAGE TARGETS AND CHOOSING KEY OUTCOME INDICATORS



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Module 5: Setting coverage targets and choosing key outcome indicators

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2. To review methods for estimating the size of priority populations	9
3. To select key outcome indicators and related targets for priority populations Exercise B Exercise C	12

Setting coverage targets and choosing key outcome indicators

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To set coverage targets for priority populations identified in Module 3.
2. To review methods for estimating the size of priority populations.
3. To select key outcome indicators and related targets for priority populations.

INTRODUCTION

In Modules 3 and 4, we worked on setting priorities for interventions with populations most affected by HIV. In this module, we will build on that work and set some initial targets for programmes.

OBJECTIVE 1: To set coverage targets for priority populations identified in Module 3

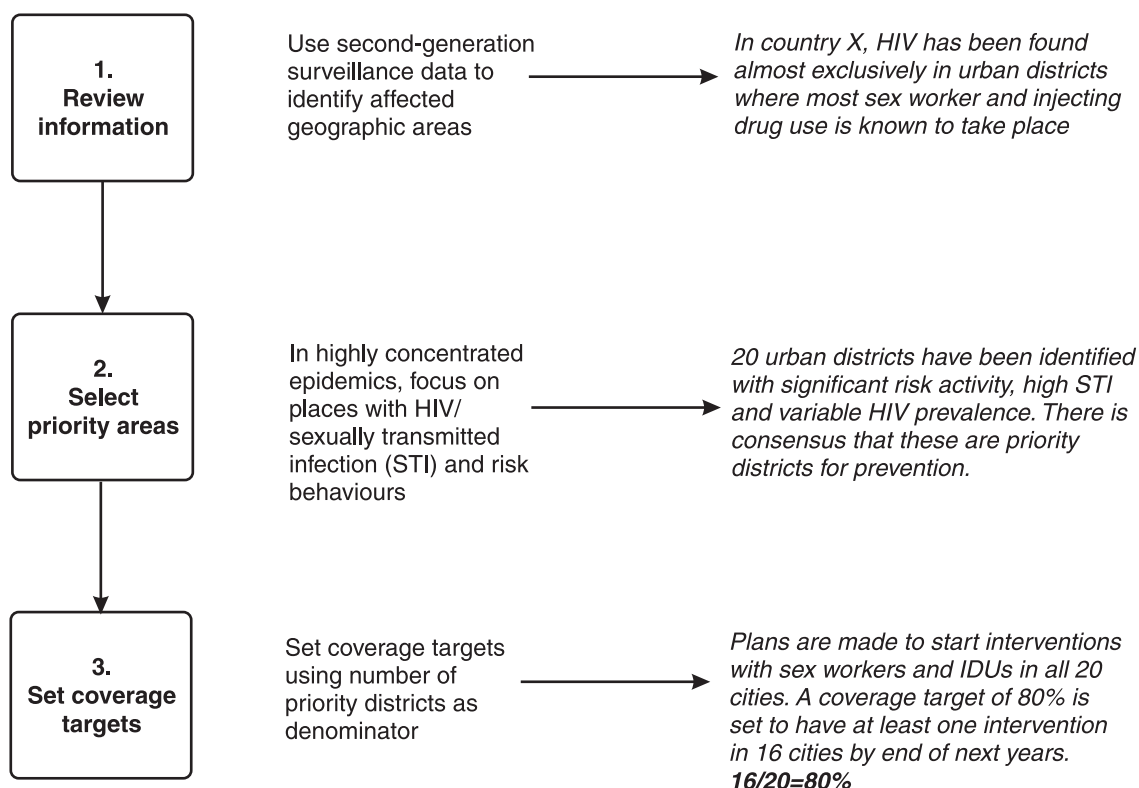
With regard to targeted interventions, coverage refers to their availability to, and utilization by, the populations concerned. There are many examples of model projects, innovative pilots and “best practices” that provide good services but reach only a small fraction of the population in need. In the South-East Asia (SEA) Region as a whole, for example, only 20% of sex workers, 3% of injecting drug users (IDUs) and 2% of men who have sex with men (MSM) are estimated to have access to even basic HIV prevention services. Even the best interventions will have little public health impact if they are implemented on a limited scale.

Programme managers should try to estimate needs and set targets to increase the coverage of priority interventions. This task requires some information about existing services, geographical distribution and the size of the populations in need (see Module 1). With this information, programme managers can set coverage targets that can be used to guide programme activities and monitor progress. Depending on the information available, targets can be set and coverage monitored in several ways:

- by geographical distribution, such as on the basis of administrative units (district, province, etc.);
- by individuals, based on population estimates;
- by combining the two methods for a more complete picture.

Estimates of coverage by geographical distribution are simpler because they do not require accurate estimates of population sizes. They do, however, require some analysis to decide which geographical units to include as the denominator. For example, a country with a low-level epidemic may decide that risk is concentrated in only 20% of districts with large urban populations and along borders. It would be reasonable to use these districts as the denominator for coverage targets. Similarly, when setting an 80% target for interventions among sex workers within two years, it would not make sense to use all districts as the denominator; rather, one would aim to establish interventions in 80% of targeted districts. Review the steps below and think about how this method of setting targets might work in your country.

example...



Estimates of coverage by individuals require more data on the size of populations (denominator) and plans for periodically measuring the number of people reached by interventions or services. While estimating coverage, priority should be given to populations most at risk, such as sex workers, MSM and IDUs. It may also be useful to set a time frame for the coverage target, for example in the short, medium and long term. A target from the country depicted above may be to reach 80% of sex workers in priority districts by the end of two years. This would require a system for recording new contacts with sex workers to track the cumulative number reached (numerator data).

Examples of these two approaches are given in the exercises below. In both cases, targets can be expressed as absolute numbers (for example, at least 16 out of 20 districts) or as percentages (at least 80%).

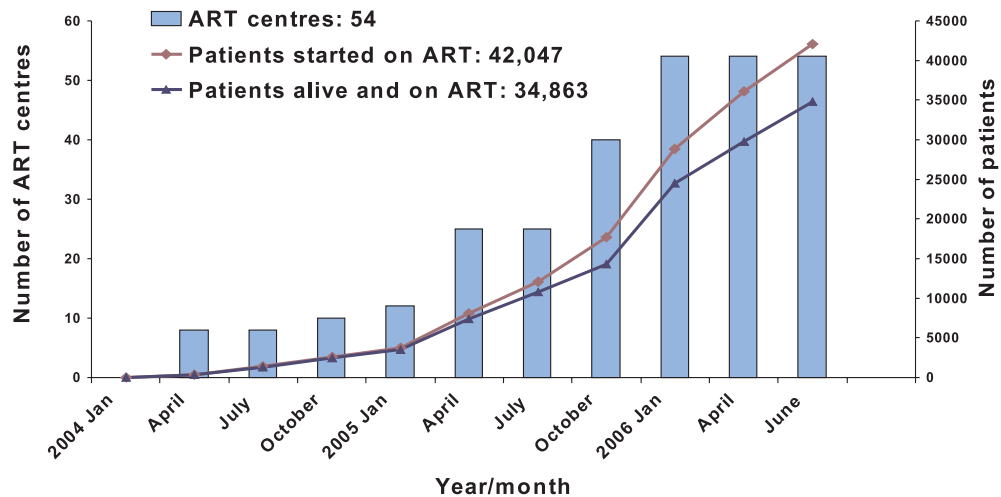
The basic steps in setting targets and monitoring progress include

1. Assessing available data and deciding whether to set targets based on geographical units or individual coverage.
2. Considering feasibility with regard to health system capacity, available resources, etc. This should include consultation with a range of partners.
3. Estimating denominators as appropriate to the method chosen in Step 1.
4. Monitoring numerator data (new districts added or new contacts) over time.

EXERCISE A

(Individual work followed by country group discussion)

Study the figure below and answer the following questions about coverage targets.



1. A country began scaling up antiretroviral therapy (ART) in early 2004. What do the data tell us about coverage? What more would you want to know?
2. Choose one intervention from Module 5 and set a realistic coverage target. Be sure to specify the unit of measurement and time period for the target. Discuss what data you will collect for the numerator and denominator and how you will collect it.

Inform your facilitator when you are ready for country group discussions.

OBJECTIVE 2: To review methods for estimating the size of priority populations

To measure reach and coverage, it is helpful to estimate the size of target populations for each intervention. The choice of method for estimating population size will depend on the characteristics of the population, how the information will be used, the types of information and resources available. Given below is a summary of the methods that are most frequently employed.

CENSUS/ENUMERATION METHODS

Synopsis: These are efforts to count all members of the target population or a sample of the target population.

Main features: In a census, all members of a population are counted. With enumeration methods, a sampling frame (i.e. a list of brothels or shooting galleries) is developed, and members of the population at the selected venues are counted. This figure is then adjusted to obtain an overall estimate of the population size.

Assumptions: These methods assume that most-at-risk populations can be reached at identified venues and then counted; however, members of most-at-risk populations can be hidden. A census can sometimes be impractical, as it is expensive and logistically difficult to conduct, particularly when members of the population move between venues.

MULTIPLIER METHODS

Synopsis: Use data from two overlapping sources.

Main features: The first set of data usually comes from a service that the population uses or an institution with which individuals come into contact. This may include, for example, the number of sex workers treated at the STI clinic or the number of IDUs arrested. The second set of data usually comes from a survey of the target population, where members are asked about their contact with the service or institution. The number served or contacted is then multiplied by the inverse proportion of the percentage of the target population that reports contact or that is covered by the service. For example, if the number served was 500 and 10% of the target population had reported contact, the estimated population size would be 5000 ($500 \times 100/10$).

Assumptions: While multiplier methods are relatively straightforward, care must be taken to ensure that the populations from both data sources correspond, so that members of the population survey have a chance to be included in the service or institutional dataset.

POPULATION-BASED SURVEYS

Synopsis: The prevalence of HIV-related risk behaviour is estimated from surveys of the general population or a subset of the general population.

Main features: Respondents from a survey of the general population or from a survey of a subset of the general population (e.g. military, youth, etc.) are asked whether or not they have practised HIV-related risk behaviours. The percentage practising a particular behaviour is then applied to census data or size estimates of the whole population to arrive at an estimate of the total number practising this behaviour.

Assumptions: These surveys are generally designed as household surveys and provide robust estimates of relatively common behaviours. As many of the behaviours that define most-at-risk populations are not common in the general population, these may be missed or estimates may not be very robust. Household-based surveys will not include those in brothels, in the street, or otherwise not at home. These surveys are most useful for estimating the number of men who engage in paid sex with a sex worker and less useful for less common, and more highly stigmatizing, behaviours.

CAPTURE–RECAPTURE

Synopsis: Uses two or more independent and overlapping samples to calculate the population size.

Main features: Researchers “mark” a random sample of members of the target population through either an interview or other means. They then take a second sample and determine the proportion also caught or “marked” in the first sample. A third random sample can also be used and the number marked—once, twice, or not at all—is used to estimate the total population size.

Assumptions: This method assumes a closed population, which means members will not move in and out of the population between rounds of the survey. It also assumes that all members of the population have an equal probability of being marked.

Other methods that have been used with varying degrees of success include the Delphi method – where a group of known experts is asked about the number of group members there are – and nomination methods – where members of a population are asked to provide other contacts from the same population. Respondent-driven sampling is a promising and innovative nomination method that has been used to estimate the size of IDUs and other populations in the United States of America.

OBJECTIVE 3: To select key outcome indicators and related targets for priority populations

While it is important to set targets and monitor progress related to programme coverage, programmes should also set targets and monitor indicators of key outcomes that they are trying to bring about.

For example, a programme may aim to reach 50% of IDUs with harm-reduction interventions in the next two years. It may also set a key outcome target of increasing the proportion of IDUs who report safe injection practices from 50% to 70% in that period. Review the figure in Exercise A. Identify indicators for coverage and outcomes. How are these different types of indicators important to programmes?

Outcome indicators are defined for most programme areas. Some examples

- Condom use during last sex (sex workers, MSM)
- Use of sterile injecting equipment (IDU)
- ART outcomes at follow-up (people living with HIV/AIDS [PLHA] on ART)

Outcome indicators should be easy to measure. For example, data collected from clinics as part of routine services are usually compiled on a regular basis (weekly or monthly). Indicators based on this kind of routine reporting permit close monitoring of trends over time.

Other outcome indicators may require special surveys. For example, most MSM are healthy and have little contact with health-care services. The programme is focusing on scaling up outreach and condom promotion in areas where MSM meet. It is possible to conduct surveys every year or two to ask about condom use, risk behaviours and STIs. If a local clinic provides services to many MSM, similar data can be collected more frequently between surveys from MSM patients. Together, routinely collected data and data from surveys provide a more complete picture.

Indicators should also be clearly defined. Review the table below and think about how the information could be obtained, how often, in what places, etc.

Different indicators can be compared or *triangulated* to give a better idea of the progress made. Key impact indicators (from second-generation surveillance, for example) should be tracked with outcomes to see if observed trends make sense. For example, increasing

rates of condom use reported by sex workers would be an indicator that prevention programmes are achieving success. If rates of STI among sex workers and clients were falling at the same time, this would be even more encouraging. Finally, declining HIV prevalence among these groups over the longer term would provide a very strong evidence that interventions were changing behaviour and having an impact on sexual transmission. The more sources of data that can be triangulated, the more confidence you will have in the indicators. Review the following indicators and think about how they can be triangulated with UNGASS/MDG indicators to monitor programme outcomes.

Risk behaviours

Indicator	Definition
Sex worker risk behaviour*	% of sex workers reporting condom use with their most recent client, in the last month
Sex work clients risk behaviour*	% of men reporting condom use in sex work contact during the last 12 months
IDU injecting risk behaviour*	% of IDUs reporting non-sharing of injecting equipment during the last 12 months
IDU sexual risk behaviour*	% of IDUs reporting condom use last time they had sex
MSM risk behaviour*	% of MSM reporting condom use in last sexual contact of risk, in the last 12 months

STI/HIV/AIDS prevalence

Indicator	Definition
STI trends (several STIs)**	% (N°) of reported STI cases over the years
HIV/AIDS prevalence rates in young adults*	% of estimated HIV-positive, estimated number of AIDS cases and deaths

For care and treatment, outcome indicators are equally important.

Indicator	Definition
Number of ART patients*	Number (%) of HIV-infected persons and those with advanced HIV infection receiving ART
Survival of ART patients	% of new ART patients alive, after 6 and 12 months of initiation of treatment

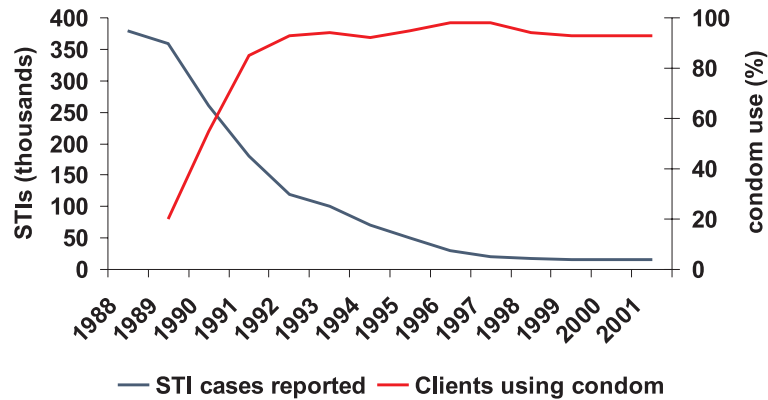
* UNGASS/MDG indicators

** STI indicators may vary from country to country but include syphilis seroprevalence as well as incidence of common syndromes (genital ulcer disease in men and women, urethral discharge in men).

EXERCISE B

(Country group work followed by intercountry group discussion)

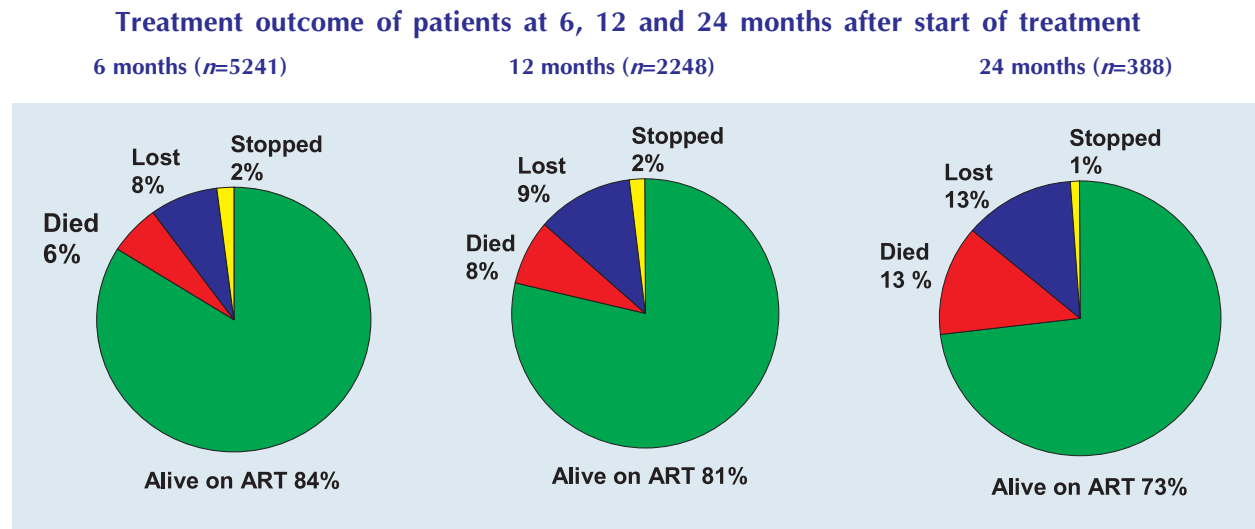
1. Thai condom use and STI data among female sex workers (or other triangulation exercise).



(a) Discuss the trends and implications for programme managers.

(b) How can different types of data (monitoring data, second-generation surveillance, etc.) best be used to monitor outcomes?

2. We have seen earlier that there was a rapid increase in the coverage of ART. What more can we say about the ART programme from the figure below?



- (a) What are the main outcomes for PLHA who have started treatment?
- (b) How do you interpret the information on outcomes in the three graphs? Based on these data, what should the programme look into?

Inform your facilitator when you are ready for intercountry group discussions.

EXERCISE C

(Country group work followed by intercountry group discussions)

Review the outcome indicators presented on page 13 in this module.

1. Rank the indicators in terms of their importance to the epidemic in your country.
2. Consider feasibility: what factors would you consider in selecting these indicators?
3. Discuss how several indicators can be triangulated to validate data.

Inform your facilitator when you are ready for intercountry group discussions.

RESOURCES

1. M&E of HIV prevention programme for most-at-risk population, UNAIDS, July 2006.
2. *Training toolkit – HIV care and ART recording and reporting system*. New Delhi, WHO Regional Office for South-East Asia, 2005.



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 6 IMPLEMENTATION OF HIV PREVENTION, CARE AND TREATMENT STRATEGIES

SUBMODULE 1 MINIMIZING SEXUAL TRANSMISSION OF HIV AND OTHER STIs



**World Health
Organization**

Regional Office for South-East Asia

National AIDS Programme Management

A Training Course

Submodule 6.1: Minimizing sexual transmission of HIV and other STIs



**World Health
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Module 7 – Managing the AIDS programme

Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

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Submodule 6.1: Minimizing sexual transmission of HIV and other STIs

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Submodule 6.1

Minimizing sexual transmission of HIV and other STIs

LEARNING OBJECTIVES

After completing this submodule, participants will be able:

1. To outline the factors that affect the sexual transmission of HIV.
2. To explain the components of the Essential Prevention Package for minimizing sexual transmission of HIV within a broader strategic response to STIs.
3. To identify priorities and strategies for strengthening the national programme using the Essential Prevention Package.
4. To describe the components of the 100% Condom Use Programme (Thailand case study).

INTRODUCTION

Sexual transmission of HIV is a key driving force behind many of the HIV epidemics in Asia. This is fuelled by high levels of other sexually transmitted infections (STIs) in the affected populations. Even in epidemics primarily driven by injecting drug use, sexual transmission is a factor in the spread of HIV from the drug user population to other populations. Reducing sexual transmission of HIV and other STIs is not a simple matter of increasing the knowledge and awareness of individuals at risk. There are complex issues of power, poverty, economics and marginalization that need to be dealt with if safer sexual behaviours are to be adopted and sustained.

This module presents a model that places the prevention of sexual transmission of HIV within a broader sexual health response, combining services for individuals with strategies that address the networks and context in which sexual transmission occurs. Desired outcomes include community norms and services that support safer sex and the prevention and control of STIs.

Submodule 6.1 • Minimizing sexual transmission of HIV and other STIs

Participants will be familiarized with the thrust of the Global and Regional Strategies for the Prevention and Control of STIs and provided with assistance to assess their country's current strategies for the prevention of sexual transmission of HIV in line with these. Key issues regarding access to condoms and other barriers to sexual transmission will also be covered.

OBJECTIVE 1: To outline the factors that affect the sexual transmission of HIV

Preventing the sexual transmission of HIV is simply a matter of adopting and maintaining safer sex practices. However, there are many complex individual and societal issues that make this difficult to achieve.

Several factors contribute to a person's ability to avoid sexual transmission of HIV. These include:

- **Knowledge** – about how HIV is transmitted and how transmission can be avoided.
- **Access to the means of prevention** – to male and female condoms and water-based lubricants.
- **Power** – being in control of one's own sexuality and able to enact safer sex decisions.
- **A supportive environment** – community and societal support for reducing risk by delaying first sex, adopting safer sex practices and carrying condoms.
- **Sexual health** – particularly the presence of other STIs that would make the transmission of HIV much more likely during unsafe sex.

KNOWLEDGE

Myths and misconceptions abound about how HIV is transmitted and about what can be done to avoid HIV transmission. Many people still do not see themselves as being at sexual risk, or hold false beliefs that the behaviours they have adopted will protect them. These misconceptions and false beliefs need to be broken down by providing clear information in a format and language that is appropriate for the target group.

ACCESS TO THE MEANS OF PREVENTION

Condoms have been promoted and made more widely available in many countries. However, some challenges still remain. Condoms need to be made available, accessible and affordable, even for people living in poverty, and of good quality to ensure proper protection. Laws, regulations and practices by police and others which punish or harass people for carrying condoms need to be addressed. Lubricant for sex workers and for men who have sex with men (MSM) is still not widely available or, if available, is too expensive. This leads to condom breakage and transmission of HIV and other STIs.

POWER

This is a complex area. For people to avoid HIV infection they need the knowledge, the

means and the power to remain safe. Many factors affect people's power in this area.

- Women who do not have the power to discuss sex and HIV risk with their husbands or sexual partners may not be able to avoid HIV infection.
- Female and male sex workers who do not have adequate food and shelter for themselves and their families may not be able to refuse a client who wants to pay for unsafe sex.
- People using alcohol and other drugs may find it difficult to make sound decisions about safer sex.
- Marginalized women working illegally as sex workers may be more prone to sexual assault.
- Prisoners and other people in environments where there is no access to a means of prevention may not be able to avoid HIV and other STIs.
- People with poor access to STI prevention and treatment services may have undiagnosed STIs that contribute to their HIV risk.

Strategies to reduce HIV transmission need to take power into account. There are cultural and structural arrangements in most societies that give power to some and take it away from others. Examining these arrangements and their effect on HIV and STI prevention and control is an important task for AIDS programmes. Ignoring them can place the responsibility for HIV prevention solely in the hands of the people who do not have the power to bring about the necessary changes.

SUPPORTIVE ENVIRONMENT

An individual's decision to have safer sex is supported by an environment in which this is the norm. Young people's decisions about when to start having sex and whether to use condoms are affected by family and community norms and peer pressure. An individual sex worker's decision to have safer sex is supported if the brothel or area has a 100% condom use policy. It is jeopardized if the owner and the clients do not support the behaviour. Police harassment and arrest of people who carry condoms are environmental factors that have a direct impact on the person's ability to sustain safer sex.

SEXUAL HEALTH

The presence of genital ulcer disease increases the risk of HIV transmission by up to 50–300 times per episode of unprotected intercourse. HIV shedding in the semen of men with gonococcal urethritis is six times higher than that in uninfected men, and reverses when the urethritis is treated. Preventing and treating STIs has a direct impact on the efficiency of HIV transmission. People who do not have STIs can still acquire HIV, but it is clear that HIV is transmitted much more readily in populations where the prevalence of other STIs is high.

OBJECTIVE 2: To explain the components of the Essential Prevention Package for minimizing sexual transmission of HIV, within a broader strategic response to STIs

THE GLOBAL STRATEGY FOR THE PREVENTION AND CONTROL OF STIs

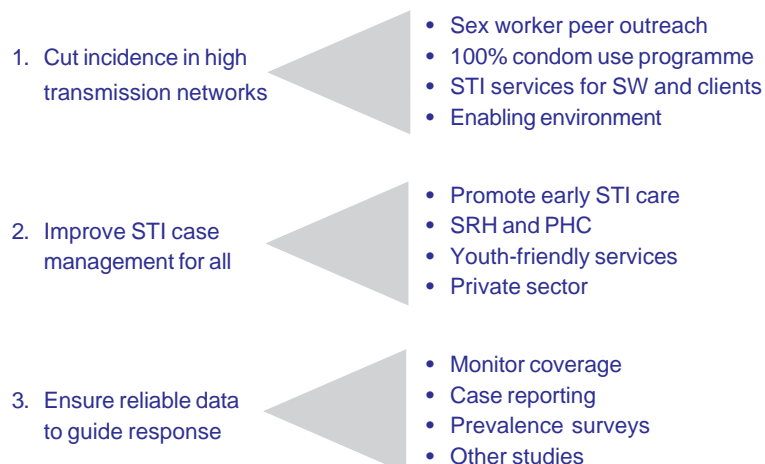
In May 2006, the World Health Assembly endorsed the Global Strategy for the Prevention and Control of STIs 2006–2015.

The Strategy promotes the following established key elements:

- reviewing policies, laws and regulations regarding STI control to ensure that they are non-punitive and non-coercive, and contribute towards the aims of STI prevention and control programmes and services;
- promoting healthy behaviours: safer sexual and health-care seeking behaviours, compliance with therapy, and responsible notification and management of STIs in sexual partners;
- delivering STI care including antenatal screening for syphilis and other STIs, ophthalmic prophylaxis at birth for neonates, and immunization against hepatitis B;
- ensuring a reliable supply of safe, effective, high-quality and affordable medicines and commodities for STI prevention and treatment, including male and female condoms and other effective barrier methods; and
- strengthening support components, including the adaptation of normative guidelines, training, information networks, commodities, logistics, laboratory support, surveillance and research.

The WHO Regional Office for South-East Asia has produced a Regional STI Prevention and Control Strategy that complements the Global Strategy and identifies the following priority areas:

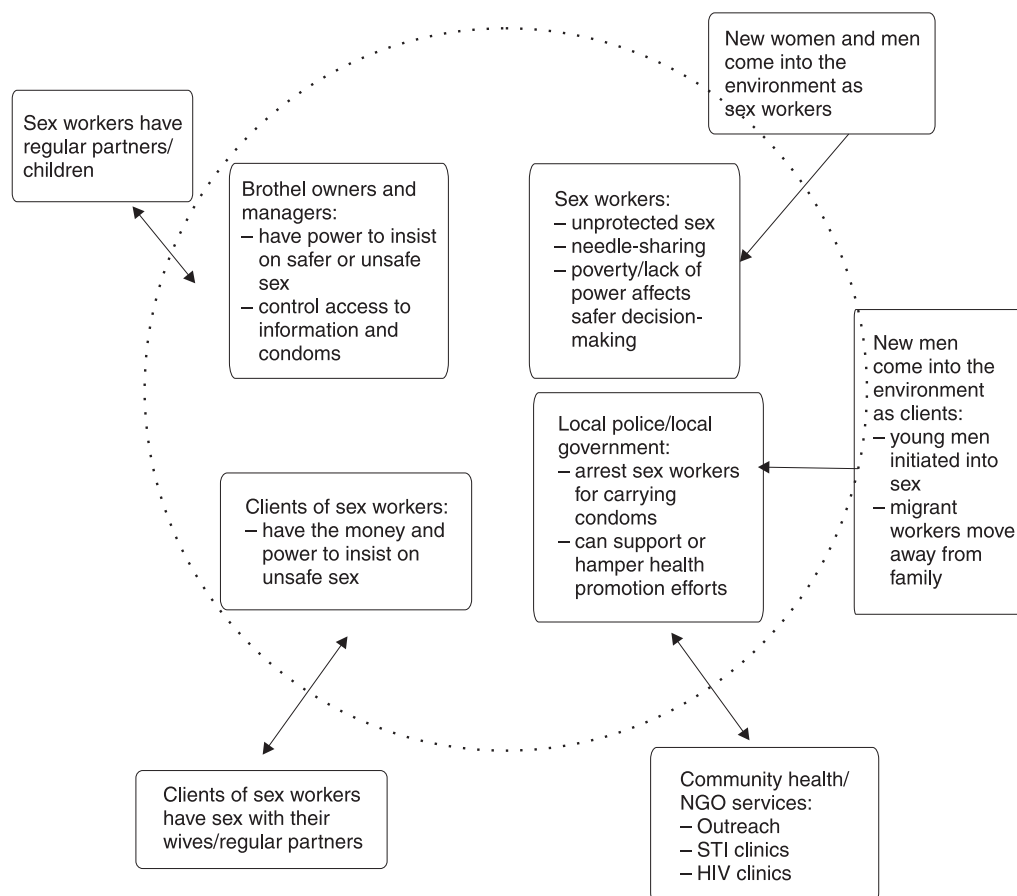
Priority overview...



High transmission networks are identified as those environments in which HIV and other STIs are most readily transmitted – male and female sex work environments and other environments in which people have multiple partners and unprotected sex. Strategic information, including risk behaviour mapping at national, provincial and local levels will assist countries to determine the networks for priority targeting (*see also* Targeted Interventions, Module 4).

Go back to the environmental maps that you developed in Module 4. The high transmission networks referred to here are the environments of risk and vulnerability that you identified in the Module 4. These are the environments of sex work and male-to-male sex. They include the populations at risk such as truckers and migrant workers who use sex workers when they are separated from their families. Do not be limited by these definitions. They are just intended to assist you to describe the patterns of HIV transmission that you see in your country. The most important task is to clearly understand the patterns of risk and transmission in your area and then focus your interventions on those environments.

Environment of risk for sex workers, clients and community



Essential Prevention Package (EPP) for sexual transmission

Information and education

- Develop and disseminate information on HIV and other STIs tailored to the language and needs of particular populations.
- Implement background campaigns to encourage safer sex, condom use and early STI diagnosis and treatment.
- Include specific information on effective use of condoms that are distributed – safer sex packs.
- Work with the media to promote the provision of accurate information.

Outreach

- Ensure wide coverage of outreach programmes for sex workers and MSM.
- Provide specific prevention initiatives aimed at clients of male and female sex workers and other sexually active men.
- Develop strong referral links between outreach programmes and STI/HIV clinical services.
- Involve affected communities (sex workers, MSM, PLHA) in prevention programmes.

Means of prevention: male and female condoms, lubricant, microbicides

- Devise strategies to increase the availability and accessibility of free or affordable good-quality condoms.
- Implement specific strategies for uninterrupted supply in high-use environments – brothels, clubs and other sex work venues.
- Ensure the wider availability of affordable female condoms and of water-based lubricant in high-use environments.

Services: STI prevention and treatment, with links to HIV testing, care and treatment

- Update policies and procedures to encourage sex workers, MSM, clients of sex workers, young people and other targeted groups, to access STI services (attitudes, opening times, procedures, cost).
- Locate STI services in environments of high incidence – sex work districts, within sex work and MSM organizations, mobile clinics.
- Provide STI services in reproductive health clinics and primary care clinics.
- Provide early and effective STI treatment.
- Engage with private sector services to increase the quality and reach of private services.

- Modify and disseminate STI diagnosis and treatment guidelines, including screening or presumptive treatment for sex workers.
- Train staff in STI diagnosis and treatment.
- Ensure a consistent supply of STI diagnostics and medicines.
- Provide HIV counselling and testing through STI services, with a routine offer for people diagnosed with an STI.

Enabling environment

- Set standards of care and train health-care workers and other providers to reduce stigma and discrimination against sex workers, MSM and other marginalized groups.
- Review and reform operational policies and procedures of key services to increase access of these groups to services.
- Review police policies and procedures to reduce harassment and stop the arrest of people who carry condoms.
- Work with the police and public security personnel to enlist their cooperation and support for prevention programmes.
- Work with the government, community and religious leaders to enlist their support.

This Essential Prevention Package is complemented by strategies to progressively increase access to HIV care, support and treatment services. These include the following.

Care, support and treatment

- Link prevention and care strategies – train outreach staff to assist sex workers, MSM and their partners who are already HIV-positive to access services, and train clinical services staff to reinforce prevention strategies when caring for them.
- Set standards of care and train health-care workers and other providers to reduce stigma and discrimination against sex workers, MSM and other marginalized groups at high risk.
- Review and reform operational policies, and procedures of key services to increase the access of vulnerable groups to services.
- Train HIV clinical staff in the particular care and treatment needs of sex workers and MSM.

OBJECTIVE 3: To identify priorities and strategies for strengthening the national programme using the Essential Prevention Package

The Essential Prevention Package set out above contains the elements of a comprehensive HIV prevention response. The modules on determining programme priorities and targeted interventions have assisted you to identify the populations that require priority targeting with prevention efforts.

EXERCISE A

(Country group work followed by intercountry group discussion)

This exercise is designed to assist you to determine the range of strategies to put in place to ensure that these populations receive the information, support and services that they need to sustain safer sex practices and reduce HIV transmission.

Select a population at high risk of sexual transmission (FSW, MSM, MSW). Review the components of EPP (pages 11–12) and complete the following matrix. Identify the key programme gaps and measures for strengthening.

	Selected population	Key programme gaps	Measures for strengthening
Awareness and information			
Outreach			
Prevention			
STI services			
Enabling environment			
Care, support and treatment			

Inform the facilitator when you are ready for intercountry group discussions.

OBJECTIVE 4: To describe the components of the 100% Condom Use Programme (Thailand case study)

This case study provides detailed information about the 100% Condom Use Programme carried out in the sex work environment in Thailand. This programme cuts across several areas of the Essential Prevention Package – outreach, access to STI services, promotion of condom use and the establishment of an enabling environment for prevention programmes. It provides an effective model for HIV and STI prevention in the sex work environment.

BACKGROUND

In 1989, the Provincial AIDS Committee of Thailand's Ratchaburi Province put in place an HIV prevention strategy that included a 100% Condom Use Programme to reduce the transmission of HIV and other STIs. This programme had the backing of the Provincial Governor and involved local government officials, provincial medical staff, police officials, school principals and people from the private sector, including employers and brothel owners.

The programme comprised the following elements:

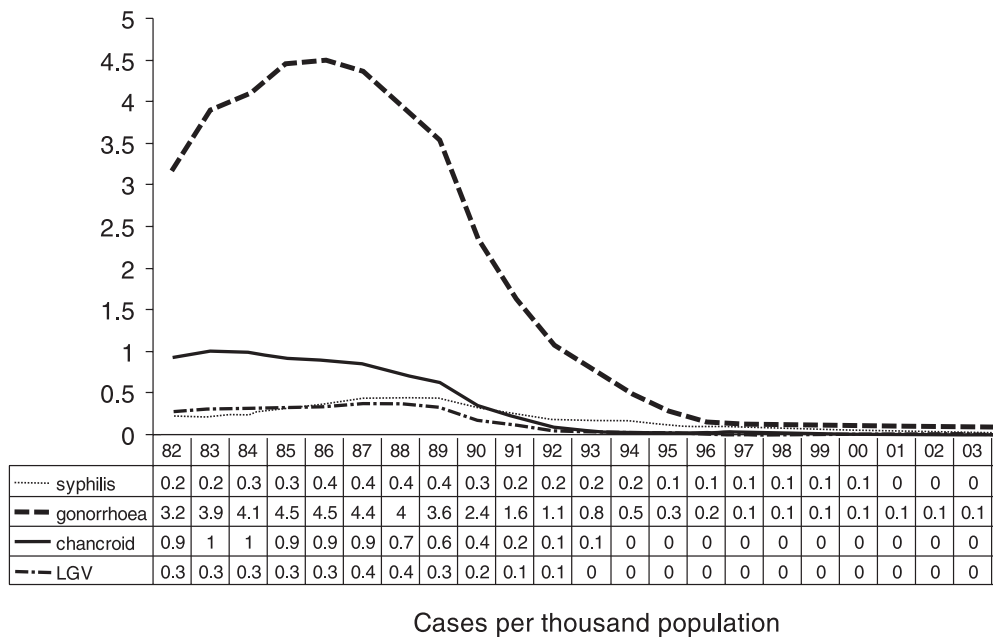
- a declaration of 100% condom use for brothels, with penalties (closure) to be imposed if brothels did not comply;
- establishment of a multisectoral committee to oversee the programme;
- campaigns to promote the carrying and use of condoms;
- regular meetings between the police and brothel owners; and
- training for sex workers.

One of the main aims of the programme was to move the responsibility for condom use from the individual sex worker onto the sex work establishment.

The programme proved successful in significantly increasing condom use and was then rolled out in other provinces. In 1991, the first National AIDS Committee meeting, chaired by the Prime Minister, endorsed the 100% Condom Use Programme and called for close collaboration at provincial level between the Governor, the Chief Medical Officer, Chief of Police and the public health office. It also called for Ministries to seek the support of their local offices for the programme. By the end of April 1992, all provinces in Thailand had 100% Condom Use Programmes in place.

STI incidence per 1000 population, Thailand 1982–2004

(Source: Chitwarakorn 2004, MoPH)



IMPACT

The graph above shows the change in incidence of major STIs in Thailand from 1982 to 2004. The 100% Condom Use Programme is credited with having contributed significantly to this reduction in incidence.

STEPS FOR IMPLEMENTING THE 100% CONDOM USE PROGRAMME

The Thailand programme identified the following steps for implementing a 100% Condom Use Programme:

1. Organize a meeting of the provincial AIDS Committee, present strategic information on HIV transmission and the elements of the 100% Condom Use Programme. Seek the endorsement of the Committee for the programme.
2. Identify who will coordinate the programme and where the resources will come from.
3. Convene a high-level meeting to explain the programme and gain support and assistance. The meeting should
 - be chaired by the provincial Governor or another person with local authority;
 - include representatives from the local government, police, social welfare, provincial health services, communicable disease control authorities, STI services staff; and
 - include brothel owners and sex worker representatives.

This meeting presents the regulations and procedures that would back up the programme – including regular health check-ups for sex workers and closure of brothels that do not comply with the programme. It sets out the benefits for brothel owners, sex workers and clients: better health, increased productivity, participation in the provincial health effort, and increased legitimacy for sex workers and brothel owners.

The meeting also provides the Police Chief with an opportunity to publicly state the Police Department's support for the programme.

4. Establish an Inspection or Compliance Committee, or a set of strategies to monitor compliance with the programme.

Compliance strategies include examining data and information from STI clinics, and visits to brothels to interview sex workers and clients. Provincial coordinators report progress every month to the Provincial AIDS Committee. This intensive tracking of progress is a key feature of the programme.

Information from the STI clinics is correlated with that from the brothel inspection. People diagnosed with STIs are asked to identify the brothel that they had used and this brothel receives a follow-up visit.

STRENGTHS OF THE 100% CONDOM USE PROGRAMME

- It produces a rapid and widespread increase in condom use.
- It reduces HIV infection and transmission of other STIs.
- It can be quickly scaled-up to cover an entire province.
- It is a cooperative, inclusive model that does not punish sex workers or clients.
- It is not affected by the mobility of sex workers as it focuses on venues.
- It has little impact on the local economy – it focuses on changing behaviour rather than eliminating sex work.
- It is more effective than broad-based awareness campaigns that may not change behaviour.

CHALLENGES AND BARRIERS ENCOUNTERED

- Interruptions in condom supplies are sometimes blamed for non-compliance.
- Poor quality condoms sometimes jeopardize the programme as they break and discourage people from using condoms in the future.
- New brothels and sex venues open all the time – local knowledge and regular follow-up is important.

- Sex workers sometimes use condoms with clients but not with regular partners. Some sex workers still contract STIs.
- The programme is criticized by some for giving power and recognition to sex workers, though this is viewed by many as a positive aspect of the programme.
- The programme does not focus on people having non-commercial sex – people meeting each other in bars, at dance parties or at other venues.
- There was a need to develop strategies to ensure that the programme also reached informal, non-brothel based sex workers.
- If political commitment and resources decrease as STI rates decline, there is the danger that STI/HIV transmission could rebound.

EXERCISE B

(Country group work followed by intercountry group discussion)

In country groups, look at the various aspects of the 100% Condom Use Programme and complete the attached table to examine how this model could be applied in your setting.

Remember that this is an intervention which is primarily focused on venues where sex takes place. Other interventions to complement this were covered in Exercise A in this submodule.

If you are covering your country, divide it up into its provinces/states or districts to help you identify the areas that can be targeted first. The 100% Condom Use Programme relies on the existence of local authorities to support the programme, hold the meetings and carry out the inspections. Reflect this in your table. Each area identified in the table should have a formal government jurisdiction (such as a city/town, district or a province) that has health officials, police officials, an AIDS Coordinating Committee and other structures that can take the programme forward.

The tables on the next two pages should be used together so that the questions relating to one area (a city/town, district or province) can be answered across the two tables.

Inform the facilitator when your country group has completed this exercise.

EXERCISE

Table 1. 100% Condom Use Programme

Areas	Estimate the number of sex venues/brothels in this area	Describe what you know about the range of brothels/sex venues in this area – number of sex workers, whether sex occurs on the premises or not	What STI services are available in this area? How can they be strengthened?
Area 1			
Area 2			

EXERCISE

Table 2. 100% Condom Use Programme

What group or committee will coordinate the programme	How will compliance be monitored?	How will condoms be made available?	How will you ensure coverage across all venues?
Area 1			
Area 2			

RESOURCES

1. *Global strategy for the prevention and control of sexually transmitted infections 2006–2015*, WHO 2006 (<http://www.who.int/reproductive-health/stis/docs/stiskeymsgs.html>).
2. *Intensifying HIV prevention – UNAIDS*, Policy position paper 2006 (http://www.unaids.org/en/Policies/Prevention/Prevention_Umbrella_Policies.asp).
3. *Regional strategy for the prevention and control of sexually transmitted infections, 2007–2015*. New Delhi, WHO Regional Office for South-East Asia, 2007.



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 6 IMPLEMENTATION OF HIV PREVENTION, CARE AND TREATMENT STRATEGIES

SUBMODULE 2 HIV PREVENTION AND CARE AMONG DRUG USERS



**World Health
Organization**

Regional Office for South-East Asia

National AIDS Programme Management

A Training Course

Submodule 6.2: HIV prevention and care among drug users

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Module 7 – Managing the AIDS programme

Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

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Submodule 6.2: HIV prevention and care among drug users

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Submodule 6.2

HIV prevention and care among drug users

LEARNING OBJECTIVES

After completing this submodule, participants will be able:

1. To describe the elements of a strategic response to HIV among drug users and the rationale for a harm-reduction approach.
2. To identify gaps and opportunities in their country's response to HIV among drug users, using the Essential Prevention Package as a guide.
3. To describe the process for assessing HIV risk and vulnerability among drug users.
4. To outline strategies for responding to HIV in closed settings – prisons and closed drug rehabilitation settings.

INTRODUCTION

Injecting drug use accounts for a significant proportion of new HIV infections in Asia. In Indonesia, and in some regions of India and Thailand, 25–50% of injecting drug users (IDUs) are reported to be HIV-positive. There is ample evidence from the Region that HIV epidemics among IDUs can be “explosive”, with escalation of HIV infection from low to high levels occurring over a very short time. For example, in Myanmar, Yunnan in China, and Manipur in North-East India, a rapid escalation in HIV prevalence from very low levels to above 50% among IDUs occurred in one year or less.

Sexual transmission to partners of drug users and subsequent transmission to their children, and the link between drug use and sex work also account for a significant proportion of new infections in Asia. In some countries of the Region, the majority of infected children are born to women who use injecting drugs or whose partners inject drugs.

Stigma and discrimination and a lack of understanding of the particular care, support and treatment needs of IDUs with HIV have contributed to poor health outcomes and a high level of preventable deaths among IDUs with HIV in the Region. Poor access to

HIV care, support and treatment services for this population, particularly in closed settings such as prisons, has also contributed significantly to this outcome.

There have been recent examples in the Region of cooperation between national AIDS programmes and national drug demand- and supply-reduction programmes to improve cooperation and reduce conflict between these important policy areas. This cooperation needs to be expanded so that both programmes are able to achieve their goals.

Some national governments have adopted comprehensive harm-reduction policies. These have resulted in the establishment of a range of prevention and care services that have brought about a reduction in HIV transmission among drug users, and between drug users and other populations, leading to an improvement in health outcomes.

This submodule sets out the strategic response to HIV among drug users. It describes the rationale and evidence for harm-reduction approaches and provides an essential package of services for HIV prevention and care among drug users.

OBJECTIVE 1: To describe the elements of a strategic response to HIV among drug users and the rationale for a harm-reduction approach

Effective HIV prevention and care for drug users requires a range of approaches and the cooperation of diverse sectors and groups. In all countries of the Region, drug users are marginalized, frequently arrested and harassed, and move in and out of prisons and compulsory rehabilitation centres. The environment of drug use is a dynamic one. It contains people contemplating drug use for the first time, people using drugs, people in recovery from drug use and people who have relapsed after recovery. It is closely linked to the environment of sex work. Stigma and discrimination drive drug users away from the health services. Long-term use of drugs can significantly affect an individual's decision-making capacity, particularly on issues of safer sex and safer injecting practices.

Despite the complexity of this environment, experience has shown that drug users are able and willing to change sharing behaviours to reduce the risk of HIV infection.

COMPONENTS OF AN EFFECTIVE RESPONSE TO HIV AMONG DRUG USERS

A sustained reduction in HIV transmission among drug users and improvement in the care, support and treatment of drug users with HIV requires a blend of strategies including:

- Provision of “information and education” to drug users, in a language they understand, from people they trust – through outreach to drug-using populations.
- Affordable and easy access to the “means of prevention” – clean needles and syringes, bleach and condoms, at the time and place of risk activity.
- Expanded access to a range of “drug substitution and treatment services”.
- Access to “comprehensive HIV care, support and treatment” for drug users with HIV.
- Creation of an “enabling policy and legal environment” that supports prevention efforts and increases access for drug users to “HIV care, support and treatment” – in all settings, including closed environments such as prisons.

These strategies are explained in detail in the Essential Prevention Package (EPP) in Objective 2. These strategies are most effective when applied over the long-term, as people continually enter and leave the drug use environment, and when these reach all geographical areas where drug use occurs. This issue of coverage is extremely important

for long-term success. Outreach cannot be carried out as a one-off activity in a single setting. Achieving sustained behaviour change for this diverse population requires regular contact between drug users and prevention and care services.

The Biregional Strategy for Harm Reduction 2005–2009 sets out the following principles for responding to HIV infection among drug users.

- **Adopting a multisectoral approach:** This is most effective, particularly when it involves all ministries that contribute to the overall social response to illicit drug use. Harmonization of drug policies and strategies with HIV policies is essential.
- **Taking account of the health and social consequences of an HIV epidemic in this population:** Responses to illicit drug use, particularly injecting drug use, and drug dependence must take account of the health and social consequences of HIV among this population and how such transmission may be reduced.
- **Involving the most affected community:** Community representatives must be involved in planning, implementing and monitoring harm-reduction initiatives. Peer education, as a cornerstone of effective approaches to HIV infection among drug users, needs to be recognized and strongly supported.
- **Respect for individuals:** Effective HIV prevention is based on respect for the individual's capacity to make choices appropriate for them. Once information is given, there must be access to the means of prevention and a supportive environment.
- **Respect for human rights:** Respect for the fundamental human right of all individuals to achieve the highest level of health attainable, consideration of gender inequities that contribute to the epidemic and nondiscriminatory service delivery are essential to HIV prevention and care.

The harm-reduction approach to HIV infection among drug users was developed in recognition of the fact that responding to HIV among drug users required an immediate and urgent response. It is a pragmatic approach that acknowledges the value of drug treatment and rehabilitation approaches, but calls for immediate action to reduce HIV transmission by providing a range of strategies to reduce immediate harm to drug users themselves, their families and communities. It is intended to complement existing drug supply- and demand-reduction strategies.

It is widely acknowledged that drug supply- and demand-reduction strategies do not bring about quick results. With HIV posing an immediate threat to individuals and communities, strategies that bring about rapid and sustained behaviour change among drug users are required.

Harm reduction is a comprehensive package of policies and programmes which attempts primarily to reduce the adverse health, social and economic consequences of mood altering substances on individuals, drug users, their families and their communities.

Harm-reduction initiatives are most effective when they:

- are appropriate to the local situation; and
- involve community-based outreach teams in implementing activities. Peer outreach groups and peer support networks are of key importance for preventing HIV transmission among IDUs.

Many countries have successfully prevented HIV epidemics through injecting drug use, and there is good evidence for what works in preventing the spread of HIV through this route. Successful initiatives include the provision of sterile injecting equipment, peer-based community outreach, and expanded drug-dependence treatment.

A detailed list of resources that describe the rationale and provide evidence of a harm-reduction approach to HIV among people who use drugs is given at the end of this submodule.

OBJECTIVE 2: To identify gaps and opportunities in their country's response to HIV among drug users, using the Essential Prevention Package (EPP) as a guide

THE ESSENTIAL PREVENTION PACKAGE

The Biregional Strategy for Harm Reduction sets out an EPP for responding to HIV among drug users. It also contains a set of strategies to improve access to care, support and treatment, and to create and sustain an enabling environment for these prevention and care initiatives.

The issue is not whether to implement this package, but how to implement it on a scale necessary to prevent or stop the spread of HIV within the community. In countries, provinces or areas with established epidemics among drug users, immediate implementation of the EPP is critical. For those yet to experience such epidemics, the opportunity exists to prevent the occurrence of significant HIV epidemics among drug users from the outset.

Essential Prevention Package for injecting drug use

Information and education

- Ensuring individuals are capable of acting to protect themselves and others is a key task. The first requirement is information and the opportunity to learn how to prevent HIV transmission.
- Targeted information in an appropriate manner and language will be most successful in reaching particular communities.
- Education is best achieved using peers as educators.
- Given the alarming trend of increased injecting throughout Asia, non-judgemental interventions to reduce initiation into injecting should be explored.

Outreach

- The most effective way to access hidden populations that inject drugs is by taking interventions to those in need through outreach.
- Outreach has been shown to be effective in reaching a larger proportion of the injecting community over a short period of time, particularly where people with experience of illicit drug use are employed as outreach workers.

- Outreach workers and other harm-reduction intervention staff may also have an important role to play in supporting equitable access and adherence to antiretroviral therapy (ART).

Means of prevention: needles and syringes, bleach, sexually transmitted infection (STI) prevention and treatment, and condoms

- To protect themselves and others, people require access to the *means of prevention*: needles and syringes, bleach, condoms, lubricant.
- Needle–syringe programmes have been proven effective in reducing the sharing of needles and syringes among people who inject drugs and in preventing HIV transmission. It has been shown that needle–syringe programmes do not increase drug use or the numbers of drug users.
- Sectoral planning should aim to ensure access to the means of prevention at those times and locations as is required to reduce sharing of contaminated equipment to a minimum.
- Needle–syringe programme development should therefore be multisectoral and include the public and private sectors: strategies should be employed to involve the private sector (e.g. pharmacies) in ensuring affordable and available access to the means of prevention; a variety of appropriate delivery models (e.g. including fixed and mobile outlets, outreach and vending machines) should be explored.
- Safe disposal is an essential component of needle–syringe programmes, ideally utilizing existing hospital waste or other incinerator facilities as an end point.
- Access to STI diagnosis and treatment also reduces sexual transmission between drug users and their sexual partners.

Services: an expanded range of drug-dependence treatment services

- Drug-dependence treatment is an effective way of reducing both the demand for illicit drugs and the risks associated with drug use.
- A range of drug-dependence treatment options is encouraged to attract more drug-dependent people into treatment.
- Drug-substitution maintenance programmes have been demonstrated to reduce or eliminate injecting. Clients of these programmes significantly decrease their illicit drug consumption, are less involved in crime, and gain greater stability in their lives.
- All drug-treatment services should have HIV prevention and education integrated into their treatment programmes and should ensure access to the means of prevention.
- Extended programmes, including, for example, vocational training and social reintegration support will improve outcomes.

- Drug-dependence treatment services also offer opportunities to provide integrated HIV treatment and care.

Enabling environment

- Strengthen political commitment for harm reduction by informing and updating politicians, key bureaucrats and community leaders. Promote multisectoral partnerships.
- Review laws to make it legal to carry clean injecting equipment.
- Work with the police and public security to enlist their cooperation and support of prevention programmes.
- Improve surveillance and research so that positive outcomes can be measured and used to increase support for the programme.

This EPP is complemented by a set of strategies to increase access to HIV care, support and treatment services. These include the following:

Care, support and treatment

- Link prevention and care strategies – train outreach staff to assist drug users with HIV to access services, and train clinical services staff to reinforce prevention strategies when caring for drug users.
- Set standards of care and train health-care workers and other providers to reduce stigma and discrimination against drug users.
- Review and reform operational policies, and procedures of key services to increase the access of drug users to services.
- Train HIV clinical staff in the particular care and treatment needs of drug users.
- Devise strategies to ensure that drug users with HIV are able to access ART.
- Improve health services in prisons and other closed settings.

FILLING IN THE GAPS

Exercise A below asks you to assess the current reach and coverage of your HIV prevention and care service for drug users.

If the range of services you provide is relatively complete, but the reach and coverage is not, then the task is to identify strategies for replicating the models and approaches being used across the main geographical areas where drug use and HIV is an issue.

This involves documenting the approaches being used in pilot or small-scale projects and identifying new partners to carry these out in the identified priority areas.

Coverage is an important consideration in reducing HIV transmission. If HIV is already in the community of drug users, then WHO recommends that 80% of people injecting drugs need to be reached regularly with essential prevention services to make an impact. There may already be good small-scale programmes in place, but if the coverage is only 20%, these will not have a significant impact on transmission rates.

If there are gaps in specific programme areas of the EPP – for instance, a lack of substitution programmes, then the task is to develop a policy that supports these programmes, and then to identify partners who are capable of carrying out these approaches. The challenge is to avoid pilot projects and to move to scale as quickly as possible.

If the national programme has no experience in reaching drug users and the groups who work with them, and if knowledge about HIV risk among drug users in the country is poor, then more formal rapid assessment techniques will need to be employed (described below).

Drug users themselves are the most valuable resource for information about the nature of interventions that will support them in prevention and care. Contact can be made with current and recovering drug users through key people, such as local community workers and NGOs who have access to the drug-using community. Focus group discussions and in-depth interviews can provide important information for planning interventions and services.

The following may be able to assist in filling the gaps in programmes.

- Social service agencies may have contact with drug users.
- Nongovernment or community-based organizations may already be running services for users. Community organizations doing related work, such as work with out-of-school youth, may be able to assist in accessing drug users.
- Drug treatment programmes have information about the numbers and characteristics of drug users who seek treatment and the drugs that are currently being used. These may provide contact with drug users who can give in-depth information on the patterns of sharing of equipment and sexual behaviours among injectors.
- Health-care facilities including hospital emergency rooms, mental health services, STI clinics and primary care sites may be points of interaction with drug users and their families. These may be able to provide information on drug users and the

complications of drug use for which they may be seeking help, or other conditions unrelated to drug use.

- Pharmacists and shopkeepers often know if they are selling equipment to drug users and may have information as to where drug users are located and how often they purchase equipment.
- Police, prisons and other law enforcement agencies can provide information on drug-related arrests. Because drug use is illegal in most countries, it is important to establish contact with the police and prison staff, and offer them general information about proposed HIV interventions.
- Traditional healers and religious workers are used in many countries to help with and treatment for drug-use issues.
- Social scientists and medical researchers in universities and independent institutions may have information from studies conducted on drug use and can provide insight into particular patterns of drug use and behaviours.

EXERCISE A

(Country group work followed by intercountry group discussion)

In country groups, assess the current response to HIV among people who inject drugs using the EPP as a guide. Complete the table below. If you do not have exact figures at hand, make an educated guess, e.g. needle–syringe exchange programmes in two cities reaching an estimated population of 5000 people.

Type of intervention/ service	What you know about the reach or coverage of your programmes (geographical areas covered, % of population reached)	Priority for scaling up	Steps to strengthen services
Needle and syringe supply/exchange			
Outreach services and peer support for drug users/drug user organizations			

Type of intervention /service	What you know about the reach or coverage of your programmes (geographical areas covered, % of population reached)	Priority for scaling up	Steps to strengthen services
Drug substitution, e.g. methadone programmes			
Effective institutional drug treatment and rehabilitation services			
Primary health-care services that are drug user-friendly			
HIV treatment and care services that encourage access for drug users with HIV			
Other services			

Inform your facilitator when you are ready for intercountry group discussions.

OBJECTIVE 3: To describe the process for assessing HIV risk and vulnerability among drug users

Assessing the extent and pattern of drug use in a country or province helps to determine the implications for the spread of HIV. Given the largely punitive approach to drug use in many parts of Asia, drug use tends to be hidden and assessing the extent of injecting drug use through direct contact with users is often a challenge. Information on injecting drug use needs to be obtained from a variety of sources to make a thorough assessment of the situation. Maintaining confidentiality and establishing trust is essential. Lack of trust of drug users can cause problems in obtaining adequate information, and can create a climate where future prevention activities have little chance of success.

The programme manager's role is to make sure these points are considered when information-gathering efforts are designed and when planning the scaling-up of effective responses. The range and quality of available data to complete the assessment will vary. In some countries, knowledge about the prevalence of drug use, the types of drugs used and the patterns of use is not immediately available, or is unlikely to be representative due to over-reliance on one source (e.g. rehabilitation centre data). Different sources of data may reveal different information according to how drug use is defined or the degree of contact with the target population.

Rapid assessment and response (RAR) techniques are described below. Remember that you can start programming for HIV prevention and care among drugs users without detailed information from RAR, and later use techniques such as RAR to guide the expansion of the programme. In this way you do not lose valuable time.

RAPID ASSESSMENT AND RESPONSE (RAR) FOR DRUG USE

The methods recommended by WHO to assess and respond to HIV among drug users are detailed in the WHO *Technical guide to rapid assessment and response*, and a brief overview is provided below.

RAR for injecting drug use is:

- A set of methods to identify the extent, nature and patterns of injecting-related risk behaviour and associated health consequences.
- A way of looking at drug-related problems from many viewpoints at the same time.
- A mix of qualitative and quantitative methods.

Advanced planning for resources is important and these should be secured before the start of RAR. Even when RAR is completed and the data analysis is presented, some donor or government agencies will only fund parts of what is needed. It is important to link various aspects of the work and involve different sectors.

Features of RAR

Timeliness

Timely response is crucial when tackling rapidly developing health issues such as those presented by HIV. New trends in drug use and associated risks and harms may occur so rapidly that the time required to conduct conventional research is unacceptable. RAR differs from traditional research in that it usually takes only a few weeks or months to complete.

Cost-effectiveness

RAR is designed to be relatively quick and inexpensive, and is often carried out by people who are already working in the field.

Existing and new data

New data-gathering exercises (such as surveys) are undertaken only where the existing sources of information are inadequate.

Use of multiple methods and data sources

RAR combines various methods and sources of data. A single method or source of data cannot encompass all facets of complex social problems, especially those that tend to be hidden. An overview is constructed from various data sources which individually may only offer a partial and incomplete description. Another important feature of RAR is triangulation. Triangulation means getting information from different and multiple sources, often using different methods, until one is confident of the validity of the information.

Practical relevance to interventions

RAR results are of limited use by themselves. Their main purpose is to assist cities and regions to design appropriate programmes.

Points to consider in assessing the current drug use situation in a country include:

- magnitude, characteristics and patterns of drug use;
- context of drug use;
- HIV risk behaviours;
- consequences of drug use;
- the activities currently being conducted to address injecting drug use; and
- current and needed interventions to address the health consequences of drug use.

OBJECTIVE 4: To outline strategies for responding to HIV in closed settings – prisons and closed drug rehabilitation settings

Many drug users in Asia spend a considerable amount of time in prisons and closed drug rehabilitation services. Universal access to HIV prevention and care will be truly universal only when the complex issues of access for people in these closed settings are addressed.

HIV risk behaviours, sexual and injecting, continue in prisons, and there is considerable movement of drug users between these institutions and the community. In programme terms, these are often thought of as closed environments with no connection to the general community. This is far from true. As access to ART increases, some drug users on ART will be arrested or will enter drug rehabilitation services. The continuum of HIV care, support and treatment will need to be extended to these settings to prevent unnecessary deaths or the development of widespread resistance to ART.

UNODC has recently released a framework for an effective national response to HIV prevention, care, support and treatment in prison settings. This framework sets out the following principles for responding to HIV in closed prisons:

1. Good prison health is good public health.
2. Good prisoner health is good custodial management.
3. Respect for human rights and international law is ensured.
4. International standards and health guidelines are adhered to.
5. Equivalence in prison health care – the same standard of care is provided inside the prison as in the community.
6. The approach to health is holistic.
7. Vulnerability, stigma and discrimination are addressed.
8. Cooperation and action taken are collaborative, inclusive and intersectoral.
9. Monitoring and quality control are carried out.
10. The prisoner population is reduced.

It could be argued that access to condoms in prisons is consistent with principle 5 – establishing the same standard of health care inside prisons as in the community, since health promotion and prevention of illness are key elements of health care.

The framework proposes the following processes for bringing about rapid improvements in HIV prevention and care in prisons.

Build momentum	<ul style="list-style-type: none"> • Identify and educate key stakeholders. • Include prison representatives in national and provincial AIDS coordinating committees. • Identify and support “champions” to lead implementation efforts. • Encourage the establishment of local and regional working groups on HIV in prisons. • Build regional networks and collaboration. • Establish concrete multiyear workplans and review these regularly.
Build knowledge	<ul style="list-style-type: none"> • Collect data on HIV risk behaviour among prisoners. • Raise national awareness of HIV and prison issues among decision-makers. • Increase training opportunities in prisons, particularly on HIV and generally on health. • Utilize technical assistance from other countries to support the development of programmes.
Build capacity	<ul style="list-style-type: none"> • Develop collaboration between prison and community services. • Learn from community practice and adapt these lessons to prison settings. • Establish pilot projects, but move quickly to scale once effective models are established • Identify and link up with existing networks. • Secure and sustain funding.

EXERCISE B

(Country group work followed by intercountry group discussion)

In country groups, look at the principles and framework above and page 13 of Module 4 and complete the table below for HIV in prison settings:

Area	Current situation	Steps towards strengthening
Involvement of prison authorities in HIV response at national and local levels		
Strategies to reduce HIV vulnerability and HIV transmission in prisons		
Access to care, support and treatment for HIV-positive prisoners		

Inform your facilitator when you are ready for intercountry group discussions.

RESOURCES

WHO and others have produced a comprehensive range of technical assistance documents to assist countries to respond to HIV among drug users. These include:

1. *The IHRA in the SEARO/WPRO Biregional strategy for Harm Reduction, 2005–2009.*
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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 6 IMPLEMENTATION OF HIV PREVENTION, CARE AND TREATMENT STRATEGIES

SUBMODULE 3 HIV COUNSELLING AND TESTING



**World Health
Organization**

Regional Office for South-East Asia

National AIDS Programme Management

A Training Course

Submodule 6.3: HIV counselling and testing

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Module 7 – Managing the AIDS programme

Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

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Submodule 6.3: HIV counselling and testing

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HIV counselling and testing

LEARNING OBJECTIVES

After completing this submodule, participants will be able:

1. To assess current HIV counselling and testing services and their linkages to prevention, care and treatment services.
2. To describe the range of service models for providing HIV counselling and testing.
3. To explain the key components for scaling up of HIV counselling and testing services.
4. To describe the process for strengthening the capacity of mainstream health services to integrate HIV counselling and testing.

INTRODUCTION

Since the development of the HIV antibody test in 1985, HIV testing has been an essential part of the response to HIV. It has been used to diagnose individuals, to track the progress of the epidemic and to secure blood supplies. The combination of HIV counselling and testing has been used as an intervention to enable individuals to know their HIV status and to channel them into care, support and treatment services. It has also provided people with an opportunity to assess their risk, to gain information about HIV transmission and to determine ways to avoid HIV transmission in the future.

As an intervention, HIV counselling and testing aims to encompass both prevention and care outcomes. It is intended to be both a pathway to care for people who test HIV-positive and a focus for HIV prevention, irrespective of whether people test HIV-positive or -negative.

The wider availability of effective HIV treatment and interventions to prevent mother-to-child transmission (MTCT) increases the importance of counselling and testing as a central strategy in the response. Despite this fact, the majority of people with HIV in the world are still unaware of their status. The wider availability of HIV treatment provides a strong case for scaling up HIV counselling and testing interventions.

This submodule focuses on HIV counselling and testing as a key intervention for the scaling up of HIV prevention, care and treatment. It outlines the components of an HIV counselling and testing programme and provides strategies for the greater integration of HIV counselling and testing into health services, including a strong emphasis in some cases on provider-initiated counselling and testing. It sets out simple recording and reporting strategies and describes the principles that can guide quality assurance of the counselling and testing programme. The use of HIV testing in HIV surveillance is covered in Module 9 on Strategic Information.

OBJECTIVE 1: To assess current HIV counselling and testing services and their linkages to prevention, care and treatment services

Most people with HIV in the world do not know their status. HIV counselling and testing should be accessible to the people who need it, and should be linked directly to prevention, care and treatment. Even in areas where counselling and testing has been considerably expanded, many of those presenting for HIV counselling and testing are lost to follow up, usually because stand-alone counselling and testing services have not provided them with a clear bridge to ongoing prevention, care and treatment.

EXERCISE A

(Country group work followed by intercountry group discussion)

In country groups, answer the following questions about your country: (You can answer the questions below or prepare a map/diagram that summarizes current access to counselling and testing services.)

1. How do people currently access HIV counselling and testing – what kinds of models are available? Describe

2. What is the geographical coverage of counselling and testing services?

3. Which populations or groups have a high need for HIV counselling and testing services, but do not currently access them?
4. What strategies would you propose for increasing access to HIV counselling and testing services for these groups?
5. What generally happens to a person who tests HIV-negative in one of your current counselling and testing services? (Try to present a range of pathways and estimate the proportion of people who follow each pathway.)
6. What generally happens to a person who tests HIV-positive in one of your current counselling and testing services? (Try to present a range of pathways and estimate the proportion of people who follow each pathway.)

Inform your facilitator when you are ready for intercountry group discussions.

OBJECTIVE 2: To describe the range of service models for providing HIV counselling and testing

The nature of the services developed for HIV counselling and testing should be shaped by a clear understanding of the aims and objectives of HIV counselling and testing and what are the expected outcomes of the programme intervention. HIV testing is a diagnostic modality that determines whether a person has been exposed to HIV or not. However, HIV counselling and testing serves several other important functions. It assists HIV-negative people to learn about HIV transmission and to take steps to avoid HIV infection. It guides HIV-positive individuals to prevent further HIV transmission and to inform people in their network who may have been at risk. Most importantly, it helps them to access the treatment, care and support services they need.

For individuals, HIV counselling and testing offers the following opportunities:

Promotes and facilitates behaviour change	Eases acceptance of serostatus and coping	Provides a pathway to ART, OI prophylaxis and treatment, and early medical care	Provides a focus for health-seeking behaviours and lifestyle changes to promote health and well-being	Provides access to interventions for preventing mother-to-child transmission (MTCT)
HIV counselling and testing				
Normalizes HIV and AIDS and reduces stigma	Facilitates referral to social and peer support	Increases access to family planning services, including condom provision	Promotes planning for the future – care of children, preparation of a will	

Source: Adapted from *Scaling up HIV testing and counselling services: a toolkit for programme managers*. Geneva, WHO, 2005.

It is important to reflect on these desired outcomes when planning counselling and testing services. The primary purpose of HIV counselling and testing services is not to count and record the number of people diagnosed with HIV. It is to provide prevention, care and treatment services to people in need.

POLICY

The practice of HIV counselling and testing needs to be guided by a national policy. While a diagnosis of HIV can lead to improvement in health by providing a person with access to care, support and treatment, it can also result in considerable stigma and discrimination. The manner in which people are diagnosed with HIV therefore needs to be regulated by a policy to ensure that people are not exploited or inadvertently harmed.

Having a national policy in place also preserves the public health benefits of the HIV counselling and testing programme. It provides people with the confidence to present themselves for HIV testing. This is particularly important for people from marginalized groups, who fear the stigma and discrimination that might result from a diagnosis of HIV infection.

A national HIV counselling and testing policy usually contains a set of principles.

- That all HIV testing will be voluntary (that the individual's consent to be tested will always be sought – except for testing donated blood in rare circumstances that are set out in the policy).
- That HIV testing will be accompanied by the provision of counselling and information.
- That people diagnosed with HIV will be referred to a range of care, support and treatment services.
- That test results will be confidential (with any information about disclosure indicated clearly in the policy and with penalties for people who breach confidentiality).
- That the quality of HIV testing will be maintained by a system of quality assurance.
- That people who are diagnosed with HIV will not be discriminated against.

The policy should clearly state that testing of individuals as a part of counselling and testing needs to be kept separate from the testing that is done as a part of surveillance or blood safety or research.

WHO/UNAIDS have recently released a policy clarification statement on HIV counselling and testing (August 2006) that reinforces the basic fundamentals.

- Not enough people know their HIV status.
- Access to HIV prevention, care, support and treatment services is being hindered by the low uptake of HIV counselling and testing services.
- The reach of counselling and testing services needs to be rapidly expanded.
- Provider-initiated counselling and testing models are appropriate in some settings and can assist in uptake.
- Provider-initiated HIV testing should be voluntary, confidential, carried out with consent and accompanied by counselling.
- These requirements are often referred to as the 3 C's.

The 3 C's

- Confidentiality
- Consent
- Counselling

WHO and UNAIDS continue to strongly endorse the expansion of counselling and testing as a key HIV prevention and care strategy.

Provider-initiated counselling and testing is the norm in South-East Asia. Very few people in Asian countries are self-referred.

COUNSELLING AND TESTING MODELS

HIV counselling and testing is provided in various settings using a range of different models.

Voluntary counselling and testing (VCT) – is usually *initiated by a client*, and takes place in a stand-alone VCT centre, or in a service administered by a health service or nongovernmental organization (NGO) as part of a broader range of services.

Provider-initiated counselling and testing – refers to a range of models under which a health provider recommends HIV testing to clients. This might be a strategy used in sexually transmitted infection (STI) clinics, TB clinics or antenatal clinics in areas where the HIV prevalence is high. Testing is still voluntary and confidential, and should be accompanied by information and counselling.

Clients are informed that HIV testing is available and they make a decision to test or not to test. There are different approaches to provider-initiated counselling and testing. Some rely on the client to actively opt for HIV testing. There are other models which inform clients that everyone who attends the service will undergo HIV testing as part of routine laboratory tests unless they specifically refuse.

HIV testing is also carried out as a tool for differential diagnosis in cases where a person presents with an illness that may be related to HIV infection or associated with AIDS. This is sometimes called “diagnostic HIV testing” and requires to be accompanied by consent, counselling and arrangements to protect confidentiality.

There has also been much debate about what sort of counselling needs to accompany HIV testing. Traditional VCT models have encouraged the use of individual pre- and post-test counselling for all people considering or undertaking HIV testing. Some services have argued against individual pre-test counselling interviews due to the lack of sufficient human resources. They conduct group pre-test counselling by providing printed information or videos in waiting rooms and carry out post-test counselling only for people diagnosed as HIV-positive.

The important points to remember when deciding on the type of counselling to offer are:

- people need to be able to freely consent, or freely refuse, without pressure from peers or health workers;
- HIV counselling and testing can be a prevention activity – therefore, people need to gain a clear understanding about how HIV is transmitted and about how they can avoid HIV from this exposure;
- people whose behaviour places them at risk, but who are diagnosed HIV-negative, need to be counselled about avoiding HIV in the future and referred to HIV prevention services specific to their risk behaviour – sex worker outreach, drug user services, etc.;
- people diagnosed as HIV-negative need to understand the window period and the importance of returning for follow-up testing if they have recently been at risk and to practise safer behaviours in future; and
- people diagnosed as HIV-positive need support and information so that they can access ongoing prevention, care, support and treatment services.

The table on pages 14–16 summarizes the different models for delivering HIV counselling and testing services and the advantages and disadvantages associated with each model. This material is covered in more detail in the WHO Regional Office for South-East Asia training materials on HIV counselling and testing.

COUNSELLING AND TESTING PROCEDURES IN DIFFERENT SETTINGS

Different clinical settings require different approaches to HIV counselling and testing, but these should be clearly outlined by the national programme to ensure consistency and quality. A set of algorithms can be developed for each setting for people who present themselves for counselling and testing in these settings.

Different settings require the use of different testing assays – depending on the geographical location of the counselling and testing service, the purpose of the testing and the needs of the population being tested. The national programme has a role in determining which assays and procedures are appropriate for each setting. A number of different tests (biological assays) are available for HIV testing. None is 100% accurate, so they must be used in combination to give a more accurate result. The national programme is required to set guidelines for the use of different assays under diverse circumstances. AIDS Programme Managers (APMs) are provided with guidelines from the WHO Regional Office for South-East Asia for HIV diagnosis and a comprehensive guide to selecting and using simple/rapid test assays that can be used to determine national protocols.

Here is a sample algorithm for counselling and testing.

Algorithm for counselling and testing

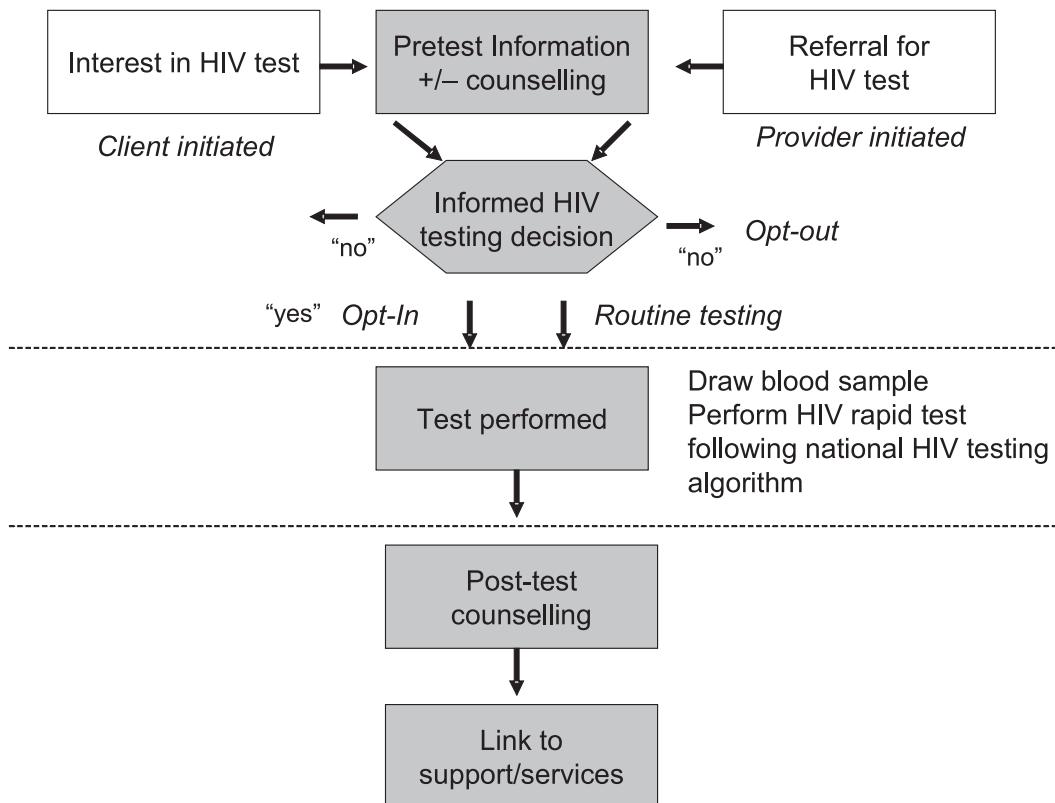


Table 1. Models for delivering HIV counselling and testing

Model	Description	Advantages	Disadvantages
Free-standing VCT service	<ul style="list-style-type: none"> • A stand-alone VCT centre or clinic • Staff specifically trained in and allocated to HIV counselling • Sometimes run by NGOs • Refers people on to prevention and care services 	<ul style="list-style-type: none"> • Anonymous service – can be more private than a general clinic • Can be located near populations at risk • Flexible opening hours • Can be staffed by people from the target population • Can host PLHA support groups 	<ul style="list-style-type: none"> • Expensive if you want to achieve geographical coverage • Can be stigmatizing as it is identified as an HIV service • Staff burnout from high caseload of PLHA
Integrated into the medical services	<ul style="list-style-type: none"> • Counselling and testing offered to people attending for other reasons – local primary care clinics • Counselling done by existing clinic staff 	<ul style="list-style-type: none"> • Lower cost than stand-alone centres • May have greater reach • Easier to scale up than stand-alone clinics • Promotes access for women who may not attend stand-alone clinics • Does not rely entirely on the client determining the need for testing and seeking stand-alone services 	<ul style="list-style-type: none"> • Result included in clinical notes – can lead to loss of privacy, stigma, discrimination • Staff may not be trained in HIV counselling • Busy clinics, little time to spend with a newly diagnosed person • Lack of knowledge of referral options
Integrated into family planning services	<ul style="list-style-type: none"> • Building HIV counselling and testing into family planning services • Combined with STI, reproductive health, MCH care • Counselling done by existing staff 	<ul style="list-style-type: none"> • Services and systems already in place • Good way to reach women 	<ul style="list-style-type: none"> • Limited access for men • Limited access for young people, unless pregnancy is an issue • Increases workload of already busy staff

Model	Description	Advantages	Disadvantages
Integrated with antenatal care	<ul style="list-style-type: none"> Provision of HIV counselling and testing as part of antenatal care Directly linked to PMTCT services Counselling done by specifically trained staff and/or existing staff 	<ul style="list-style-type: none"> Opportunity to prevent HIV transmission to the child Can form normalized part of comprehensive care 	<ul style="list-style-type: none"> Not as useful if pregnant women are not a population at high risk in a country's epidemic Can result in the woman being blamed for HIV in the family – increased stigma and discrimination Limited access for men and for couple counselling
Integrated with STI services	<ul style="list-style-type: none"> Counselling and testing offered to people who attend STI services Counselling done by specifically trained staff and/or existing staff 	<ul style="list-style-type: none"> Safer sex counselling reduces transmission of STI and HIV High detection rate – people with STIs at greater risk of HIV infection and transmission Systems in place for partner notification, disclosure Staff already trained in STI counselling 	<ul style="list-style-type: none"> Limited access for asymptomatic people Some people fear the stigma of attending STI services
Integrated with TB services	<ul style="list-style-type: none"> Counselling and testing offered to people diagnosed with TB Counselling done by specifically trained staff and/or existing staff 	<ul style="list-style-type: none"> High detection rates Better TB treatment outcome can be achieved if you know the patient has HIV-related TB Structures already in place for good geographical coverage, follow up and adherence 	<ul style="list-style-type: none"> Does not reach asymptomatic people TB clinic staff might feel that offering HIV counselling and testing has a negative effect on people availing TB services

Table 1. Models for delivering HIV counselling and testing (cont.)

Model	Description	Advantages	Disadvantages
Private sector	<ul style="list-style-type: none"> HIV testing through private pathology services, laboratories and clinics 	<ul style="list-style-type: none"> Wide coverage Can be anonymous, more confidential 	<ul style="list-style-type: none"> Usually diagnostic only, consent rarely taken and counselling or information rarely provided May not follow guidelines on test assays and algorithms Excludes the poor and marginalized No follow up or referral networks
Mobile/community outreach	<ul style="list-style-type: none"> HIV test offered as part of a mobile service 	<ul style="list-style-type: none"> Good for marginalized groups who do not trust health services Anonymous Can refer people to other services 	<ul style="list-style-type: none"> May be difficult to provide follow up in the days after a result is given Confidentiality is of concern in these settings Resource intensive—only one person seen at a time to maintain confidentiality

Source: *HIV counselling and testing training curriculum, Module 5: Models of VCT service delivery*. New Delhi, WHO/SEARO, 2004.

EXERCISE B***(Country group work followed by intercountry group discussion)***

The algorithm above represents a client's movement through the various parts of the counselling and testing process in a stand-alone service, and what decisions are to be made at each point by the person providing the service.

In country groups, take a different setting, for example:

- a prevention of mother-to-child transmission (PMTCT) service incorporated into an antenatal care clinic, or
- an HIV counselling and testing service incorporated into an STI clinic, or
- injecting drug users (IDUs) attending a primary care clinic.

Choose a group or setting and develop an algorithm that shows the decisions that are made by the persons and the service at each point in the HIV counselling and testing process.

Inform your facilitator when you have finished your algorithm and are ready for intercountry group discussions.

OBJECTIVE 3: To explain the key components for scaling up of HIV counselling and testing services

Scaling up HIV counselling and testing requires strategic planning, technical advice and the cooperation of a range of groups and sectors. WHO has produced a toolkit for APMs that details the scaling-up process and includes references to technical materials that provide assistance and guidance.

The components of the scaling-up process include:

1. Determining the policies that will guide counselling and testing services and advocating for national policies that support a public health approach.
2. Mobilizing the community to create a supportive environment for increased testing – increasing the demand for counselling and testing, and reducing stigma and discrimination experienced by people living with HIV/AIDS (PLHA) and people assumed to be at risk of HIV.
3. Determining which commodities will be purchased and how their continued availability will be managed.
4. Determining where HIV counselling and testing will be provided, setting standards and guidelines and monitoring compliance with these, assisting services to integrate HIV counselling and testing.
5. Having a skilled workforce to carry out HIV counselling and testing by providing training, setting appropriate staff levels, determining who will carry out counselling and testing tasks, and monitoring quality.
6. Developing systems to coordinate and manage the counselling and testing programme.
7. Determining costs and securing finances for scaling up the services.

This process can be assisted by establishing a national advisory committee comprising:

- health service planners from national ministry of health, particularly those coordinating primary care, maternal and child health (MCH) and STI services;
- people with expertise in HIV counselling and testing;
- people from national AIDS programme;
- representatives of PLHA groups;
- people from health worker training institutions;
- laboratory services managers;
- people from procurement and logistics departments; and
- NGOs providing health services to the community.

OBJECTIVE 4: To describe the process for strengthening the capacity of mainstream health services to integrate HIV counselling and testing

The scaling up of HIV counselling and testing needs to be strategic and should be based on information that identifies the gaps in access for populations that are of the highest priority in the response to AIDS for the country.

One clear way to expand access to HIV counselling and testing services is by providing it through a range of existing health services – primary care clinics, antenatal care clinics, STI clinics and so on. Adding HIV counselling and testing to the array of services that a clinic or health service provides requires careful planning. It is not a simple matter of deciding to carry out HIV tests. There are complex issues to consider. One of the first issues to consider is what will happen to people diagnosed with HIV? Who will counsel them? To what extent will their privacy and confidentiality be preserved? Who will help them to discuss their result with their partner and family? How will they find their way to ongoing HIV care, support and treatment services?

Health services planning to integrate HIV counselling and testing into their services should consider the above questions, develop policies and procedures, and satisfy themselves that their staff has the necessary skills and knowledge to provide this service before they start HIV counselling and testing. Services also need to decide how samples will be tested, how supplies will be procured and managed and how quality of results will be maintained.

Steps to follow for strengthening the provision of HIV counselling and testing through the existing health services

Step 1: Identify

Which services would be suitable and where for the incorporation of HIV counselling and testing?

Key questions

- Who is at risk, their HIV status and their access to existing HIV counselling and testing services?
- What services do these people or populations currently use?

- What skills and resources already exist in these health services that could be brought to use in HIV counselling and testing?

The obvious places to consider are STI clinics, maternal and child health clinics, primary health-care centres and services that already target specific populations, such as NGOs delivering services to sex workers, IDUs and men who have sex with men (MSM). It is important to start with the services that currently serve the people you most want to access.

Step 2: Decide

How will HIV counselling and testing be integrated into the service?

Key questions

- Will HIV testing be offered during the consultation with the doctor?
- How will pre-test counselling be given?
- How will the person's consent be obtained?
- Where will the samples be tested?
- What testing assays and algorithm will be used?
- Will the client be charged?
- Who will be responsible for giving the result?
- Where will counselling take place – are there private spaces available?
- Who will provide post-test counselling?
- What about partner notification?
- How will confidentiality be preserved?
- How can it be ensured that the client has been linked to the necessary services?

Services need to develop a set of policies and procedures, based on the national HIV counselling and testing policy, which clearly explains to the staff and clients how HIV counselling and testing will be carried out.

Step 3: Decide whose capacity needs to be strengthened

Once the personnel who will be involved in the HIV counselling and testing have been identified, what are their capacity development needs?

Key questions

- Who will carry out HIV counselling?
- What are their current skills?
- What are their training needs?

- Which other staff members require training – clerical staff, records staff, laboratory staff?
- Who will conduct the training – NGO, health worker, training institution?

Look back at the gaps that you identified in Exercise A in this submodule and think about how answering the above questions might help fill those access gaps.

EXERCISE C

(Country group work followed by intercountry group discussion)

Country group brainstorming exercise: On a sheet of flip chart paper, come up with a set of strategies for a significant expansion in access to HIV counselling and testing in your country which particularly addresses the gaps in access that you identified in Exercise A.

Inform your facilitator when you are ready for intercountry group discussions.

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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 6 IMPLEMENTATION OF HIV PREVENTION, CARE AND TREATMENT STRATEGIES

SUBMODULE 4 THE CONTINUUM OF CARE FOR PEOPLE LIVING WITH HIV/AIDS AND ACCESS TO ANTIRETROVIRAL THERAPY



**World Health
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National AIDS Programme Management

A Training Course

Submodule 6.4: The continuum of care for people living with HIV/AIDS and access to antiretroviral therapy

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Module 9 – Strategic information

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Submodule 6.4

The continuum of care for people living with HIV/AIDS and access to antiretroviral therapy

LEARNING OBJECTIVES

After completing this submodule, participants will be able:

1. To identify the elements of the continuum of care for PLHA.
2. To identify strategies for reducing HIV-related stigma and discrimination.
3. To describe the role of community support, peer support and counselling in HIV prevention, care and treatment.
4. To list the steps for strengthening clinical and community care for PLHA, including the scaling up of ART.
5. To assess the progress of national programmes towards meeting the needs of PLHA across the continuum of care.

INTRODUCTION

At the United Nations General Assembly's high-level meeting on AIDS in June 2006, Member States agreed to work towards the broad goal of "universal access to comprehensive prevention programmes, treatment, care and support" by 2010. Working towards universal access is a very ambitious challenge for the international community, and will require the commitment and involvement of all stakeholders, including governments, donors, international agencies, researchers and affected communities. Among the most important priorities is strengthening of the health services so that they are able to provide a comprehensive range of HIV/AIDS services to all those who need them.

It has been recognized that the primary health-care strategy, based on practical, scientifically sound and socially accepted methods and technology, should be made universally accessible to individuals and families in the community. The concept of a continuum of care for people living with HIV/AIDS (PLHA) evolved on the basis of the

principles of primary health care. This concept puts the individual and family at the centre of the care and support system.

A continuum of care is needed for PLHA as their requirements for care vary and change over time. Following the diagnosis of HIV, PLHA require regular access to prevention, care, support and treatment services. They may need extensive psychological support, counselling for positive living, and information on HIV and sexually transmitted infection (STI) prevention.

To meet the overall goals of the programme – reducing HIV transmission and providing care, support and treatment to people affected by HIV and AIDS – a range of factors that contribute to the long-term health and well-being of the affected people should be considered.

The needs for care, support and treatment for PLHA are lifelong and these needs change over time. Effective clinical care is essential, but so are adequate nutrition, shelter, security and support.

This submodule describes strategies to strengthen the continuum of care and increasing access to antiretroviral therapy (ART) for those affected by HIV. It provides guidance for assessing current AIDS programmes so as to be able to identify their progress and the priorities for the strengthening of continuous care.

This submodule should be read particularly in conjunction with the modules on HIV counselling and testing, and management systems for the AIDS programme.

OBJECTIVE 1: To identify the elements of the continuum of care

In the case of people affected by HIV and AIDS, effective prevention, care, support and treatment begins at the time of diagnosis and involves a wide range of community- and institution-based services and programmes.

A continuum of care can be established by understanding the elements that constitute the health and well-being of a person with HIV. People designing services and programmes need to take this into account, as providing access to only one aspect while neglecting the others will leave the person without support and jeopardize the goals of the programme.

ELEMENTS OF THE CONTINUUM OF CARE FOR PLHA AND ANTIRETROVIRAL THERAPY

- An enabling environment in which stigma and discrimination against people affected by HIV and AIDS are minimized, they have access to the full range of services they need, and are able to participate in community life;
- Community support to assist PLHA to maximize their health and well-being, including spiritual care, nutrition, shelter, emotional support, access to employment and to poverty alleviation and livelihood programmes;
- Community support for families looking after people with HIV and AIDS at home, along with institutional back-up;
- Support to PLHA to prevent HIV transmission;
- Clinical monitoring, treatment and care that is of consistently high quality, locally accessible and affordable.

For example, giving a person a month's supply of ART and sending them back into an environment where they have no access to clean water, shelter and adequate nutrition is unlikely to result in an improvement in their health. Diagnosing people with HIV in voluntary counselling and testing (VCT) centres without referral to ongoing counselling, as well as community and peer support, is unlikely to result in a reduction in HIV transmission or help the affected people come to terms with the diagnosis.

The continuum of care involves a range of institutions.

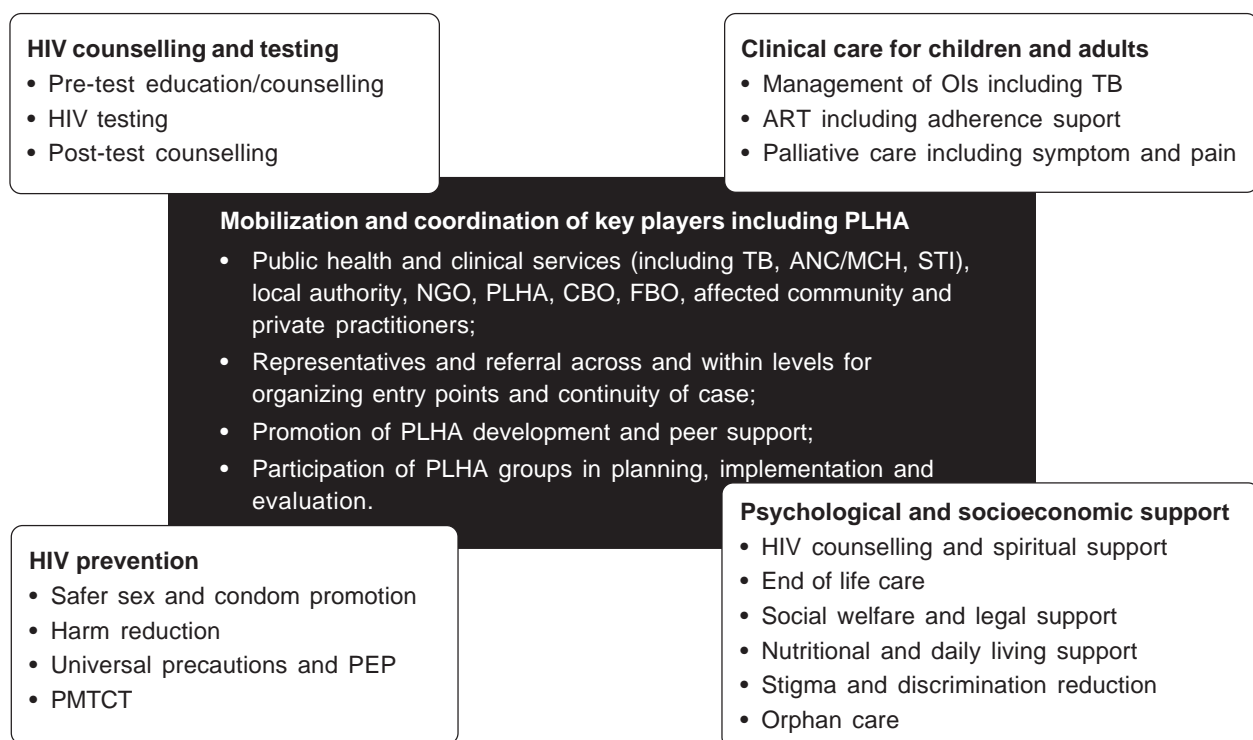
- Community and nongovernmental organizations have a key role to play in ensuring that individuals and families affected by HIV and AIDS can participate in community

life, have access to food and shelter, and have economic security.

- Existing health services and programmes are an essential part of the continuum of care.
- It is often inefficient and unsustainable to establish a set of HIV-specific services, when there is a range of mainstream support services and community resources that can be mobilized.
- In many places, the continuum of care can be broadened significantly by assisting the existing services and programmes to reach a point where they are comfortable with providing PLHA access to their services and programmes.

The key to an effective continuum of care is planning and coordination. Rather than providing a fragmented and unlinked set of services and programmes, the AIDS programme manager must ensure efficient coordination between prevention, care, support and treatment services so that PLHA can access the full range of services they need throughout their lives. Services need to be made available where they are required, and designed in a way that will maximize their use by the people who need them the most. Involving local PLHA in the design of the services that you want them to use is the surest way of ensuring this.

The diagram below provides a useful model for planning across the continuum of care.



Source: Adapted from *HIV/AIDS care and treatment: a guide for implementation*. Manila, WHO WPRO, 2004.

EXERCISE A

(Country group work followed by country group discussion)

Describe in country groups, the current availability of clinical care services.

Draw a map of your country, setting out where services are currently available. Try to use the map to answer the questions below. The information from this exercise will assist you in carrying out the final exercise in this module.

1. Where do PLHA currently access HIV clinical services?

2. What HIV services are provided at different levels?
 - Tertiary hospital (national or provincial capital city)
 - District hospital and out-patients department
 - Primary care clinic
 - Aid post, or local or community health service

3. How does this map match with what you know about the geographical distribution of PLHA?

Inform your facilitator when you are ready for country group discussions.

OBJECTIVE 2: To identify strategies for reducing HIV-related stigma and discrimination

The term “enabling environment” is used in AIDS programme planning to refer to a set of characteristics or factors that work together to assist the programme to meet its goals. In the early years of the response to HIV, fear about HIV transmission and moral judgements about the people who were affected by HIV led to an environment of stigma and discrimination. PLHA and families affected by HIV faced isolation and violence, and found it difficult to access the services and community support they needed. Many people isolated themselves and did not seek services or the community support they would normally have sought, as they feared rejection.

Strengthening the enabling environment means putting in place a set of policies and laws that will support the goals of the programme and reduce stigma and discrimination; training health and community workers to reduce their fear and increase their understanding of the needs of PLHA; establishing standards of care and support; revising laws, policies and procedures that work against the goals of the AIDS programme; and working with religious and community leaders to increase tolerance, reduce stigma and improve the level of care and support in communities.

The government, PLHA and institutions should protect PLHA from discrimination not only because of the need to ensure the human rights of every individual in general, but also to promote sound principles of public health. Discriminatory practices jeopardize public health in the following ways.

- Individuals who know or suspect that they have HIV may adopt evasive behaviours or be driven underground by discriminatory practices. Consequently, the very people who are at the greatest risk of acquiring and transmitting HIV are not accessible and reaching them with educational messages about the prevention of HIV becomes difficult.
- Valuable people, such as those with HIV who have access to or knowledge about important target groups, and who could be involved in peer education about HIV and AIDS, may decide against being involved in these activities because they fear the consequences of discrimination and stigma.
- Attempts to identify and even confine or isolate PLHA provide the general public with a false sense of security that all PLHA are known and confined or out of reach, and that precautions against the transmission of HIV are no longer necessary.

THE NATURE OF HIV-RELATED DISCRIMINATION

Discriminatory practices, or practices that lead to discrimination, may occur because there is a law or regulation mandating a discriminatory practice (for example, mandatory testing). They may also occur because there is no legal protection from discrimination for individuals in formal interactions, such as those between an individual and employer, landlord or health-care provider. Other discriminatory practices are related to the negative attitudes held by the general public or by certain important groups, such as peers, family members, community members or caretakers.

The following are some examples of practices that discriminate against PLHA, or which can lead to discrimination.

- (a) **Imposing mandatory HIV testing:** There is no public health rationale for mandatory HIV testing. It is not cost-effective and knowledge of the HIV status on its own does not change behaviour.
- (b) **Denying appropriate health care to PLHA:** PLHA should have the same access to care as is available to others with chronic or terminal illnesses, or to those who are HIV-negative with similar conditions, such as pneumonia or tuberculosis (TB).
- (c) **Denying access to employment, educational facilities, shelter, health insurance, welfare benefits, or other social services:** The risk of HIV transmission does not arise in any situation linked to these services.
- (d) **Denying freedom to travel or migrate for employment or further educational opportunities, or to seek asylum or refugee status:** A policy which debar PLHA from entering a country only increases the fear surrounding the disease, forces PLHA to go underground and shun prevention, care and treatment.
- (e) **Imposing a quarantine or detaining persons with HIV infection:** Confining or isolating PLHA provides a false sense of security to the general public because they believe that all PLHA have been identified.
- (f) **Breaches of confidentiality that are either deliberate, such as informing an employer or others without the individual's consent, or are involuntary, especially in cases where medical records are not adequately protected or where reporting procedures are ineffective:** Without the protection of confidentiality, persons at risk of HIV infection are likely to avoid contact with health-care. Breaches in confidentiality about a person's HIV status may result in violence, rejection, loss of access to such services as employment, housing, insurance or social security benefits, and so on.
- (g) **Forcing women with HIV infection to undergo abortion:** As with mandatory testing, mandatory abortions may drive women with or at risk of, HIV underground, making it difficult to educate them on the prevention of HIV and on antenatal care.

GATHERING THE INFORMATION NEEDED TO ADVOCATE FOR CHANGES IN DISCRIMINATORY PRACTICES

To gather the information necessary to advocate for changes in discriminatory practices, programme managers should work with PLHA groups, nongovernmental organizations (NGOs) and service providers to determine the extent of these practices. The following are required for this purpose.

- Identifying the discriminatory practices, or recording those that others report
- Identifying where the practice occurs and the people affected by it
- Determining who is responsible for designing and implementing the policy or who is behind the practice
- Determining the reasons that led to the establishment of the policy or practice.

INITIATING A PROCESS TO LIMIT DISCRIMINATORY PRACTICES

To promote the protection of individuals from discrimination, individuals, government organizations (GOs) and NGOs should consider the following actions.

- Change current laws or regulations whose purpose or intention is to allow for discrimination against PLHA.
- Advocate for laws or regulations that protect PLHA when no other legal protection exists. This relates to situations in which individuals face discrimination in formal interactions, such as those between an individual and a landlord, employer or health-care provider.
- Provide information and education to help change the attitudes both of the general public and target audiences. Health-care or social workers should be educated on the impact of discrimination and on ways to improve reporting so that confidentiality is maintained.

To promote changes in laws, regulations and practices that improve support for and limit discrimination against PLHA, coordination among the health, legal, welfare and social sectors including NGOs is essential and could be facilitated by a multisectoral decision-making body that can mobilize political support and action for limiting discriminatory practices. Involving the community, especially PLHA, would help the National AIDS Programme (NAP) to collect information on the extent of discriminatory practices.

The NAP does not have the authority to change discriminatory practices or policies that may lead to them. However, the NAP management staff plays an important role in facilitating the efforts of those who can take corrective action to change discriminatory practices. The NAP manager should use the information gathered about discriminatory

practices to initiate a process aimed at limiting such policies and practices. The NAP management should:

- (a) inform the national AIDS committee (NAC) and other appropriate institutions and organizations, such as the Ministries of Health, Justice and Foreign Affairs;
- (b) indicate the reason(s) why the discriminatory practice
 - impedes public health objectives in general
 - impedes the main objectives of the NAP;
- (c) propose alternative activities that promote individual rights and limit discrimination against PLHA, and which are specifically designed to remedy the harm caused by the discriminatory practice that has been identified; and
- (d) collaborate with and obtain assistance from national and international agencies.

EXERCISE B

(Individual work followed by country group discussion)

Review the list of discriminatory practices listed on page 12. These are practices that should be avoided. Then answer the following questions.

Identify a discriminatory practice that you know has occurred in your country in the recent past.

1. Specify where the practice is followed and whom it affects (that is, the target population). Indicate whether the practice is occurring incidentally, whether it is a regular practice, or the result of an institutionalized policy.

2. What do you think is the underlying reason for this practice?

3. Who has the capacity and power to change the practice? If you do not know, how can you find the answer to this question?

4. Describe the actions that you think need to be taken by the NAP management to bring about these changes.

Inform your facilitator when you are ready for country group discussions.

OBJECTIVE 3: To describe the role of community support, peer support and counselling in HIV prevention, care and treatment

COMMUNITY SUPPORT

The need for support, information and counselling starts from the time an individual is diagnosed with HIV. The main aim of programmes and services at this stage are:

- to help PLHA adjust to their diagnosis by providing ongoing support and counselling;
- to link them to support networks, NGOs, PLHA groups, community groups or other supportive structures;
- to assist them to devise and put in place long-term strategies to remain healthy and prevent HIV transmission;
- to help them identify ways in which they can maximize their health and well-being – good nutrition, adequate shelter, economic security, maintaining hope and a sense of purpose, reducing stress;
- to introduce them to the range of clinical services including ART that they may need in the future;
- to work with community leaders and members to ensure that PLHA and their families are not cut off from community support.

The array of support services required at the community level depends on several factors. These are the number of PLHA thought to be present in the area concerned; the existence of support structures in the community that could be mobilized to provide HIV support; the capacity of local NGOs to contribute to support; and the setting, for example, the support that is needed or feasible in a poor urban area may differ significantly from that required in a rural area.

The AIDS programme has several roles to play in the setting up of support services:

- Helping networks of PLHA to provide information and support
- Working with national NGOs that have established contacts with the community, and assisting them to mobilize resources for care and support
- Ensuring that PLHA have non-discriminatory access to government programmes, such as those on poverty alleviation, food security, income support and vocational training
- Developing and monitoring laws and policies that reduce discrimination against and exploitation of PLHA

- Working with religious and community leaders to encourage them to provide PLHA with access to their support programmes and services at all levels
- Working with provincial and local governments to devise appropriate models and sustainable strategies for increasing local access to support
- Working with the Ministry of Health and private health service providers to assist them to develop strong links with community care and support services and programmes.

LINKING HIV PREVENTION, CARE AND TREATMENT

This should be read together with the module on reducing HIV transmission (see Submodules 6.1 and 6.2), but it is important to think about the contribution that HIV care, support and treatment services can make to HIV prevention.

While programme planners often separate HIV prevention, care and treatment, people affected by HIV and AIDS do not usually make this distinction. The latter are encouraged to maximize their health and well-being, and minimize HIV transmission (positive prevention).

Health-care workers are also being encouraged to better recognize their role in assisting positive prevention.

Strategies that help encourage positive prevention are:

- employing PLHA as peer counsellors and outreach workers in health services;
- training clinical staff in HIV prevention counselling, including assisting PLHA to disclose to others who may be at risk, reinforcing safer behaviours and reducing vulnerability;
- providing PLHA networks with resources to inform and support newly diagnosed PLHA;
- producing and distributing written materials on maximizing health and well-being and minimizing HIV transmission, in the local language and at the appropriate literacy level;
- ensuring that condoms are available at the health services/facilities;
- developing strong referral links between HIV clinical services and illicit drug treatment, substitution and rehabilitation services.

OBJECTIVE 4: To list the steps for strengthening clinical and community care for PLHA, including the scaling up of ART

GUIDING PRINCIPLES

Several guiding principles should be kept in mind while planning clinical care and treatment services for PLHA. These are as follows.

- Involving PLHA in the design and evaluation of health services increases the latter's effectiveness and improves access.
- Health care starts from the time of diagnosis and while people may live for many years without symptoms, it is important for PLHA to have an ongoing relationship with a clinical service that can monitor their health.
- Decentralization of services is essential – PLHA need to be able to access clinical services as close to home as possible, so that they can continue to work and participate in community life.
- Strong links between HIV services and other services, particularly TB services, lead to better health outcomes.
- Preventing or treating opportunistic infections (OIs) is a crucial part of HIV care, as many PLHA die from preventable or treatable OIs.
- The provision of ART is more effective if it is supported by a set of strategies for treatment preparedness and treatment adherence in the community.
- Interruptions in the supply of OI drugs and ART lead to unnecessary deaths.

THE RANGE OF CLINICAL SERVICES REQUIRED

PLHA require a range of clinical services to help them maximize their health, though all these services need not be provided in one place. Further, an individual's need for these services changes over time. The range of services includes:

- monitoring the nutritional state, general health, progression of HIV infection, strength of the immune system;
- prevention, diagnosis and treatment of OIs, particularly TB;
- access to ART, monitoring the response to ART, changes in treatment regimens as required;
- treatment of HIV-related cancers, neurological disorders, mental illness and other illnesses associated with HIV infection;
- diagnosis and treatment of STIs;

- treatment to prevent mother-to-child transmission (PMTCT); and
- drug substitution, drug treatment and rehabilitation for injecting drug users (IDUs) with HIV.

DECIDING WHICH SERVICES TO PROVIDE AT EACH LEVEL OF THE HEALTH SYSTEM

It is not feasible, or desirable, to provide specialized HIV treatment and care services at every local clinic. On the other hand, it is not possible for every PLHA in a given province or district to travel to the capital city for every aspect of their HIV-related health care. Hence, strategic decisions need to be made about where to locate health services and the NAP, along with the Health Ministry, has to play the primary role in coordinating this strategic planning.

The following steps are suggested for planning clinical care and treatment services.

- Establishing a multisectoral planning group, with representatives from relevant public and private sectors and NGOs:
- Examining the available strategic information to determine the distribution of needs, geographically and across population groups.
- Obtaining additional data on the services needed and those currently in use, if necessary.
- Examining available models of decentralized clinical care and treatment and adapting these to the context.
- Determining the set of services to be made available at each level of the system, and the site for the delivery of these (primary health clinic, maternal and child health clinic, STI clinic, etc.).
- Identifying the financial and other resources required.
- Determining the training needs of health-care workers.
- Establishing systems for the development of support services – procurement and supply of drugs and diagnostics, stock monitoring, patient data systems, standards of treatment and care.

The model proposed by WHO sets out packages of care and treatment at three levels.

Advanced package of services and activities

Provincial or tertiary-level hospitals

- Advanced diagnostic services
- Management of complicated cases
- Specialized services and support

Essential package of services and activities

Day-care centres and basic hospital services

- Comprehensive services, including ART and coordination
- Peer support for PLHA

Supportive package of services and activities

Health centre, community and family

- Basic care
- ART adherence support

GUIDELINES AND STANDARDS FOR CARE AND TREATMENT

Global and regional guidelines are available to assist programmes to set standards of care. WHO has recently published revised versions of the guidelines for the management of HIV infection and ART in infants and children, and adults and adolescents.

The NAP has a key role in coordinating the adaptation of these guidelines at the national level. This is generally done by bringing together clinicians, PLHA, procurement and supply managers, and national and provincial health officials, who examine the global and regional guidelines and adapt them to local needs and available resources.

In addition to treatment guidelines, universal infection control guidelines need to be adapted, disseminated widely and enforced. These measures minimize unnecessary isolation of PLHA, occupational exposure to HIV and the transmission of HIV from patient to patient (*see also* Submodule 6.6).

Once the guidelines have been adapted, they need to be widely circulated and made a part of in-service and tertiary health sector training. Evolving and implementing plans for the development of a health workforce are essential elements of maintaining standards of care.

PARTICULAR ISSUES INVOLVED IN SCALING UP OF ART

A well-coordinated ART access programme is now a central feature of any programme providing care, support and treatment as the consistent availability of ART significantly improves life expectancy and the quality of life of PLHA, and reduces the burden of HIV

on individuals, families and communities. It can also have a secondary impact on the prevention of HIV by providing hope and a sense of future for PLHA and hence encouraging people to learn about their HIV status to maximize their health and the health of others.

Many countries have a specific plan for the scaling up of ART, or have included it in their care, support and treatment plans. Providing consistent access to ART requires careful planning and coordination. The WHO ARV Scale-up Toolkit (2003) sets out the main elements required for the successful scaling up of ART. These are as follows.

- **Counselling and testing services**
- **Trained personnel** with sufficient knowledge of HIV prevention and care and ART.
- **Basic medical services** that are capable of identifying and treating common HIV-related illnesses and OIs, providing OI prophylaxis, initiating and monitoring ARV care, and referring individuals to higher levels of care or into community- and home-based care services.
- **Reliable laboratory services** including referral for CD4+ T-lymphocyte counts, viral load estimations, and drug resistance tests to monitor therapy.
- **Reliable, affordable and continuous supplies** of quality ART and OIs medicines and other essential commodities.
- **Support to PLHA for treatment preparedness and adherence**
- **Effective patient monitoring systems** to improve the quality of care and reporting on outcomes.

TREATMENT ADHERENCE

Assisting PLHA to adhere to ART is an essential factor in ensuring the success of HIV treatment programmes. PLHA leave prescribing clinics with a one-month supply of ART. It is important that they receive the support they need between clinic visits to adhere to their treatment regimen, as interruptions in taking their treatment, or taking ineffective doses of treatment will lead to drug resistance, illness and death.

There are several ways in which the national programme can support this.

- Support the involvement of PLHA groups in treatment preparedness – assist individuals and communities to understand ART and the strategies required to maximize the benefits of treatment.
- Ensure that clinical staff is trained to provide PLHA with counselling and information on adherence.

- Train and support PLHA and members of affected communities to be adherence counsellors in clinics and the community.
- Produce and disseminate easy-to-understand written information on adherence.

LINKS WITH THE TB PROGRAMME

TB remains the most significant OI for PLHA in Asia.

The NAP has a key role in strengthening collaboration between the HIV and TB programmes. This collaboration must be bidirectional – ensuring that people diagnosed with TB are offered HIV testing and that PLHA receive effective TB prophylaxis, diagnosis and treatment.

South-East Asia Regional Office has developed a Regional Strategic Plan on HIV and TB that provides clear information, recommendations for programming and indicators for measuring progress.

Strategies for improved prevention and management of HIV/TB

1. Prevent HIV transmission through:

- targeted interventions
- the 100% Condom Use Programme
- harm reduction among injecting drug users
- management of STIs
- scaling up of HIV voluntary counselling and testing (VCT)

2. Prevent progression of latent TB infection to active TB among people living with HIV by using:

- INH prevention therapy (IPT) to decrease progression from latent TB
- TB preventive therapy to decrease the risk of recurrent episodes after completion of treatment

3. Decrease morbidity and mortality for people with HIV-related TB by:

- implementing a comprehensive directly observed therapy, short-course (DOTS) strategy
- expanding ART access to strengthen the immune systems of PLHA with evidence-based ART regimens for people with HIV/TB
- providing comprehensive care and support for PLHA
- increasing access to co-trimoxazole prophylaxis

4. Strengthen the health system's response to HIV/TB by:

- enhancing collaboration between HIV and TB programmes
- advocating for political commitment to tackle HIV/TB
- mobilizing resources
- improving surveillance
- building partnerships with communities, PLHA and NGOs
- strengthening the health system's capacity to provide prevention, care and treatment services
- establishing referral systems
- ensuring accountability, monitoring and evaluation
- conducting operational research

Source: Adapted from the SEA Regional Strategic Plan on HIV/TB, 2003.

Cooperation between the HIV and TB programmes is essential. TB services need to be encouraged to incorporate an assessment of HIV risk and an offer of HIV counselling and testing into their care of people newly diagnosed with TB. HIV services need to encourage TB prophylaxis for people with HIV and to have strong links with TB services so that people with HIV-related TB are effectively treated.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

Key lesson

Providing early access to ART for women with HIV who are either contemplating pregnancy or are pregnant eliminates the need for specific PMTCT treatment and has the additional benefit of maximizing the health and well-being of the mother.

Effective PMTCT touches upon all areas – prevention, counselling, testing, care, support and treatment (for more details, see Submodule 6.5).

HOME-BASED AND COMMUNITY CARE

In many countries, during the early stages of the epidemic, PLHA spent much of their time in AIDS wards, being cared for until their death, often isolated from the family and community. As the health services became overburdened by increasing demand, effective models of home-based and community care were developed. This was also a response to the desire of PLHA to be cared for as close to the home and family as possible.

Many innovative models of home and community care have emerged as a result. One example from a district in Thailand shows that the quality of life of PLHA can be enhanced with care and support from the hospital and from the community. Multisectoral collaboration, including government sectors, NGOs, non-profit private organizations, religious organizations, PLHA groups and other community organizations, is essential to provide home and community care.

The following factors need to be considered when planning for home and community care.

- What are the resources for care that already exist in the community? Who in the community currently cares for the sick?
- Are there tolerant and caring people in the community who can be mobilized to participate in home and community care – retired nurses, religious groups, NGOs?

- What would they need (training, supplies, additional funding) to incorporate the care of PLHA into what they do?
- What would families need in order to feel confident to provide home-based care – training, medical/nursing back-up?
- Can marginalized communities be trained and used as a resource to provide care for their own community members with HIV (sex workers, IDUs, men who have sex with men, ethnic minorities)?
- What links can be developed between local health services and families or communities giving home- or community-based care?

Securing the resources for home and community care often involves carrying out a cost analysis that compares the cost of institutional care with the cost of supporting NGOs, local health services and communities to provide home and community care.

OBJECTIVE 5: To assess the progress of national programmes towards meeting the needs of PLHA across the continuum of care

Effective HIV care, support and treatment programmes bring together all the elements discussed so far to ensure that PLHA receive the care they need, at the place and time that they need, throughout their lives. Gaps in the continuum of care result in unnecessary isolation, suffering and death, and in increased HIV transmission.

EXERCISE C

(Country group work followed by intercountry group discussion)

In this exercise, you will assess the strengths and weaknesses of some key aspects of your current care, support and treatment programme and set priorities for the future.

Take your time to work progressively through the table on the following pages in country groups. If you do not have accurate information on the reach or utilization of services, say what you do know, or make some sort of educated guess. The main aim of the table is to generate a discussion on what exists at the moment and what needs to be strengthened first.

Inform your facilitator when you are ready for intercountry group discussions.

Table 1: Assess the current situation and make suggestions for improvement

Programme elements	What is the current situation ?	How can this area be strengthened?
Consistency and quality issues: – existence of guidelines, training, monitoring of compliance with guidelines		
ART access, monitoring progress, adherence to treatment and drug resistance		
Consistent supply of ART and drugs for OIs		

Table 1: Assess the current situation and make suggestions for improvement (cont.)

Programme elements	What is the current situation ?	How can this area be strengthened?
HIV support <ul style="list-style-type: none">– PLHA groups/networks– counselling– social support/welfare– spiritual care		
Prevention incorporated into care		
Ensuring a skilled, motivated and available workforce		
Home and community care		

RESOURCES

1. <http://www.who.int/hiv/pub/guidelines/adult/en/index.html>.
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8. *Care, involvement and action – mobilizing and supporting community responses to HIV/AIDS care and support in developing countries*. Brighton, UK, International AIDS Alliance, 2003.
9. *Ensuring equitable access to ART for women*. WHO/UNAIDS Policy Statement, 2004.
10. *Community engagement for antiretroviral treatment – participatory tools and activities for civil society organizations working with people with HIV – trainers’ manual*. Brighton, UK, International AIDS Alliance, 2006.

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11. *Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults in resource-limited settings – recommendations for a public health approach*. Geneva, WHO, 2006.
12. *Antiretroviral therapy for HIV infection in adults and adolescents in resource-limited settings: towards universal access – recommendations for a public health approach*. Geneva, WHO, 2006 (<http://www.who.int/hiv/pub/guidelines/adult/en/index.html>).
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14. *Antiretroviral therapy of infants and children in resource-poor settings – towards universal access – recommendations for a public health approach*. WHO, 2006.
15. *SEA Regional Strategic Plan for HIV and TB*.

16. *Management of HIV infection and antiretroviral therapy in infants and children – A clinical manual*. New Delhi, WHO Regional Office for South-East Asia, 2006.
17. *Antiretrovirals for HIV: A compilation of facts and product information*. New Delhi, WHO Regional Office for South-East Asia, 2006.
18. *Management of HIV Infection and antiretroviral therapy in adults and adolescents – A clinical manual*. New Delhi, WHO Regional Office for South-East Asia, 2007.



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 6 IMPLEMENTATION OF HIV PREVENTION, CARE AND TREATMENT STRATEGIES

SUBMODULE 5 PREVENTION OF MOTHER-TO-CHILD TRANSMISSION



**World Health
Organization**

Regional Office for South-East Asia

National AIDS Programme Management

A Training Course

Submodule 6.5: Prevention of mother-to-child transmission



**World Health
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Module 9 – Strategic information

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Submodule 6.5: Prevention of mother-to-child transmission

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2. To assess barriers to accessing services for prevention of mother-to-child transmission	9
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3. To plan activities to reduce mother-to-child transmission of HIV infection	11
Exercise B	

Prevention of mother-to-child transmission

LEARNING OBJECTIVES

After completing this submodule, participants will be able:

1. To describe the components of a comprehensive approach to the prevention of mother-to-child transmission of HIV.
2. To assess barriers to accessing services for prevention of mother-to-child transmission.
3. To plan activities to reduce mother-to-child transmission of HIV infection.

INTRODUCTION

This submodule sets out the components of a comprehensive strategy for the prevention of mother-to-child transmission (MTCT) of HIV infection, and provides an opportunity for participants to assess their country's current response in this area.

The rate of transmission of HIV from pregnant women with HIV to their infants has decreased to less than 2% in industrialized countries through the use of antiretroviral therapy (ART) for the prevention of vertical transmission (and for treating the mother) combined with elective Caesarean section and replacement feeding from birth. Some countries, such as Thailand, have also succeeded in reducing the number of children infected with HIV. A rapid decline in the number of AIDS cases among children under 5 years of age has been observed in Thailand since programmes for the prevention of mother-to-child transmission (PMTCT) of HIV were first introduced in 1997. This decline in the number of paediatric cases is also associated with a reduction in the prevalence of HIV among women attending antenatal clinics, as a result of intensive HIV prevention efforts.

Despite these isolated successes, access to PMTCT services remains unsatisfactorily low in many countries (around 2% of the women in the world who would qualify for PMTCT services are able to access it). This is either because they do not know their

HIV status, or because PMTCT interventions are not available to them. Without interventions, the risk of transmission remains high, which is indicated in the following table:

Condition	Risk of transmission
During pregnancy	5–10%
During labour and delivery	10–20%
During breastfeeding	5–20%
Overall without breastfeeding	15–30%
Overall with breastfeeding till 6 months	25–35%
Overall with breastfeeding till 18–24 months	30–45%

OBJECTIVE 1: To describe the components of a comprehensive approach to the prevention of MTCT of HIV

A comprehensive approach to the prevention of MTCT of HIV involves:

1. **Primary prevention of HIV infection** – minimizing the transmission of HIV to women.
2. **Prevention of unintended pregnancies among women with HIV** – by improving women's access to information, education, sexual and reproductive health services including family planning.
3. **Prevention of HIV transmission from mothers with HIV to their infants** – by increasing women's access to ART, providing antiretroviral treatment during labour, ensuring safer delivery procedures and reducing transmission through breastfeeding.
4. **Care, support and treatment for mothers living with HIV, their children and families** – to improve the health of the mother and the family to the extent possible.

In countries where epidemiological data supports the need for this, a routine offer of HIV counselling and testing to pregnant women who present for antenatal care is an effective strategy for increasing the access to PMTCT services and reducing HIV infection among infants and young children. These interventions to minimize HIV transmission are most effective when they are integrated into existing maternal and child health (MCH) services. This provides an opportunity to incorporate PMTCT alongside other important public health initiatives such as syphilis testing and treatment.

Given the high proportion of women who do not access antenatal care during pregnancy in many countries in the Region, links between MCH services and traditional birth attendants also need to be strengthened.

The diagram on page 8 sets out the services that can contribute to the prevention of MTCT.

Associated prevention measures

Safer delivery practices

Invasive obstetrical procedures, such as artificial rupture of membranes, fetal scalp monitoring and episiotomy may increase the risk of transmission of HIV to the infant. Their use in HIV-infected women should be limited to cases where absolutely necessary. It has been shown that an elective Caesarean section can help to reduce the risk of MTCT. This, however, may not be an appropriate intervention in resource-constrained settings, because of limited availability, cost and the risk of complications.

Comprehensive services for the prevention of MTCT: women seen during pregnancy

Package of services for antenatal care

1. Essential antenatal care services, including routine offer of HIV counselling and testing
2. Management of malaria in stable malaria areas
3. Clinical and immunological assessment of HIV-positive women
4. Screening, prevention and treatment of tuberculosis (TB)
5. Screening for and management of liver diseases
6. Screening, prevention and management of sexually transmitted infections (STIs)
7. Screening for and management of injecting drug use
8. Initiation of ART and antiretroviral (ARV) prophylaxis for PMTCT
9. Counselling and support on nutrition
10. Counselling and support on infant feeding

For all HIV-positive women in the postpartum period

1. Provide counselling and support on infant feeding
2. Provide follow-up care for mother and infant:
 - HIV-related care and ART when indicated
 - Co-trimoxazole prophylaxis for women and their infants
 - Sexual and reproductive health services
 - Counselling and support on nutrition
 - Diagnosis of HIV infection in infants
3. Adherence support for women receiving ART

Source: Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants in resource-limited setting.

Infant-feeding, counselling and support

Breastfeeding can add to the risk of HIV transmission by 5–20%. Lack of breast-feeding, however, can expose children to an increased risk of malnutrition or infectious diseases other than HIV. While avoiding breastfeeding would seem logical when the mother has HIV, striking the necessary balance of risks is in fact more complicated. All mothers with HIV should receive counselling that includes information about the risks and benefits of various infant-feeding options, and guidance in selecting the most suitable option for their situation. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, breastfeeding by mothers with HIV should be avoided. Otherwise, exclusive breastfeeding is recommended during the first few months of life and should then be discontinued as soon as it is feasible.

Follow up of mothers and infants

Mothers and infants receiving treatment for PMTCT need to be able to access follow-up services. These include access to care, support and treatment for the mother, and access to viral load testing for the infant, and ongoing care, support and treatment services if diagnosed with HIV.

Take some time to look at the above diagram, which shows details of comprehensive services for PMTCT. Think about how it relates to the services that you provide currently in your country and use it for Exercise A.

OBJECTIVE 2: To assess barriers to accessing services for prevention of mother-to-child transmission

Pregnant women attending antenatal clinics are included in HIV sentinel surveillance in many countries. The results give useful information about the extent of HIV prevalence in this group and an estimate of the risk of infants being infected with HIV.

For many years now, the cost of antiretroviral (ARV) drugs has been seen as the key hurdle to implementing interventions that can prevent HIV infection in infants and young children in resource-constrained countries. Now, with the negotiation of more advantageous pricing agreements, as well as large-scale donations of some drugs, the possibility of access by pregnant women in these countries to ARV drugs has increased enormously.

Even with the cost barrier removed, many hurdles to implementing interventions remain. The most important limiting factor may be the inability of health systems in some of the worst affected countries to deliver the necessary services. In many of these countries, the use of antenatal care is too limited at present to provide efficient and widespread interventions that prevent HIV infection in infants and young children.

Moreover, antenatal care must be used effectively. It is often restricted to one visit only (usually late in pregnancy) and may not be associated with skilled assistance by a health-care worker at the time of delivery. Furthermore, in many of the countries where the need is greatest, access to HIV counselling and testing – essential if women seeking antenatal care are to know their HIV status and make use of specific prevention and care interventions – seldom exists. To enable wide delivery of the interventions needed to prevent HIV infection in infants and young children, these issues must be addressed.

EXERCISE A

(Country group work followed by intercountry group discussion)

In country groups, estimate the following: (You may not have accurate data available. Make an estimate based on your knowledge.)

% of pregnant women who attend antenatal services	
% of these women who are offered HIV testing	
% of these women who access HIV testing in antenatal care	
% of these women who test HIV-positive	
% of these women who receive their results	
% of these women who receive PMTCT treatment	

Now answer the following questions:

1. What sources and methods are useful in gathering information about MTCT of HIV in your country?
2. From the available information, what activities are currently being carried out in your country to prevent MTCT of HIV? What are the gaps?

Inform the facilitator when your country group is ready for intercountry group discussions.

OBJECTIVE 3: To plan activities to reduce MTCT of HIV infection

A number of activities will be required to implement the above interventions.

- Adapt international guidelines on prevention of MTCT of HIV including counselling and testing, use of ARV drugs, and counselling on infant feeding.
- Train health workers in the use of ARV drugs for prevention of HIV infection.
- Procure and distribute ARV drugs to be used to prevent MTCT of HIV.
- Train health workers and outreach workers in infant-feeding counselling.
- Develop and implement guidelines on safer delivery practices.

Assigning roles and responsibilities and timelines is an important part of planning.

Example

Activity	Organization	Department or individual
Adapt international guidelines on the use and distribution of ARV drugs to prevent MTCT of HIV	Ministry of Health	National AIDS Programme Manager
Train health workers in the use of ARV drugs to prevent MTCT of HIV	Ministry of Health	National AIDS Programme Manager
Prepare and distribute guidelines on safer delivery practices	Ministry of Health	MCH Director

(As an example, a sample timetable of some activities to prevent MTCT of HIV is given below.)

Sample timetable: Activities to prevent MTCT of HIV, 2007

Activity	Tasks	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Procure ARV drugs to prevent MTCT of HIV	Coordinate ARV procurement with donors and suppliers	X	X										
Distribute ARV drugs for prevention of HIV	Designate 25 centres for distribution	X	X										
	Specify locations for distribution	X	X										
	Meet with responsible individuals		X	X									
	Provide stock		X	X	X	X	X	X	X	X	X	X	X
	Check with centres to determine re-stocking of ARV drugs				X		X		X		X		X
Train health-care workers in prevention of MTCT	Coordinate with MCH Director	X											
	Provide training		X	X									

EXERCISE B

(Country group work followed by intercountry group discussion)

Answer the following questions in your country group:

1. What steps can you take to expand access to PMTCT services in your country?

2. What are the limiting factors to this expansion?

3. What can be done to overcome these limiting factors?

Inform the facilitator when your country group is ready for intercountry group discussions.

RESOURCES

1. *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants in resource-limited settings – towards universal access: recommendations for a public health approach*. Geneva, WHO, 2006 (<http://www.who.int/hiv/mtct/en/>).
2. *The global strategy for the acceleration of PMTCT scale up to eliminate HIV and AIDS in infants and young children*. WHO (Draft), 2007.



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 6 IMPLEMENTATION OF HIV PREVENTION, CARE AND TREATMENT STRATEGIES

SUBMODULE 6 PREVENTION OF HIV TRANSMISSION THROUGH BLOOD



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Submodule 6.6: Prevention of HIV transmission through blood

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2. To review guidelines, assess practices and plan activities for screening of blood and blood products for HIV	11
3. To review guidelines, assess practices and plan activities for appropriate use of blood	13
4. To state the role of the national programme in coordination of activities Exercise B	14
PART II: Prevent HIV transmission in health-care and other settings	
5. To review guidelines, assess practices and plan activities for ensuring universal infection control in health-care and other settings	18

Prevention of HIV transmission through blood

LEARNING OBJECTIVES

After completing this submodule, participants will be able:

Part I. Ensure a safe blood supply

1. To review guidelines, assess practices and plan activities for recruitment of low-risk donors.
2. To review guidelines, assess practices and plan activities for screening of blood and blood products for HIV.
3. To review guidelines, assess practices and plan activities for appropriate use of blood.
4. To state the role of the national programme in coordination of activities.

Part II. Prevent HIV transmission in health-care and other settings.

5. To review guidelines, assess practices and plan activities for ensuring universal infection control in health-care and other setting.

INTRODUCTION

Three interventions make up the strategy for prevention of HIV transmission through blood:

- by ensuring a safe blood supply;
- by ensuring aseptic conditions for invasive, skin-piercing, surgical and dental procedures;
- by preventing unsafe drug behaviours.

This submodule discusses how to plan activities related to providing a safe blood supply and safe medical procedures. The submodule is divided into two parts:

- Part I examines the three components for ensuring a safe blood supply:
 - motivate, recruit and retain low-risk donors
 - screen blood and blood products for HIV
 - use blood appropriately to reduce the number of unnecessary blood transfusions
- Part II enumerates steps in universal precautions for invasive, skin-piercing, surgical and dental procedures to prevent HIV transmission in health-care and other settings.

PART I: ENSURE A SAFE BLOOD SUPPLY

Safe blood supply, which is a part of the National Blood Transfusion Service (NBTS), is the responsibility of the Ministry of Health or the responsibility may be delegated to a non-profit nongovernmental organization (NGO), such as the Red Cross Society. The role of the national AIDS programme (NAP) manager is to stress on the importance of government commitment and to recommend and coordinate HIV-related plans and activities within the NBTS.

Some of the problems associated with providing a safe blood supply include:

- safety and quality of blood varies greatly in developing countries;
- efficiency of transmission through blood transfusion is very high – more than 90%;
- risk of transmitting HIV varies considerably depending on the prevalence rate in the blood donor population; and
- the number of voluntary non-remunerated donors has not yet reached 100% in many countries.

Preventing HIV transmission through blood transfusion is an achievable goal. It requires following guidelines for establishing and maintaining a safe blood supply, strengthening efforts to improve general health, and developing basic health-care facilities.

This section focuses on the three aspects of ensuring a safe blood supply.

1. Motivate, recruit and retain low-risk donors
2. Screen blood and blood products for HIV
3. Use blood appropriately

The NBTS is responsible for ensuring the implementation of these components of the safe blood supply. The NAP manager coordinates with the NBTS for maintaining a safe blood supply. However, funds of the NAP are not meant to be the sole source of funding for blood safety programmes. Blood safety is a much broader issue than HIV testing and requires more effort than the approaches identified in this module.

OBJECTIVE 1: To review guidelines, assess practices and plan activities for recruitment of low-risk donors

Low-risk donors are the cornerstone of a safe blood supply. They are voluntary, non-remunerated donors who donate blood regularly of their own free will and are chosen from low-risk populations. They do not receive any payment, either in cash or in kind. Donations from those at risk of HIV infection must be avoided to improve the safety of blood. Family replacement donors do not belong to the group of low-risk donors.

REVIEW RECOMMENDED GUIDELINES FOR IDENTIFYING AND RECRUITING LOW-RISK DONORS

The following are recommendations for developing a source of safe donors.

- Establish a programme to motivate, recruit, and retain low-risk donors.
- Develop media campaigns stressing on the need to donate regularly and to self-defer if any risk factors exist.
- Recruit donors who are not likely to have HIV infection.
- Discourage people at risk of HIV infection from donating blood.
- Develop a registry of low-risk donors.
- Assess risk status of all potential donors.
- Maintain donor confidentiality.
- In case of a positive test result for HIV infection, refer donor for follow-up, where appropriate facilities exist.
- Promote donor retention.

ASSESS CURRENT DONOR RECRUITMENT PRACTICES

Given below are a set of questions that will help in assessing current donor recruitment practices for determining areas of strength and discrepancies.

- Who is in-charge of blood donation recruitment campaigns?
- What are the existing plans to increase the numbers of low-risk donors? For example, mass media campaigns and campaigns in schools, factories and other areas with low-risk donors.
- Are there cultural constraints against blood and blood donations?
- Are donors paid? Do families pay donors to serve as “family replacement” donors? In many hospitals, a patient is given blood transfusion only if family members donate an equal number of blood units. Sometimes families pay someone else to donate blood.

- How are low-risk donors recruited?
- Which group of population tends to donate blood the most?
- Are the donation sites accessible to low-risk donors?
- Is there a process of self-deferral?
- Are mobile donation sites well organized?
- What systems exist to maintain records of blood donors, protect confidentiality, and facilitate donor recall?
- Do donor sites provide privacy during the interview and physical examination?

PLAN ACTIVITIES TO MOTIVATE, RECRUIT AND RETAIN LOW-RISK DONORS

The following are the key activities to motivate, recruit and retain low-risk donors.

- Carry out media campaigns encouraging people with low risk to donate blood.
- Carry out campaigns in schools and workplaces to promote blood donations from low-risk individuals.
- Change from the paid donor system as well as family replacement system to a system emphasizing voluntary non-remunerated regular donations.
- Compile lists of potential donors from schools, factories, offices and general public.
- Devise standard questionnaires for use in all blood banks.
- Train health workers to appropriately interview and clinically examine potential donors.
- Establish individual and confidential donor records and counselling referral service.
- Establish separate sites for voluntary counselling and testing (VCT).

IDENTIFY ORGANIZATIONS TO IMPLEMENT DONOR RECRUITMENT ACTIVITIES

Typical organizations involved in implementing donor recruitment activities include the NBTS and NGOs, such as the Red Cross Society and voluntary blood donor organizations.

Questions to consider while identifying organization to be involved in recruitment activities include:

- How is the NBTS coordinating with the NGOs that recruit low-risk donors?
- Is there a clear delineation of responsibilities between the organizations involved?
- Is there a recognized authority responsible for all aspects of donor recruitment?
- Is there a firm commitment from the NGOs to carry out the planned activities?

4. Does your country have:

- a blood donor recruitment officer to coordinate the activities?
- adequate funding to support donor recruitment and retention efforts?
- sufficient staff to maintain records?

If answer to any of these is “no”, what can be done to improve the situation?

Inform your facilitator when you are ready for country group discussions.

OBJECTIVE 2: To review guidelines, assess practices and plan activities for screening of blood and blood products for HIV

The second component of providing a safe blood supply is to screen all blood donations for HIV and other infectious agents. Continuous screening is vital to maintain the effectiveness and credibility of the blood transfusion services. The effectiveness of blood services in developing countries is often hampered by a variety of factors that may need to be addressed when planning screening activities.

Some of the typical problems are given below:

- Lack of organized blood services.
- Inappropriate selection of the testing reagents, such as the use of ELISA (enzyme-linked immunosorbent assay) instead of simple/rapid tests in peripheral facilities.
- Inability to perform the tests on donated blood at the centres.
- Lack of organized stock control of screening assays.

REVIEW RECOMMENDED GUIDELINES FOR SCREENING OF BLOOD

Recommendations for screening of blood and blood products include:

- Conduct the appropriate test, whether simple, simple/rapid or ELISA, polymerase chain reaction (PCR) or nucleic acid test.
- Develop and/or maintain a quality assurance scheme to ensure good laboratory practice.
- Provide for confidentiality of test results.
- If a result is inconclusive and needs to be re-checked, refer donated blood for appropriate follow-up.
- If the result is positive, provide for follow-up of the donor.

ASSESS CURRENT BLOOD SCREENING PROCEDURES

Given below are a set of questions that will help in the assessment of blood screening procedures for determining the areas of strength and discrepancies.

- Which screening tests are used and why?
- What kind of training is provided on screening procedures?
- What record-keeping procedures are in place for screening activities?

- Do blood transfusion sites have an adequate and uninterrupted supply of HIV test kits?
- How are the procurement, storage and distribution of HIV test kits managed?

PLAN ACTIVITIES FOR SCREENING OF BLOOD AND BLOOD PRODUCTS

Examples of the key activities for screening include:

- coordinating procurement, storage and distribution of test kits;
- determining appropriate types of tests to be used at each site;
- trained personnel to perform tests and administer follow-up procedures;
- developing laboratory protocols and standard operating procedures (SOPs) for blood transfusion service including HIV testing;
- establishing record-keeping procedures to provide confidential test results to donors.

OBJECTIVE 3: To review guidelines, assess practices and plan activities for appropriate use of blood

Blood transfusion can be life saving. However, transfusions have the potential to transmit HIV, hepatitis B and other infectious agents. Moreover, blood is often scarce and expensive. Establishing and adhering to guidelines for the appropriate use of blood is necessary to ensure an adequate blood supply.

REVIEW RECOMMENDED GUIDELINES FOR THE APPROPRIATE USE OF BLOOD

Recommendations for the appropriate use of blood include:

1. Transfuse blood or blood products only when it is absolutely necessary to save life or to treat major illness.
2. Transfuse blood which has been obtained only from appropriately selected donors and which has been screened for infectious agents.
3. Use plasma substitutes such as crystalloids or colloids, whenever possible.
4. Improve basic health-care facilities, maternal and child health (MCH) and family planning programmes to reduce the need for blood transfusions. For example, provide good antenatal care and ensure the availability of iron, folic acid, antimalarial and antihelminthic drugs to avoid anaemia.

ASSESS THE CURRENT USE OF BLOOD SUPPLY

Given below are a set of questions that will help in assessing the current use of blood for determining areas of strength and discrepancies.

- When and why is blood transfused?
- Is a national assessment on blood usage being carried out?
- Is the use of blood being monitored and evaluated?
- Are guidelines available for the appropriate use of blood?

PLAN ACTIVITIES TO PROMOTE THE APPROPRIATE USE OF BLOOD

Key activities to promote appropriate use of blood include:

- review blood usage patterns and update criteria for transfusions, if necessary;
- develop and distribute national blood use guidelines;
- train medical students and doctors in appropriate use of blood;
- strengthen health-care services to reduce the need for blood transfusions by improving antenatal care and prevention and management of anaemia; and
- Promote and provide plasma substitutes (crystalloids and colloids).

OBJECTIVE 4: To state the role of the national programme in coordination of activities

IDENTIFY THE ORGANIZATIONS

First identify the organizations involved in the various aspects of blood safety. Then review the activities planned to provide a safe blood supply and designate the responsible organizations, departments or individuals. A table such as the following could be used for this purpose.

Example

Activity	Organization	Department or individual
Devise standard questionnaire for use in all blood banks	NBTS Blood banks National health authority	NBTS Director Donor Recruitment Officer
Determine appropriate tests to be used at each site	NBTS Blood banks	NBTS Director Pathologist Chief Laboratory Technician
Develop guidelines for appropriate use of blood	NBTS Blood transfusion committee	NBTS Director Director, Health Services

ESTABLISH A TIMETABLE TO IMPLEMENT ACTIVITIES

Page 15 shows a sample timetable of activities designed to provide a safe blood supply.

Sample timetable: Activities to prevent HIV transmission through blood, 2007

Activity	Tasks	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Recruit low-risk donors	Identify target groups	X											
	Prepare recruiting materials, presentations		X	X									
	Recruit donors				X	X	X	X	X	X	X	X	X
Establish donor management system	Prepare guidelines for interviews and physical check-ups	X											
	Train staff to do physical check-ups and donor deferral		X										
	Establish donor record and confidentiality procedures, self-deferral system		X										
Screen blood and blood products	Select tests to be used	X											
	Develop laboratory protocols, guidelines and quality assurance procedures	X	X										
	Define and establish support systems: procurement, storage, distribution			X		X				X			X
	Establish record keeping and confidentiality procedures			X									
	Train staff				X	X	X						
Plan appropriate use of blood	Review blood usage pattern	X	X										
	Develop national blood use guidelines			X	X	X							
	Provide education workshops on "appropriate use of blood"						X	X	X	X	X		
	Monitor and evaluate guidelines											X	X

EXERCISE B

(Country group work followed by intercountry group discussion)

In your country group, select one component of providing a safe blood supply (recruiting safe donors, screening blood and blood products, or using blood appropriately) which needs to be addressed in your country. Answer the following questions about the component selected. Countries will share their responses in a large group discussion.

1. Component to be discussed:

2. Review the recommended guidelines listed in the module for the component chosen. List any discrepancies between current practices in your country related to the component and the recommended guidelines.

For example, one discrepancy may be in the use of ELISA technology instead of simple/rapid tests in areas where small number of blood units are being tested.

3. Identify activities to reduce or eliminate any discrepancies.

4. Which organizations in your country would be responsible for implementing activities in this component?

Inform your facilitator when your country team is ready for intercountry group discussions.

PART II: PREVENT HIV TRANSMISSION IN HEALTH-CARE AND OTHER SETTINGS

This section deals with the second intervention related to preventing HIV transmission through blood: provide universal infection control procedures for invasive, skin-piercing, surgical and dental procedures.

HIV may occasionally be transmitted from one person to another through blood in health-care setting via contaminated medical equipment, from patient to health worker via accidental exposures, and from health worker to patient via accidental exposures. Accidental exposures may result from needle pricks, scalpel cuts or splashes in the mouth or eyes. HIV may also be transmitted at homes, pharmacies or other sites through such practices as tattooing, immunizations, circumcisions and home births.

Transmission through these procedures is extremely rare in both health-care and other settings. Nonetheless, adherence to universal precautions can help to prevent transmission by any of these modes. Blood and other body fluids are considered to be infectious, regardless of whether laboratory tests are positive, negative or not conducted.

Proper cleansing of hands and appropriate sterilization of all instruments that come in contact with the body fluids are important to prevent transmission of the virus. HIV is easily destroyed, and standard methods of sterilization and disinfection designed to inactivate other viruses, such as the hepatitis B virus, will inactivate HIV.

The NAP manager's role is to work with the Ministry of Health to establish effective guidelines for universal precautions in health-care and other settings.

OBJECTIVE 5: To review guidelines, assess practices and plan activities for ensuring universal infection control in health-care and other settings

REVIEW RECOMMENDED GUIDELINES

Guidelines for universal precautions need to be reviewed in all health-care settings. The recommendations for universal precautions include:

- Wash hands before and after performing each procedure, between each patient, and before and after using gloves. *This is probably the most important step.*
- Disinfect surface where procedure will be performed or instruments will be placed.
- Wear gloves, eye-protection and other protective clothing while performing procedures which require them or if open wounds or infectious drainage are present.
- Sterilize skin-piercing instruments and dental equipment with heat. Do the best possible. If you cannot autoclave, boil. If you cannot boil, disinfect. If you cannot disinfect, wash thoroughly with soap or detergent and water.
- Place contaminated disposable materials in containers to be burned or buried in a deep pit with a strong disinfectant, such as Lysol.
- Dispose liquid wastes such as bulk blood, suction fluids, excretions and secretions in a sewer system or pit latrine that has been treated with a strong disinfectant.
- Place needles and other sharp instruments in a rigid plastic, glass or metal container and dispose them appropriately, either by destruction or sterilization.
- Carry safe containers for disposal of contaminated equipment and materials when procedures are carried out at home or other settings.

ASSESS CURRENT PRACTICES IN HEALTH-CARE AND OTHER SETTINGS TO DETERMINE DISCREPANCIES WITH RECOMMENDED GUIDELINES

Given below are a set of questions that will help in assessing the universal precautions.

- Do health workers understand the concept of universal precautions?
- What precautions are health-care providers using to prevent HIV transmission?
- Are health-care providers following universal precautions even if they perceive the patient has a low risk of HIV infection?
- Is there proper equipment for sterilization?
- Are there quality assurance programmes in place to see if health-care providers are following sterilization procedures?

- Are gloves available in sufficient quantities in health-care settings? Are health-care providers using gloves when required?
- How are needles and other sharp instruments handled after use? Are they being recapped or placed in containers? Most needle stick injuries occur when medical staff try to recap them after use or when they are disposed incorrectly, thus causing accidental injury to cleaning staff who are unaware of their presence when clearing materials.
- How are contaminated materials and body fluids disposed of in health-care and other settings?
- Are containers used for depositing contaminated materials like sharps, inflammables, plastics and liquids, or body fluids and tissues, such as a placenta, when medical functions are performed at health-care, home or other settings?
- Is there a provision for post-exposure prophylaxis (PEP) in case of accidental exposure?

PLAN ACTIVITIES TO PROMOTE ASEPTIC CONDITIONS IN HEALTH-CARE AND OTHER SETTINGS

Activities to promote aseptic conditions are outlined below:

- Identify skin-piercing or other invasive procedures performed in health care and other settings.
- Urge Ministry of Health to issue guidelines for universal precautions during skin-piercing procedures in health care and other settings.
- Encourage the establishment of an infection control committee and the appointment of infection control officer in each hospital.
- Promote universal precautions during traditional practices, such as tattooing, circumcision and scarification.
- Train health-care providers in universal precautions.
- Develop educational materials to inform the public about preventing HIV transmission in invasive, skin-piercing, surgical and dental procedures.
- Provide for PEP in case of accidental exposure.



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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 7 MANAGING THE AIDS PROGRAMME



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National AIDS Programme Management

A Training Course

Module 7

Managing the AIDS programme

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Module 4 – Targeted HIV prevention and care interventions

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Module 6 – Implementation of HIV prevention, care and treatment strategies

Module 8 – Management systems for the AIDS programme

Module 9 – Strategic information

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Module 7: Managing the AIDS programme

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Managing the AIDS programme

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To describe the attributes and skills required for management of the AIDS programme and identify areas for professional development.
2. To outline strategies for strengthening leadership, advice and support for the AIDS programme from others.
3. To outline strategies for strengthening and supporting multisectoral partnerships.
4. To describe the elements that support good governance of the AIDS programme.
5. To develop strategies for managing crises and emerging issues.
6. To identify strategies for mobilizing and coordinating internal and external resources for the AIDS programme.

INTRODUCTION

National AIDS programmes have become increasingly complex over the past ten years and the role of the programme manager has expanded to accommodate this complexity. The complexity of this role varies from country to country, and is somewhat easier in countries with larger AIDS programmes, in which roles are distributed across a multidisciplinary team.

This module focuses on the skills and attributes required for management of an AIDS programme and on the strategies that can be put in place to improve internal management of the programme and the external environment. It complements Module 8, which discusses the management and support systems that maximize the efficiency and effectiveness of the programme. It also upholds the “Three Ones principles” that have been adapted by governments, all major international donors and UNAIDS co-sponsors in order to ensure a harmonized, coordinated and, above all, a country-owned and country-led response to the epidemic.

Three Ones principles

- One agreed HIV action framework
- One National HIV Coordinating Authority with a broad-based multisectoral mandate
- One agreed HIV country-level M&E system

This is not a skills-building module, but assists participants to identify areas for skills building and programme strengthening.

OBJECTIVE 1: To describe the attributes and skills required for management of the AIDS programme and identify areas for professional development

What makes a good manager? To some extent, the answer depends on whom you ask. Those being led might say that a good manager is someone who respects them, includes them in decisions, is fair, supports them, and helps them to carry out their jobs. Someone in authority might say that a good manager is someone who is tough, gets the job done and delivers the required outcomes. Leadership is probably therefore not a single quality, but a collection of attributes that allows the person to respond to the range of challenges posed by the programme.

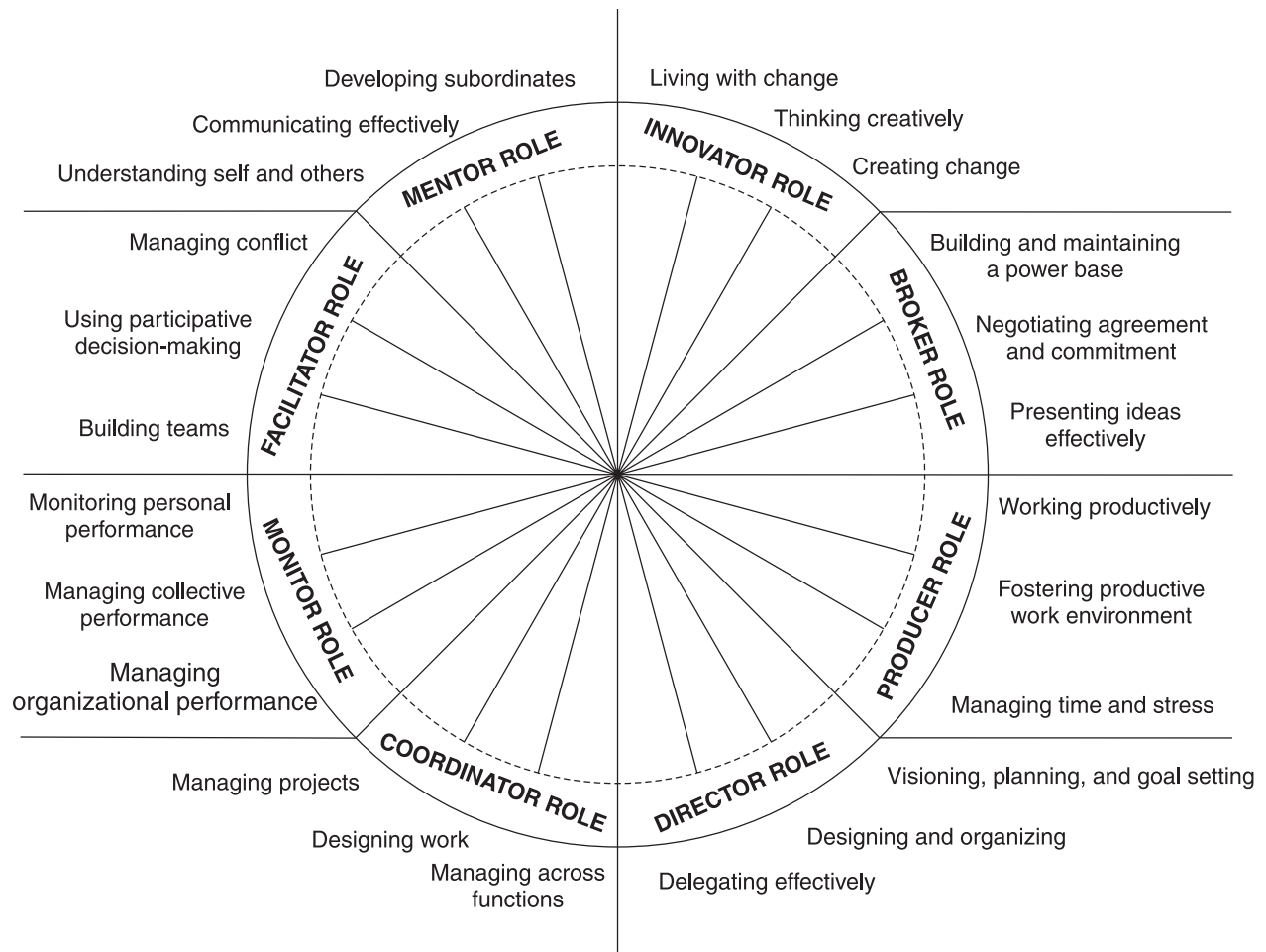
AIDS programmes operate in a dynamic environment that presents some particular challenges for the managers:

- They deal with some controversial and sensitive areas – sex, drugs, morality and culture.
- They rely on cooperation between a wide range of sectors and groups, not health alone.
- Their work involves, or has the potential to involve, large sums of money.
- They attract great interest from the media and often cause bitter debate in communities.
- Their decisions may have life-and-death consequences.
- They have to deal with a wide range of competing interests and lobby groups.
- They have to be aware of debates, nationally and internationally, about which approaches to adopt.
- In view of rapid and frequent advances in knowledge and evidence, they should be able to regularly review, reflect and change their approaches or priorities.

This dynamic environment requires a range of leadership qualities and management skills.

There are many theories of leadership and management, and many ways to describe the attributes required. One method of categorizing management describes eight roles for a manager. These are given in the diagram on the following page.

Managerial competencies



These eight roles – innovator, broker, producer, director, coordinator, monitor, facilitator and mentor – provide a useful framework for examining the skills that the AIDS programme manager needs.

EXERCISE A

(Individual work followed by individual feedback)

Look at the range of tasks set out in the diagram on page 8. Think about your skills as a manager, and the tasks that you are required to perform as an AIDS programme manager. Complete the table below describing your current strengths and how you would strengthen your capacity in new areas.

Role	Current strengths	Areas in which you would like to strengthen your capacity	How you would do this
Innovator	<ul style="list-style-type: none"> – living with change – thinking creatively – creating change 		
Broker	<ul style="list-style-type: none"> – building and maintaining a power base – negotiating agreement and commitment – presenting ideas effectively 		
Producer	<ul style="list-style-type: none"> – working productively – fostering a productive work environment – managing time and stress 		

EXERCISE A (cont.)

Role	Current strengths	Areas in which you would like to strengthen your capacity	How you would do this
Director <ul style="list-style-type: none">– visioning, planning and goal-setting– designing and organizing– delegating effectively			
Coordinator <ul style="list-style-type: none">– managing projects– designing work– managing across functions			
Monitor <ul style="list-style-type: none">– monitoring personal performance– managing collective performance– managing organizational performance			
Facilitator <ul style="list-style-type: none">– managing conflict– using participatory decision-making– building teams			
Mentor <ul style="list-style-type: none">– developing subordinate skills– communicating effectively– understanding self and others			
Other skill areas or roles			

Discuss with your facilitator if you would like assistance or advice.

OBJECTIVE 2: To outline strategies for strengthening leadership, advice and support for the AIDS programme from others

The AIDS programme requires leadership and support from a range of people, including senior politicians, senior government officials, community leaders and religious leaders. This is because the success of the programme depends on cooperation across a range of sectors, government departments and at various levels of government.

National AIDS programmes raise sensitive issues and advocate approaches that some people within society may find difficult to comprehend or accept. They target populations that are marginalized within most societies – sex workers, drug users and men who have sex with men (MSM) – and they take a pragmatic approach to minimizing harm within these populations and from these populations to other groups. AIDS programmes may attract criticism from a range of people, who believe that these marginalized populations pose a threat to the health and development of the nation and its culture. In resource-poor settings, these programmes may also be criticized for their exceptional or special nature and for making demands on resources that could be used for overall development.

AIDS programmes require support from a high level of leadership if they are to succeed. AIDS programme managers have a role in fostering this leadership and support.

IDENTIFYING LEADERS

One way to build support for the programme is to identify people from a range of sectors who can provide support and leadership, and invest time and resources in helping them to find ways to provide leadership within their individual sectors.

Following are some of the strategies that can assist in fostering this leadership.

- Providing key people with regular briefings on emerging issues, so that they know what messages to deliver.
- Helping them to organize leadership briefings within their sector, bringing people together to discuss various aspects of the AIDS programme and the rationale for the approaches being taken.
- Providing them, or their institutions, with resources or technical assistance to prepare briefing materials for other leaders within their sector.

- Encouraging them to join advisory committees so that they can interact with other people involved in the programme.
- Sending them on field visits or study tours so that they can better understand the effect of the current approaches to the HIV epidemic in other settings.

WORKING WITH CRITICS

The programme should also engage with its critics. It is useful to focus on key people who are critical of the AIDS programme and work with them to identify the nature of their objection to the programme and ways by which they may be able to better support the programme's goals. This is not always easy and depends on the nature of their objection. If they are critical because they do not fully understand the rationale and evidence of certain approaches, this can be remedied by providing the relevant information and by allowing them to experience first-hand the impact of the programme's work.

Obviously, not all critics can be harnessed as future leaders or supporters of the programme, but it is important to try to work with people to bring them to a point where they understand the work more clearly. The skills and position that make them powerful critics can sometimes be harnessed to support the programme.

MANAGING "UP"

One of the most important ways that the AIDS programme can inspire leadership is to provide senior politicians and senior government officials with the information that they need to provide leadership for the programme. It is often effective to have the Minister of Health, or the Prime Minister speak out positively about AIDS.

It usually requires a high level of judgement and diplomacy, but can be a very powerful way to build and strengthen leadership for the programme.

BUILDING SUPPORT ACROSS ALL POLITICAL PARTIES

Leaders and governments come and go. It is important to put strategies in place to ensure that leadership continues even if there are changes in the government or key ministers. In some countries, the existence of a Parliamentary Committee on AIDS has provided some stability for the programme. Leaders from all political parties are provided with briefing materials and the opportunity to engage with the work of the programme. This can, in some instances, reduce criticism of the government's approach and prepare future leaders for their role in overseeing the programme. Different parliaments have

different committee structures. Putting AIDS on the agenda of relevant committees can be a good way to strengthen the programme.

Managing advice to the programme is a critical part of programme management. There are several advantages in having a set of advisory committees to the programme.

- It brings expertise to the programme from a range of sectors and fields.
- It can support the staff of the programme – they can say that the approaches they want to take are not just their own views, but the views of a panel of experts.
- It can provide some protection for politicians if they are criticized for adopting controversial approaches – they can attribute responsibility for the approach to their panel of experts.
- It can silence some critics – involving them in advisory committees means that they support the decisions of the committee to some extent, unless they formally dissent.
- It promotes participation and transparency.
- It can streamline decision-making – the minister responsible can delegate some decision-making to the committee, avoiding lengthy bureaucratic processes.

Advisory structures are a way of managing a diverse set of contradictory inputs to the programme.

There are several strategies that the programme can put in place to get the most out of its advisory structures.

- Do not have too many committees. Work out what resources you have before you set up committees. Some, such as the surveillance and data committee, might need to be standing committees (running continuously) while others may be ad hoc (running for a limited time).
- Maintain an agenda and good records. Make sure that minutes are circulated between meetings for correction and approval. Keep a running sheet of decisions and actions.
- Provide the committee with good information in advance of meetings. Circulate the agenda and papers in advance. It is important for people to have time to think and consult with others before coming to the meetings.
- Manage the agenda, or at least manage the Chair. Prepare an agenda that is in line with the strategic plan and focuses on the needs of the programme. Brief the Chairperson before the meeting so that she/he can conduct the meeting according to a focused agenda.
- Orientate new committee members about the committee, programme and workplan before their first meeting.

4. Identify strategies for improving this system or for filling in gaps in advice.

Inform your facilitator when you are ready for intercountry group discussions.

OBJECTIVE 3: To outline strategies for strengthening and supporting multisectoral partnerships

It is clear that AIDS programmes require the cooperation of a range of sectors, government departments and levels of government. This is not always easy to achieve and requires investment of time and resources.

There are several strategies that can be used to strengthen partnerships between sectors and groups.

1. Have a national AIDS policy and strategy in place that refers to the need for partnership. Including all sectors in the preparation of the national policy and strategy establishes them as partners and is more likely to ensure their ongoing participation.
2. Set out what is expected from each partner. It is important to specify who needs to be involved and what contribution they can make to the partnership. It is also important to provide partners and other stakeholders with a clear sense of how the various sectors will work together to achieve HIV prevention and care outcomes. Multisectoral partnership is an attempt to acknowledge that the needs of people at risk for and those with HIV infection cut across a number of sectors and are better addressed if these sectors work in collaboration.
3. Pay attention to issues of power. Not all partners are equal. However, try to make sure that partners can participate effectively by ensuring that they have the resources and authority to participate.
4. Foster leadership within each sector. Use the strategies outlined in the previous section to promote leadership within each sector.
5. Foster participation and open communication. Find ways to promote discussion and communication across the partnership.

OBJECTIVE 4: To describe the elements that support good governance of the AIDS programme

The AIDS programme is strengthened by good governance. The UNDP South-East Asia Development Programme has set out the elements of good governance for AIDS programmes. These are:

- Participation of groups and sectors in decision-making, policy and programme development, monitoring and evaluation.
- Justice with freedom from corruption and effective mechanisms for complaints and conflict resolution.
- Transparency in the workings of the programme.
- Consensus building on approaches and policies among people.
- Equity in internal and external processes including recruitment of staff, awarding of contracts, major decisions, participation of women, and access to education, health services and other programmes, and opportunities.
- Effectiveness and efficiency in the use of its resources.
- Accountability of the programme to all stakeholders with transparent financial processes.
- Strategic vision in the work of the programme.

OBJECTIVE 5: To develop strategies for managing crises and emerging issues

There are frequent crises and emerging issues to be dealt with in the response to HIV and AIDS. It is not always possible to avoid these, but it is possible to plan so that their destabilizing effect on the programme can be minimized.

Crisis management is a matter of judgement and experience. A potential crisis can be averted by early and careful intervention, and ignoring it makes it much worse.

Here are some strategies that may assist in crisis management.

1. The best way to manage a crisis is not to have it in the first place. Planning, tracking developing situations and intervening early are good ways to avoid crises. Prepare carefully for events like the launch of new surveillance data or research findings, a change in programme approach or a controversial safer sex initiative.
2. The worst way to manage a crisis is to not manage it at all. There will be occasional crises in AIDS programmes, so plan ahead and talk within your team about how crises will be managed.
3. Have good policies in place on key issues. Put in place a proactive process for developing policy and guidelines on key issues such as the management of people who knowingly put others at risk for HIV; consent and confidentiality in HIV counselling and testing; HIV, migration and immigration; access to antiretroviral therapy (ART); and condom promotion.
4. Have good internal and external communication systems in place. Keep communicating as you manage the crisis so that different parts of the organization do not contradict each other. Make sure that you have a good internal filing system so that you can easily access the records and other documents you may need to assist you in responding.
5. Work proactively with the media. Important measures for getting cooperation from the media include:
 - Hold media workshops to familiarize key journalists with HIV and AIDS issues and increase their knowledge.
 - Have a set of fact sheets available on key issues, so that when journalists call about a story, you can provide them with accurate information.
 - Prepare press releases that transmit the message you want with clarity and in the language you prefer, rather than leaving it to the journalist to write their own story.

- Interpret information and data for the media – do not leave the interpretation of data up to them. When you release figures, explain what they mean, and not merely state what they are.
6. Maintain strong external relationships with key individuals and agencies. Seek out critics of the programme and work to bring them around. Invest time in keeping the external relationships strong and healthy, including those with nongovernmental organizations (NGOs) and people living with HIV/AIDS (PLHA).

OBJECTIVE 6: To identify strategies for mobilizing and coordinating internal and external resources for the AIDS programme

The resources utilized for the national response to AIDS come from a wide range of internal and external sources. Some are financial, such as budget allocations, donor assistance for specific projects and donor support to government budgets. Others are non-financial, such as external technical assistance, the donation of goods and equipment, and the integration of AIDS initiatives into existing national programmes. Coordinating the mobilization and application of these resources is a complex task.

EXTERNAL RESOURCES

There has been considerable debate about the most appropriate role for national AIDS programmes in the management or coordination of external resources. Some argue that all external resources for AIDS should be managed by the national programme and come through the programme. Others argue that this is too bureaucratically cumbersome and that the national programme should have a coordinating role only. They argue that the national programme should include decisions about how external resources are used, but not be responsible for managing the resources.

Whatever level of control or coordination the national programme has over external resources, the key to the strategic application of these resources is the national strategy. A country which has a national AIDS strategy that clearly sets out its priorities, the approaches it wants to take and the measures for dealing with current gaps in implementation is in a better position to work constructively with government and nongovernment donors on the use of external resources.

Here are some strategies that can assist the national programme to make better strategic use of external resources.

- Keep the national strategy and implementation plan updated and use it in negotiating with donors.
- Develop strategies for the Global Fund Country Coordinating Mechanism (CCM) and the National AIDS Committee to work together, with the National Strategy as the key guiding document.
- Develop a “Capacity Development Plan” that sets out priorities for external technical assistance, and use this while negotiating with donors and international organizations.

- Establish consultation guidelines for the design of externally funded AIDS projects, and memoranda of understanding (MoUs) for their implementation.
- Develop a clear and accountable financial management system for the programme and guidelines for recipients of financial grants (see Module 8).
- Develop a system for documenting and tracking the external resources used for AIDS projects and programmes.
- Facilitate regular meetings between the programme and donors, international organizations and major projects and programmes, to reduce duplication and increase collaboration, information-sharing and resource-sharing.
- Work with donors and other agencies to streamline and harmonize reporting requirements (see Module 9).
- Establish a system for coordinating the donation of equipment and goods, so that the most appropriate equipment is donated and used in the most appropriate setting.

INTERNAL RESOURCES

In many countries governments are increasing the contribution of internal resources to the AIDS response, directly by establishing a national AIDS budget allocation and indirectly by including AIDS initiatives in existing programmes.

Here are some strategies that may assist in mobilizing internal resources.

- Work with the national Department of Finance, Ministry of Health and other relevant ministries to understand the process for establishing a national AIDS budget.
- Include costing and budgets in the national AIDS strategy and implementation plans.
- Develop a system for recording and tracking AIDS allocations made in government departmental budgets.
- Assist government departments to identify opportunities for including HIV interventions in their current programmes, or to adjust current programmes so that they have improved HIV prevention and care outcomes. This could mean lobbying for the inclusion of PLHA in poverty alleviation programmes, and social support and housing programmes. It could also include lobbying for inclusion of groups such as sex workers in women's development programmes; for example, funding for self-help groups and micro-finance projects.
- Establish and maintain effective and accountable internal financial management systems (see Module 8).

The internal resources within a country that can assist the programme to achieve its goals are not always financial. Resources of knowledge, expertise and time that may be available with communities and organizations can be mobilized to support the response to AIDS.

EXERCISE C

(Country group work followed by intercountry group discussion)

In country groups, set out the current sources of financial support and coordination mechanisms for the AIDS programme and national response.

1. What are the major current sources of internal and external financial support for the national AIDS response?

2. Complete the following table:

Area	Current coordination mechanism	Opportunities for strengthening
Coordinating financial inputs to the programme – government budgets, Global Fund, donor funds, etc.		
Developing new projects and programmes – by donors, government departments, etc.		
External technical assistance – from international organizations, consultants, etc.		

Inform your facilitator when you are ready for intercountry group discussions.

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Module 8: Management systems for the AIDS programme

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Management systems for the AIDS programme

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To describe a range of human resource management systems that assist in the effective management of the AIDS programme.
2. To outline strategies for strengthening financial management systems that support the efficiency and accountability of the AIDS programme.
3. To describe the elements of an effective commodity management system and set out a plan for effective condom procurement, supply and distribution.
4. To describe the elements of an effective strategic information management system.

INTRODUCTION

This module outlines some of the systems that can support the efficient management of a national AIDS programme. These include human resource management, financial management, commodity management and information management.

Although it is not possible to cover these systems in great detail, the basic elements of each system are presented. Participants have an opportunity to assess the current systems in their country against these elements. They are also guided towards a set of resources and sources of ongoing technical assistance for the development of these systems.

OBJECTIVE 1: To describe a range of human resource management systems that assist in the effective management of the AIDS programme

This section sets out some of the systems that can assist in managing the human resources available to the programme. It examines workforce planning and capacity issues. It also covers systems for internal management of human resources – recruitment, deployment, delegation and performance management. The final section sets out some of the systems required for efficient and effective management – subcontracting and the management performance of implementing partners.

WORKFORCE PLANNING

The AIDS programme has a key role in assisting the health sector and other sectors that are involved in the response to HIV in strengthening the capacity of the workforce to contribute to HIV prevention and care. This involves policy development, planning, training and the appropriate allocation of tasks and responsibilities. It also involves working with educational institutions to ensure that relevant information about HIV and AIDS is included in undergraduate and postgraduate curricula and that training opportunities exist for the workers in the sectors expected to be involved in the response to AIDS.

WHO and the International Labour Organization (ILO) have developed a set of guidelines to assist in workforce development for HIV prevention and care.

The guidelines call upon governments to:

- (a) build capacity in all components and at every level of national health systems;
- (b) provide and maintain an effective continuum of care through the coordination of services and the sharing of resources, including information and training;
- (c) improve institutional capacity for planning and management of health services;
- (d) draft and reform legislation on the development of human resources for health services to cover planning, education and training, and regulation of the qualifications and conditions of practice for health personnel, including certification and accreditation requirements;
- (e) prioritize the development and implementation of human resource plans and strategies that enable health systems to deliver services;

- (f) prioritize and make adequate budgetary provisions for human resources, infrastructure, equipment and materials for effective service delivery to patients and protection of health-care workers.

A workforce development plan

The need to scale up HIV prevention and care places significant pressure on health and community workforce that is already under-resourced and having difficulty coping with the existing workload. The presence of HIV in the workforce can further weaken it by taking trained people out of the workforce.

Putting in place a national HIV workforce development plan can assist in identifying needs and allocating resources to ensure that a skilled, motivated and capable workforce is available to contribute to HIV prevention and care.

The elements of this plan could include the following:

- **Identifying needs:** Matching the tasks and initiatives to the existing workforce and identifying gaps.
- **Task shifting:** Examining the current roles and responsibilities of workers and reassigning responsibilities if necessary
- **Providing in-service training of the existing workforce and pre-service training** in vocational and university training.
- **Improving remuneration and working conditions:** Aimed at slowing down the drain of trained workers, particularly out of the public health system.
- **Working with the private sector:** Assisting private sector employers to strengthen the capacity of their workforce.
- **Mobilizing alternative labour sources:** For example, strengthening the role of nongovernmental organizations (NGOs) supporting the participation of people living with HIV/AIDS (PLHA) groups and tapping community human resources.
- **Providing safer working conditions:** Improving care and support and reducing stigma and discrimination by introducing policies and procedures that provide workers with the safest possible working environment.
- **Supporting learning:** Providing resources for networking, conferences, operational research and the further development and dissemination of knowledge, so that the workforce is able to continually update its knowledge and skills.

For countries in which the health workforce is being severely depleted by AIDS, WHO has developed a Treat, Train, Retain Strategy and is assisting countries to adapt this to their needs.

INTERNAL HUMAN RESOURCE MANAGEMENT

The effective management of AIDS programme staff increases the efficiency of the programme and is essential for accountability. There are several systems that can assist in effective personnel management.

Recruitment systems

Recruitment needs to be merit-based, transparent and fair. Positions need to be advertised and appointment decisions made by a selection panel in a transparent manner, with any conflicts of interest declared and dealt with. Developing a policy that sets out a standard recruitment practice will help in maintaining consistency.

Documenting the decisions of the recruitment panel will assist in dealing with any appeals that might be made against its decisions.

Assigning roles and responsibilities

The following can help in getting the most out of the people employed.

- An orientation programme for the new staff.
- A policy and procedures manual that sets out organizational policies, delegated authorities, lines of management, standard procedures, and so on.
- A clear job description for each position.
- A contract of employment that makes the duration of employment, remuneration and employment conditions clear.

Performance management

Every member of the staff should be given regular feedback on their performance through a formal performance management system. Those who fund the programme (government, external donors, etc.), on the other hand, have the right to expect that the staff will be assisted to work to their full potential and that those who are not able to perform the assigned tasks will be either provided with training or re-deployed. The performance management system needs to be linked to capacity-building and training. The performance management system needs to be transparent and formal – setting out how often performance management reviews will be conducted, how reviews will be documented and how issues of performance will be dealt with.

Communication

Organizations often succeed or fail, depending on their ability to maintain effective internal communication. This involves setting aside time for people to interact with each other

and to understand their roles in the organization, setting up an organizational culture that makes it possible for people to seek help, share ideas and collaborate with each other, and having regular staff and team meetings to improve linkages and communication.

Maintaining an accessible filing system is also a key to effective communication. People regularly reinvent the wheel when they do not have ready access to briefing notes, press releases, letters, reports and other materials that the organization has produced in the past.

EXERCISE A

(Country group work followed by intercountry group discussion)

In country groups, consider the systems for internal management outlined below. To what extent do these apply to your national AIDS programme?

Area	Current system/situation	Areas that need to be strengthened
Recruitment of staff		
	<ul style="list-style-type: none">• advertising of positions• merit-based employment• documented recruitment panel decisions	
<hr/>		
Assigning roles and responsibilities		
	<ul style="list-style-type: none">• policy and procedures manual• orientation programme• job description• clear delegation of duties	

Area	Current system/situation	Areas that need to be strengthened
Performance management		
<ul style="list-style-type: none">• standard system in place• regular performance review• link to training/capacity-building agenda		
Communication		
<ul style="list-style-type: none">• regular staff and team meetings• efficient central filing system• clear lines of communication		

Inform your facilitator when you are ready for intercountry group discussions.

MANAGEMENT WITH OTHERS – SUBCONTRACTING AND WORKING WITH OTHER IMPLEMENTING PARTNERS

Managing the performance of external partners is enhanced by the development of clear systems of contracting and performance management. Developing a standard and clear contract format can help ensure consistency.

Maintaining a register of all contracts, including key dates of deliverables, milestones and expiration of contracts, can assist in managing a diverse set of providers.

Performance management

Managing the performance of other providers can be time-consuming and requires the allocation of significant resources. The AIDS programme may still be required to commit

considerable resources to ensure that the goods and services are properly provided. This might entail:

- identifying new implementing partners and assisting them to develop proposals for the programme;
- regular monitoring of progress, including site visits;
- technical assistance for designing interventions;
- policy and advocacy assistance to remove barriers;
- providing opportunities for implementing partners to get together and share ideas, experiences and learning across the programme;
- identifying and documenting good practice and disseminating it to others; and
- management of emerging issues, problems, conflicts or unsatisfactory performance.

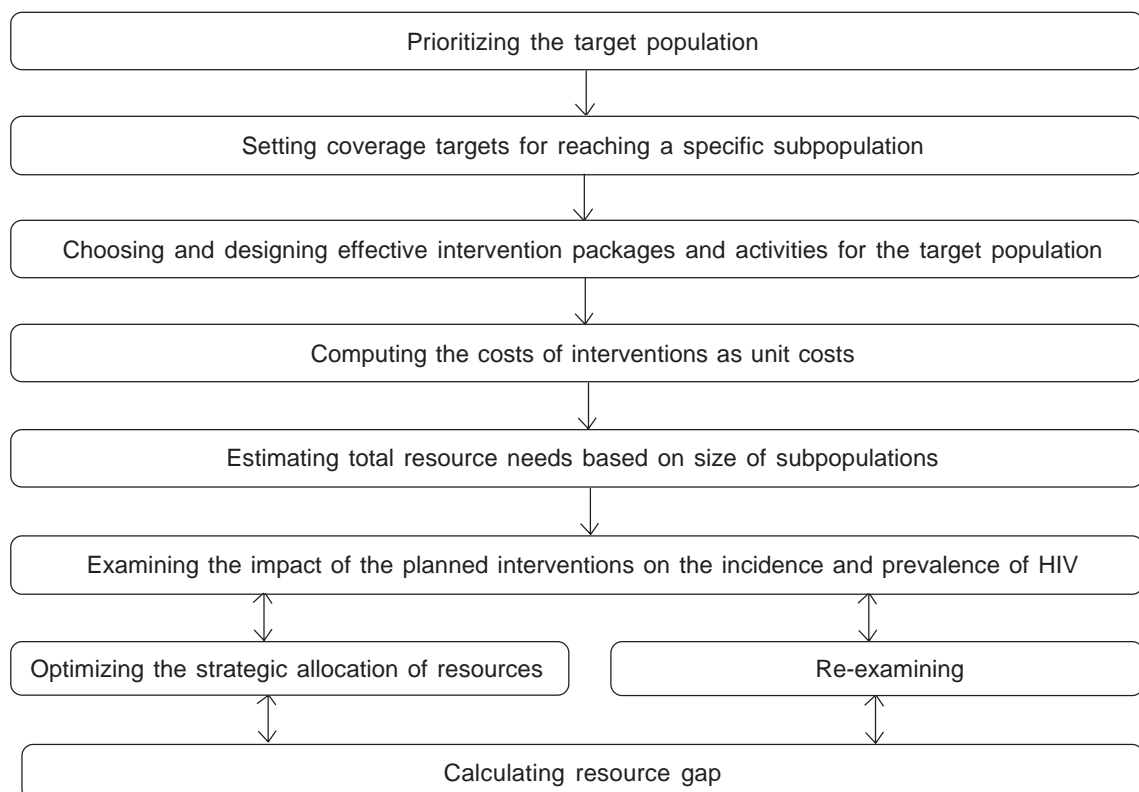
It is best to link performance management to capacity development. The AIDS programme needs to play an active role in coordinating and strengthening the work of the implementing agencies it works through.

OBJECTIVE 2: To outline strategies for strengthening financial management systems that support the efficiency and accountability of the AIDS programme

The AIDS programme needs financial management systems that help it manage the cost of interventions and programmes, allocate resources for programmes, set out and monitor budgets and spending, report to government and donors on spending and mobilize further financial resources. Each country will have its own system of financial management that the programme will need to comply with.

Some of the elements that AIDS programme managers will need to consider are as follows.

The guidelines identify the following steps for planning and costing



COSTING OF INTERVENTIONS AND PROGRAMMES

Several software packages are available to assist programme managers in this area. These include INPUT Software, the GOALS Model and the Resource Needs Model. A

useful introduction to the use of these in AIDS programmes is contained in the *Costing guidelines for HIV/AIDS intervention strategies – for use in estimating resource needs, scaling up and strategic planning in the Asia/Pacific Region*, UNAIDS, ADB, 2004.

While identifying the target population is relatively simple, setting coverage targets can be more complex. This has already been dealt with in Modules 3 and 5, and the priorities and targets identified through the processes set out in these modules need to be used to develop programme costs.

Identifying unit costs is also a complex task. Certain commercial software packages can be used to do this. The cost tables set out in some planning documents, such as the *Strategies for an expanded and comprehensive response (ECR) to a national HIV/AIDS epidemic* (FHI, 2001), can also be used.

Unit costs are average figures, including assumptions and coverage. Working out the unit cost is an exercise aimed at estimating the cost per intervention for the purpose of planning resource needs and allocation.

Example

Estimation for a unit cost of condom promotion

Targeted SW	Clients per SW	Working days	Coverage (%)	Condoms needed (pieces)	Excess supply (20%)	Total cost (\$0.02 per condom)
20,000	3/d	260	80	12.5 million	15.0 million	300,000

BUDGET ALLOCATION

Annual budgets need to be allocated according to the priorities set out in the national strategy and annual plan. The National AIDS Committee often has a role in recommending these priorities and assisting the programme to mobilize the resources necessary to carry out the tasks set out in the annual plan.

This task is complicated by the existence of multiple sources of funding, for example, the national government allocation, Global Fund grants and other donor loans and grants. The financial management system needs to be flexible enough to meet the requirements of the different funding sources while maintaining an overall picture of the total spending on AIDS.

Budgeting involves the following.

- Identifying priorities and costing them
- Preparing budget submissions and lobbying for the required allocation (upstream budgeting)
- Adjusting the programme in accordance with the resources received (downstream budgeting).

The AIDS programme has to compete with other programmes for allocations. Hence, programme managers need to lobby for what they need and to negotiate with the government, donors and others to secure the resources they require. There is often a gap between what is required and what is provided. This results in difficult decisions on trimming the allocations to different intervention areas, or reducing the range of interventions.

REPORTING

The AIDS programme needs to report financial spending clearly to stakeholders to promote transparency and accountability. Although there have been some attempts recently to streamline financial reporting and to reduce its burden on countries, this is still a complex area, complicated further by different donor requirements.

Thailand case study: The Thailand national AIDS spending assessment 2000–2004

In 2005, Thailand carried out a study to detail its AIDS spending from 2000–2004. The assessment put together all the available data on government and donor AIDS spending for that period. It examined spending in the major programme areas.

The assessment provided the national programme with an opportunity to see exactly where funds had been spent and where the main gaps in programming lay. This allowed the programme to make the following recommendations for strengthening the national response.

1. Increase public spending on HIV prevention and focus interventions on high-risk behaviour.
2. Seek innovative funding mechanisms to secure additional funding for antiretroviral therapy (ART).
3. Establish an integrated information system for the better management of HIV/AIDS resources.

Having a strong financial management system in place significantly strengthens the country's ability to argue for more resources or for the redistribution of resources.

OBJECTIVE 3. To describe the elements of an effective commodity management system and set out a plan for effective condom procurement, supply and distribution

INTRODUCTION AND OVERVIEW

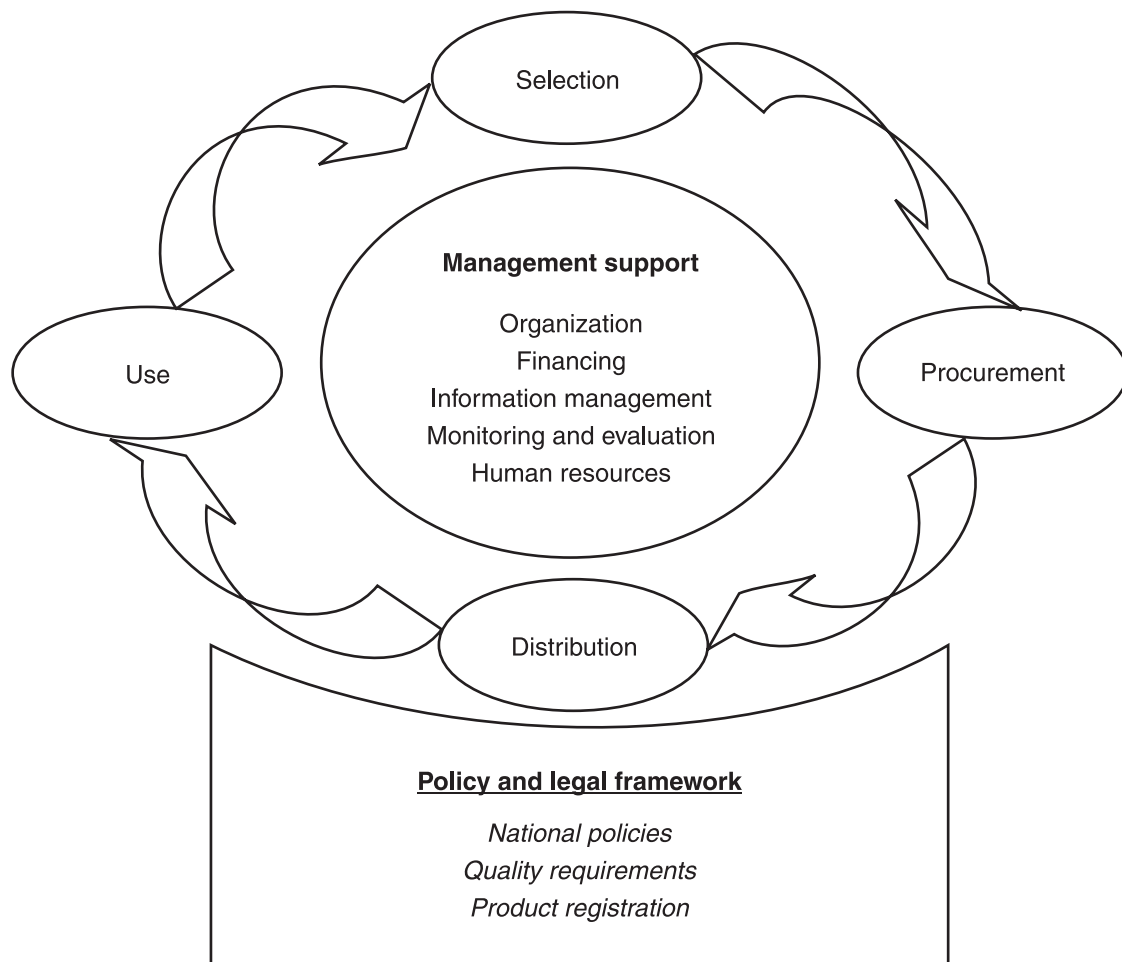
The successful scaling up of HIV prevention and care programmes relies on the steady supply of a wide range of commodities: HIV test kits, laboratory reagents and supplies, condoms, antiretroviral (ARV) drugs and opportunistic infection (OI) medicines, bleach, clean needles and syringes for outreach programmes and medical supplies for HIV and AIDS care. AIDS programme managers have a key role in ensuring that the procurement and supply systems are efficient enough to guarantee an uninterrupted supply of these essential commodities.

The following are some key elements of successful procurement and supply of commodities.

- The right commodities based on guidelines, advice of experts and feedback from users
- In the right quantities based on estimate of demands, and avoidance of stock-outs as well as wastage
- In the right condition and of good quality
- At the right place when they are needed
- At the right time when needed and avoiding stock-outs
- At the right cost aiming to minimize the cost and with the assistance of international organizations, if necessary.

THE LOGISTICS CYCLE

The diagram on page 16 summarizes the logistics cycle. The roles of management support and of the policy and legal framework have an important influence on this cycle. The effective management of procurement and supply requires dedicated human and financial resources.



Source: Adapted from *A public health approach for scaling up ARV treatment – a toolkit for programme managers* WHO, October 2003; and *HIV/AIDS medicines and related supplies: contemporary context and procurement – technical guide*, The World Bank, 2004.

COORDINATING THE PROCUREMENT AND SUPPLY SYSTEM

Who can help with supply management?

For the sustainability and efficiency of supply management, it is important to use the existing structures including the government and nongovernment agencies. Find out how medicines and supplies are currently managed by these agencies and the resources, training or education that may be needed to include HIV commodities in these systems.

Who can help with selection and quantification?

Clinicians, in collaboration with managers of the drug supply programme, will take primary responsibility for advising on medical supply and medication needs. The national

treatment guidelines for HIV, prevention of mother-to-child transmission (PMTCT), OIs and sexually transmitted infections (STIs) are an essential foundation for making selection decisions. The primary users of the means of prevention (condoms, lubricant, bleach, disposable needles and syringes) can inform supply managers about usage preferences.

For determining commodity needs, there must be a link between the procurement and supply system and the strategic information system. The latter can provide data on:

- the number of people to be targeted in prevention programmes;
- the number likely to present for HIV testing and the sites at which they are likely to be tested;
- the number with HIV requiring OI treatment and prophylaxis;
- the number potentially qualifying for ART, and the sites at which they are most likely to access it; and
- the changing patterns of service use at specific sites.

The regulatory environment

The regulation of goods required for the HIV programme is usually covered by a number of ministries.

- Health: for drug quality, prescribing, laboratory practice
- Trade: for importation, sale
- Finance: for taxation, foreign exchange
- Home affairs: for policing, prosecution of breaches.

One needs to examine the impact of the regulatory environment on the supply of HIV commodities. This means examining:

- the supplies that are available in the country.
- what can be imported.
- the existing patent regulations and competition laws which will affect procurement.
- other trade regulations that may prohibit or increase the cost of imports.
- any restrictions on who is qualified to prescribe certain drugs.
- the absence of drug categories in the national drug list for policy reasons, e.g., methadone.

Most countries have their own regulatory processes for medicines and diagnostic tests. International agencies can also assist in dealing with regulatory issues. The United Nations Pre-qualification Programme, managed by WHO, provides advice to Member States on the quality assurance of the HIV medicines and diagnostic tests available on national and international markets. It also assists with advice on pre-qualified quality control laboratories.

There are complex issues of intellectual property to be considered, on the basis of whether the country of origin or the country of import is a member of the World Trade Organization (WTO) and is bound by the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement. A detailed analysis of this is contained in the World Bank Technical Guide and from groups such as Consumer Project on Technology (www.cptech.org).

Sourcing and pricing

This involves identifying producers and suppliers, checking the credentials of the producers and the quality of the goods, comparing the prices of goods of equivalent quality, and negotiating prices on the basis of quantity and competition.

In situations where donors are acting as sources of commodities, attention must be paid to issues of sustainability, and donor-sourced and government-sourced commodities need to be compared.

The pricing of ART, in particular, is complex. Technical assistance is available from WHO and groups like Médecins Sans Frontières. The Clinton Foundation (www.clintonfoundation.org) has also provided some countries with assistance in negotiating better prices for ART.

Inventory control

It is essential to have a good system for tracking commodities. This involves

- Tracking storage and movement of the commodities at every level of the system, from central storage to stocks available in primary health care or nongovernmental organization (NGO) settings
- Enabling managers to know the exact amounts of supplies in the system, the location of those supplies and when they approach their expiry date
- Recording all acquisition and dispatch of stock
- Recording use, anticipating changes in usage patterns.

Effective use of commodities

The use of the commodities completes the cycle, and a new cycle begins of requirement. The procurement and supply system needs to assist in ensuring that:

- the goods are used efficiently for the intended purpose, according to the guidelines set;
- records are kept about how the commodities are used – for which patients and why, for which prevention activities and to target which groups;

- the users' feedback on the appropriateness of the commodities is entered into the system – this applies to formulations of ART that maximize adherence, acceptability of particular types of condoms or types of disposable syringes and needles.

Monitoring and evaluation

The system needs to be monitored and evaluated so that problems relating to stock-outs, waste of expired stock or inappropriate purchasing can be addressed.

EXERCISE B

(Country group work followed by intercountry group discussion)

This exercise provides an opportunity to examine how the major commodities that are used in the response to AIDS in your country are managed. In country groups, discuss what you know about the procurement and supply of the commodities set out in the table on the next page. This will assist you to examine the extent to which the procurement and supply of essential commodities is currently organized and to identify opportunities for streamlining, coordinating and strengthening the procurement and supply system.

Condom procurement and supply has been covered in greater detail in the next section.

Item	Who orders or supplies these? (e.g., national AIDS programme, donors)	Who is currently responsible for estimating needs and managing stocks?	How are they distributed to sites?	How often have sites run out of supplies? Are there problems with procurement? With distribution?	How could the system be strengthened?
HIV test kits					
Condoms					
Disposable needles and syringes					
ART medicines					
OI medications					

CONDOM PROCUREMENT AND SUPPLY

A large and sustained increase in condom use is central to HIV prevention strategies. This can be achieved only if free or affordable condoms of good quality are available each time a person needs to make a decision about safer sex.

Maintaining a supply of condoms in the places where they are needed requires careful planning and coordination and cannot be left to chance. Collaboration between the national AIDS programme (NAP) and the public and private sectors, including NGOs, is essential because condom distribution can take place through more than one channel and involves agencies and organizations, such as the Ministry of Health and other ministries, NGOs, international agencies, multinational suppliers and manufacturers, commercial sector supply and sales networks, and community-based distribution networks.

Logistics

The success of a plan to promote the use of condoms depends on condoms being available. The consequences of condoms not being available when people want or need them could be an increase in the spread of STIs and HIV infection. Systematic planning for the procurement and distribution of condoms would help the NAP ensure that condoms are provided to users.

The purpose of a logistics system is to ensure the movement of products in a timely and secure way from the point of manufacture to outlets where consumers and clients may obtain them. An understanding of the logistics system is important not only for the procurement and distribution of condoms, but also for the drugs and supplies needed to carry out STI and HIV/AIDS care activities. An effective logistics system for the procurement and distribution of condoms includes the following steps.

Planning for procurement

- Review information on user requirements from all distribution channels
- Set condom specifications, and evaluate whether they meet programme needs

Procurement

- Select condom suppliers
- Carry out or contract for compliance testing to ensure vendor's product meets specifications
- Calculate amounts to order

Distribution

- Process orders when they are received
- Repackage, if required
- Provide sufficient storage capacity at central and field locations
- Process orders from distribution outlets
- Move condoms from receiving system to distribution outlets
- Monitor condom quality

Use

- Provide access to target populations and general public through an appropriate mix of delivery channels
- Obtain feedback from users on acceptability, accessibility, affordability and quality

The AIDS programme should be involved in ensuring an efficient condom logistics system through planning and coordination, monitoring and supervision.

EXERCISE C

(Country group work followed by country group discussion)

Meet with other participants from your country to answer the following questions on estimating the number of condoms needed for HIV prevention activities.

1. How does the NAP project future condom needs in your country?

2. What information is used to make the estimates?

3. How is the information obtained?

4. In which areas should improvements be made to estimate the condom needs for HIV activities?

Inform the facilitator when you are ready for country group discussions.

How are condoms distributed?

The NAP needs to coordinate its condom procurement and distribution activities with all agencies involved in the national condom distribution system. In many countries, condoms used for family planning and disease prevention are distributed through *distribution channels* such as

- Government distribution programmes
- NGO distribution programmes
- Commercial sales, including private sector sales as well as social marketing programmes

People obtain condoms from “*distribution outlets*”, such as clinics, pharmacies, shops, truck stops, public meeting places, bars, brothels, and hotels. Outreach workers often provide condoms as part of their work with people from affected communities. Access to condoms is strengthened when they are provided to users through an appropriate mix of channels and outlets.

A country’s distribution channels and related outlets might include the following.

Distribution channels	Distribution outlets
Government: Distribution systems such as the Essential Drug Programme and Ministry of Health distribution programmes for family planning and disease prevention	<ul style="list-style-type: none"> • Family planning clinics • Maternal and Child Health (MCH) clinics • Hospitals • STI clinics • Rural health centres
NGOs: For example, NGO programmes targeting sexually active youth for disease prevention activities, including condom promotion	<ul style="list-style-type: none"> • Community-based distribution activities targeting populations at risk, such as sex workers, men having sex with men (MSM) and migrant workers • Family planning activities
Commercial sales: For example, distribution to private sector retail outlets and social marketing programmes	<ul style="list-style-type: none"> • Pharmacies • Tea shops, local stores • Social marketing programmes to provide general public and target populations with wide access to condoms in outlets such as supermarkets, bars, clubs, brothels, truck stops and railway stations

EXERCISE D

(Country group work followed by country group discussion)

In this exercise, you will consider information about condom distribution channels and outlets in your own country. The information you list will be used to monitor condom

orders and assess the condom distribution system for any improvements required. Meet with other participants from your country and do this exercise together.

1. Use the chart below to list the condom distribution channels and outlets you know about in your country. Also list any additional outlets anticipated as a result of plans to promote the use of condoms during the next one to two years. Then answer questions 2 and 3.

Condom distribution channels and outlets

Distribution channels	Distribution outlets
Government distribution channels	
NGO distribution channels	
Commercial sales, including social marketing	

2. What proportion of condoms currently being distributed through each channel is available for STI/HIV prevention activities?

3. Have contacts been established between the NAP management staff and managers of distribution channels? If not, how can contact between them be established?

Inform the facilitator when your country group has completed this exercise.

Selecting suppliers and coordinating orders

In the public sector, condoms are usually obtained in one of the following ways.

- Donors supply condoms directly to national programmes.
- Donor and government funds are used to procure condoms from an international procurement agency.
- In cases where programmes have resources and have developed a procurement capacity, condoms are purchased directly from either international or local manufacturers.

When the NAP obtains condoms directly from manufacturers, the programme management staff follows standard purchasing procedures, such as obtaining bids and sample products from suppliers, evaluating sample condoms for their quality, selecting suppliers, preparing purchase agreements, and so on. However, NAPs may also obtain condoms directly from international organizations and agencies. These procedures provide for bulk purchasing and independent quality assurance. They also help programmes to obtain low-cost, good-quality condoms. The following steps can be used to obtain condoms.

Step 1. Identify funding sources

The programme management staff should identify the sources of funding in consultation with management staff from public, private and NGO channels who have experience in obtaining condoms and contraceptives.

Step 2. Select suppliers

The programme management staff can consult other procurement experts (such as MOH family planning officials and advisors, and social marketing coordinators) to select the suppliers.

Step 3. Review condom specifications with the procurement agency

The programme management staff should compare the specifications of condoms currently being obtained with the recommended specifications. The staff may need to determine whether the characteristics (size, thickness, texture, colour) of the condoms meet the needs of the consumers in the country. It must determine the requirements for packaging (aluminum or plastic packaging; number of condoms per strip, if the condoms will be packaged in strips; culturally appropriate instructions to accompany the package for correct condom use and disposal of used condoms).

Step 4. Coordinate the condom order

The NAP management staff can meet with the managers of the agencies and organizations to decide upon the timetable for plans to promote condom use and coordinate this timetable with that for procuring and distributing the condoms. The following must be considered to facilitate coordination:

- The quantities of condoms to be ordered by the NAP and through other channels for constituent programmes and projects;
- The capacity of the central warehouse, previous ordering schedules and policies for inventory – levels;
- The documentation required for obtaining the release of shipments from customs and transport carriers and to facilitate their release to representatives of the constituent programmes;
- The procedures for receiving shipments directly from manufacturers and from donors.

As improvements are made and the capacity of the distribution systems is increased, the programme management staff can revise orders accordingly.

EXERCISE E

(Country group work followed by country group discussion)

Consult other participants from your country to answer these questions. Consider the information on condoms ordered through the public sector and how the coordination of information on condom orders takes place between the NAP and other sectors. Then discuss the areas in which you think improvements could be made.

1. How does the NAP coordinate information on condom orders with the staff of other sectors in your country?

2. Are condoms ordered from one or various suppliers? What are the sources of funding used?
3. Do you think the quality of condoms currently being purchased for distribution through all channels is satisfactory?
4. What improvements could be made in the procurement system?

Inform your facilitator when your country group is ready to discuss this exercise.

Improving the condom distribution system

You can compare the pipeline that provides water to communities with the condom distribution system that provides condoms to people who want or need them. The linked distribution system that receives, stores and delivers condoms to clients and customers is also called a “pipeline”.

Condoms are distributed to outlets through a series of storage and receiving facilities. Condom quality control is monitored throughout the system. The parts of the condom distribution system and their functions include the following.

- *Customs:* The shipment of condoms is processed to establish ownership. Duty, if any, is paid; and the quantities and types of condoms are verified with the shipping and other documents.
- *Receiving:* The condoms are received from the customs. The staff assesses the cleanliness and integrity of the cartons and boxes in which the condoms are packed.
- *Storage:* The condoms are stored in compliance with the guidelines and inventory policies.
- *Delivery:* The condoms are delivered through the pipeline according to the distribution policies (for example, shipping of the oldest manufacturing date first).
- *Outlets:* Outlets are the endpoint of the system. They are located in places where people can obtain condoms when they want or need them.
- *Quality assurance management:* The condoms are tested for quality at key points in the distribution system, to assure that they meet the national or international standards.

OBJECTIVE 4: To describe the elements of an effective strategic information management system

It is a big challenge to develop and maintain a system for managing the vast amount of information that an AIDS programme needs to collect and collate. The most important point to remember is that the information management system is a tool. Only data that is essential for planning, accountability and reporting should be collected and stored.

AIDS programmes require information in various forms from a range of sources. The main forms of strategic information they collect are:

- second-generation surveillance data
- data from operational research and specific studies
- data from monitoring and evaluation of initiatives and programmes
- financial information.

ELEMENTS OF AN EFFECTIVE NATIONAL AIDS STRATEGIC INFORMATION MANAGEMENT SYSTEM

The elements of strategic information consist of surveillance, monitoring and evaluation mechanisms, operational research, social and cultural research and information from specific studies that assist in shaping the response to AIDS.

Managing strategic information at the national level consists of the following.

1. Establishing a strategic information unit within the national AIDS programme with capable and dedicated staff responsible for surveillance, monitoring and evaluation and operational research.
2. Developing and maintaining a strategic information framework.
3. Developing and updating guidelines for surveillance.
4. Developing and updating monitoring and evaluation guidelines.
5. Developing and updating tools and systems for data collection, analysis and reporting – paper-based or computerized.
6. Developing human resource capacity.
7. Allocating adequate resources.
8. Developing and maintaining strategies and processes to link data to decision-making in the programme.
9. Preparing and disseminating quarterly and annual strategic information reports.

Module 9 provides more details on some of these areas.

RESOURCES

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NATIONAL AIDS PROGRAMME MANAGEMENT

MODULE 9 STRATEGIC INFORMATION



**World Health
Organization**

Regional Office for South-East Asia

National AIDS Programme Management

A Training Course

Module 9

Strategic information



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Module 2 – Policy and planning

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Module 4 – Targeted HIV prevention and care interventions

Module 5 – Setting coverage targets and choosing key outcome indicators

Module 6 – Implementation of HIV prevention, care and treatment strategies

Module 7 – Managing the AIDS programme

Module 8 – Management systems for the AIDS programme

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Module 9: Strategic information

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Strategic information

LEARNING OBJECTIVES

After completing this module, participants will be able:

1. To describe the elements of strategic information that contributes to guiding the national response.
2. To describe the components of second-generation surveillance and the process of developing a national HIV, AIDS and sexually transmitted infection (STI) surveillance plan.
3. To formulate a monitoring and evaluation framework to support the national response to AIDS.
4. To describe the role of the national programme in setting and coordinating a national research agenda for guiding the programme.

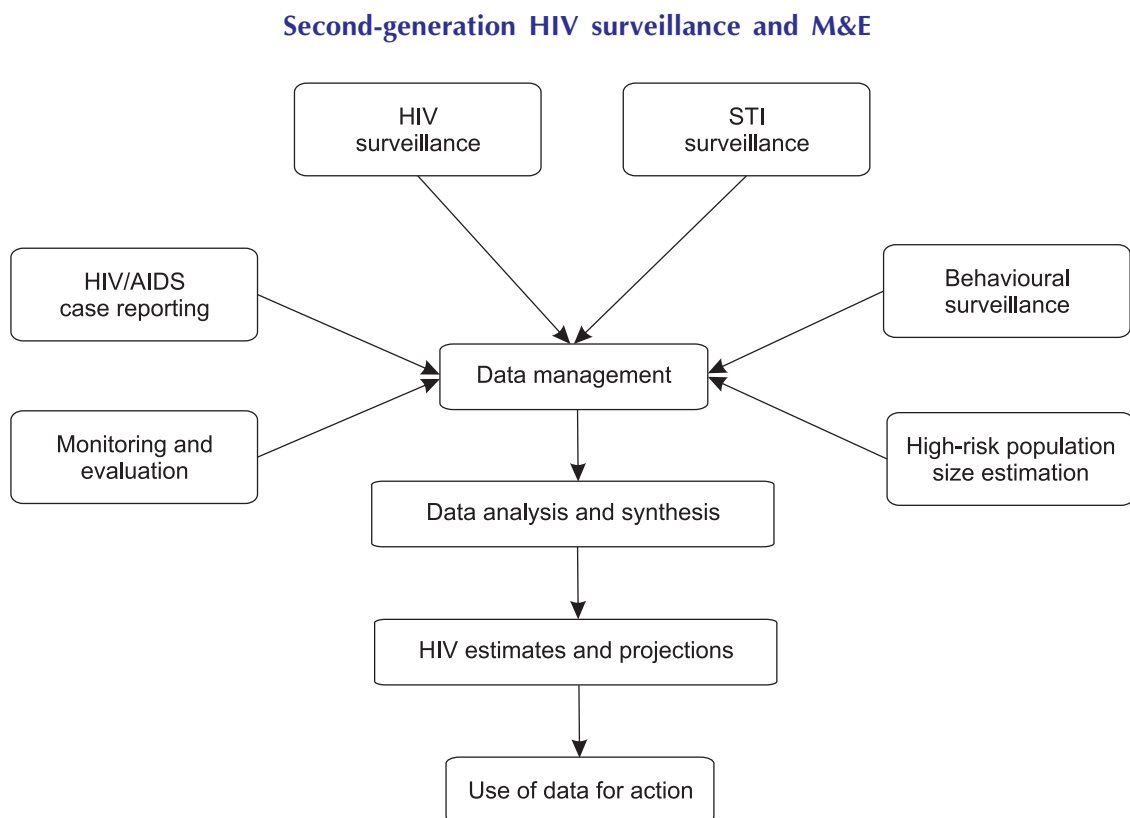
INTRODUCTION

This module covers the elements of strategic information necessary for developing a clear understanding of the exact nature of the AIDS epidemic and the response to the epidemic in a particular place: the surveillance systems that provide information on HIV prevalence and changing patterns of risk and vulnerability; the monitoring and evaluation framework that provides information about the process, outcome and impact of the interventions; and the strategic research agenda that can fill in gaps in information and provide guidance for reviewing interventions and strategies.

OBJECTIVE 1: To describe the elements of strategic information that contributes to guiding the national response

THE STRATEGIC INFORMATION FRAMEWORK

Strategic information to guide the national AIDS response is based on several sources and key strategies. These are indicated in the framework below:



Bringing these elements together is essential for effective programme planning and review. Although these are presented in the last module of the training, they complete the cycle and are directly linked to Module 1 – Situation analysis. They contribute to the processes in the flowchart – determining policy, setting priorities, targets and indicators, deciding on interventions and establishing systems for management. Remember that strategic information is essential for guiding the programme in both prevention and care.

As outlined in Module 8, the national programme needs to set aside specific resources, human and financial, to manage the collection, collation and analysis of these data. Each of these elements is covered in more detail in the next three objectives.

OBJECTIVE 2: To describe the components of second-generation surveillance and the process of developing a national HIV, AIDS and STI surveillance plan

In the early years of the epidemic, HIV sentinel surveillance and AIDS case reporting were the main sources of data and information to guide policy and programmes. Many countries also used short- and long-term behavioural surveys to construct a clearer picture, and although these studies provided important information to guide prevention interventions, they rarely included behavioural surveillance in their regular surveillance systems.

The following data collection methods were used singly, or in combination, to provide information about the epidemic:

1. Biological surveillance

- Sentinel HIV serosurveillance in defined subpopulations
- Regular HIV screening of donated blood
- Regular HIV screening of occupational cohorts or other subpopulations
- Surveillance of drug resistance

2. Behavioural surveillance

- Repeat cross-sectional surveys in the general population
- Repeat cross-sectional surveys in defined subpopulations

3. Other sources of information

- HIV and AIDS case surveillance
- Voluntary counselling and testing
- Registration of deaths
- STI and tuberculosis (TB) surveillance
- HIV testing of specimens taken for other purposes, e.g. in general population surveys

Second-generation surveillance focuses on lesser-used methods, particularly behavioural surveillance to provide a comprehensive picture of changing patterns in the epidemic.

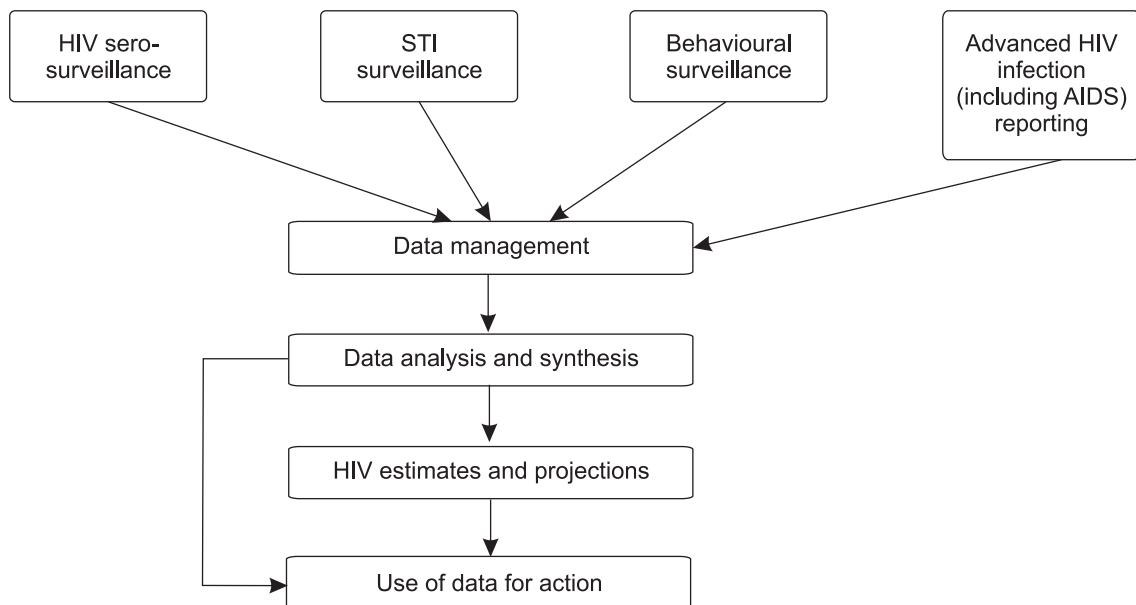
The principles that define second-generation surveillance are:

- better understanding of trends over time;

- better understanding of the behaviours that drive the epidemic in the country;
- surveillance on subpopulations at highest risk for infection;
- flexible surveillance that adjusts with the needs and the state of the epidemic;
- better use of data to increase understanding and to plan prevention and care.

Second-generation surveillance will not provide all the information required to guide AIDS programmes, but they will add significantly to the information generated through earlier surveillance methods.

The components of second-generation surveillance



The major variables used in second-generation HIV surveillance are listed below:

Biological variables

- HIV prevalence
- STI incidence and prevalence
- TB prevalence
- Number of adult cases with advanced HIV infection (including AIDS)
- Number of paediatric AIDS cases

Behavioural variables

- Sex with a non-regular partner in the past 12 months
- Condom use at last sex with a non-regular partner
- Age at first sex

- Use of unclean injecting equipment reported by drug injectors
- Number of clients in the past week reported by sex workers

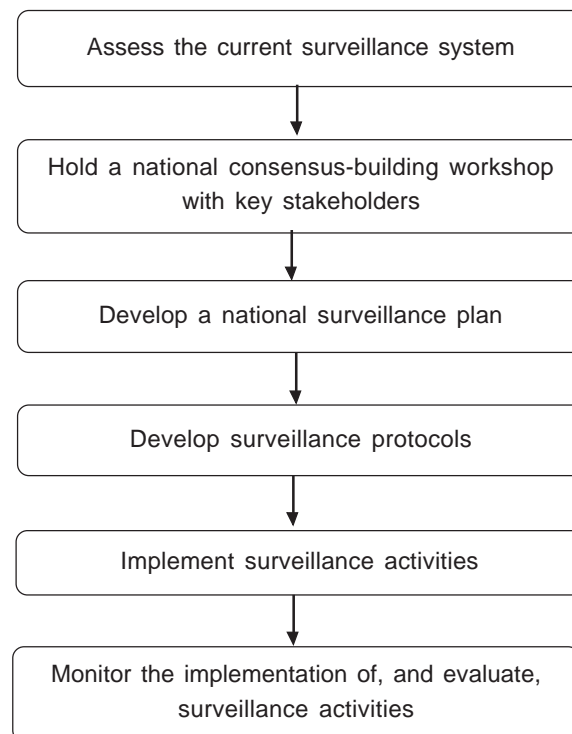
Sociodemographic variables

- Age
- Sex
- Socioeconomic or educational status (may include occupation)
- Residency or migration status
- Parity (for antenatal sites)
- Marital status

The WHO Regional Office for South-East Asia has recently developed training materials covering HIV, STI and behavioural surveillance.

DEVELOPING A SECOND-GENERATION SURVEILLANCE STRATEGY

WHO has proposed the following framework for implementing second-generation surveillance.



Rapid assessment protocols are available to assess HIV, STI and behavioural surveillance systems. The assessment can be done by questionnaire, document review and key informant interview. The main components to be considered for review are:

- HIV/AIDS/STI surveillance framework
- HIV/AIDS case reporting
- Sentinel surveillance for HIV
- Laboratory practices and quality assurance
- Behavioural studies
- Management and information systems
- Resources
- Use of the surveillance information
- Other relevant HIV research studies.

The national consensus workshop should identify the monitoring and evaluation (M&E) indicators required for measuring progress against the objectives of the national strategy. The surveillance strategy should include the methods and indicators to be used for surveillance, the action plan for implementation and the surveillance tools to be used during the process.

The surveillance plan needs to cover the following.

- Identification of the structure of the surveillance unit, coordination, and resource mobilization and dissemination
- Priority areas of the National Strategy, including the link between the surveillance plan and the national strategy
- General strategy for HIV surveillance
- Main objectives and expected results
- Identification of populations, locations and time-frames
- Surveillance of HIV and other STIs, sexual behaviour
- Schedule of activities
- Resources needed
- M&E of the surveillance system

EXERCISE A

(Country group work followed by country group discussion)

In country groups, identify the elements of second-generation surveillance that currently contribute to your country's strategic information framework.

Element	Current situation (regularity, sites, groups included)	Gaps and opportunities for strengthening
HIV serosurveillance		
STI surveillance		
Behavioural surveillance		
Advanced HIV infection (including AIDS) reporting*		

* to be used carefully – these data are usually not representative and must be used with caution.

Inform your facilitator when you are ready for country group discussions.

OBJECTIVE 3: To formulate a monitoring and evaluation framework to support the national response to AIDS

Monitoring and evaluation is required at a macro level (across the whole programme) and at a micro level (within projects, services and other initiatives). AIDS programme managers have to develop an interest in M&E across the entire programme. An extensive amount of information is usually collected throughout the projects, services and initiatives of the programme. The programme manager needs to coordinate a process for deciding how to manage this information and determining the indicators that are to be used to report on the programme as a whole.

DEFINITIONS

Monitoring is the routine tracking of the key elements of programme/project performance (usually inputs and outputs) through record-keeping, regular reporting and surveillance systems, as well as health facility observations and surveys. Monitoring helps programme or project managers to determine which areas require more effort and identify areas that might contribute to an improved response. In a well-designed M&E system, monitoring contributes greatly towards evaluation. Indicators selected for monitoring will be different from those for evaluation, depending on the reporting level within the health system. It is very important to select a limited number of indicators that will actually be used by programme implementers and managers. There is a tendency to collect information on many indicators and report this information to levels where it will not and cannot be used for effective decision-making. In addition, monitoring is used for measuring trends over time; thus the methods used need to be consistent and rigorous to ensure an appropriate comparison. More information is needed at project management level than at national or international levels. The number of indicators reported on should decrease substantially from the subnational to the national and international levels.

Evaluation is the episodic assessment of the change in targeted results related to the programme or project intervention. In other words, evaluation attempts to link a particular output or outcome directly to an intervention after the passage of a period of time. Evaluation thus helps programme or project managers to determine the value or worth of a specific programme or project. Cost-effectiveness and cost-benefit evaluations are useful in determining the added value of a particular programme or project. In addition, evaluation should also relate the outputs of a project/programme to wider national trends in behaviour and health outcomes. This type of evaluation is important

even if the project/programme is only one part of a collective effort to impact the disease.

Monitoring and evaluation have different objectives and the methodology used for each is different. In general, evaluations are more difficult in view of the methodological rigour needed: without such rigour, wrong conclusions can be drawn on the value of a programme or project. They are also more costly, especially outcome and impact evaluations, which often require population-based surveys or other rigorous research designs. However, evaluation should leverage data and surveys that are nationally available and regularly undertaken, e.g. demographic and health surveys, vital registration or sentinel site disease data.

FEATURES OF A GOOD M&E SYSTEM

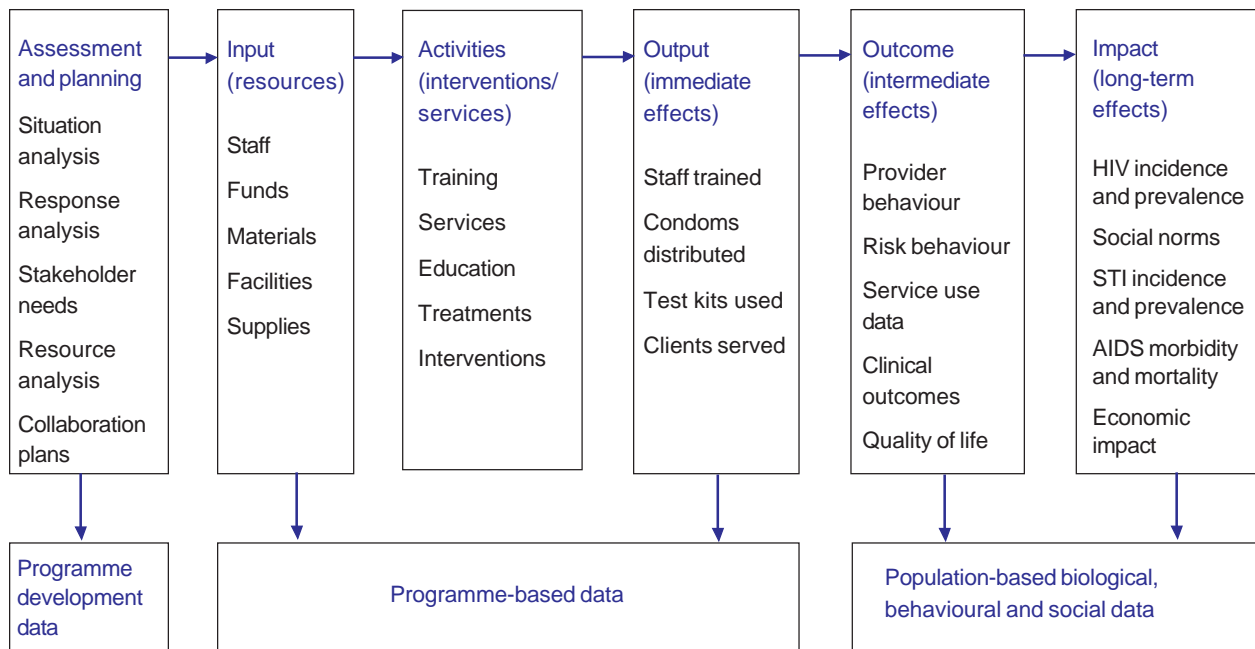
Examine the points given in the table and think about how they relate to your current M&E system.

M&E unit	<ul style="list-style-type: none"> • An established M&E unit within the national AIDS programme, with experienced technical and data management staff. This unit should be integrated with the broader statistical services of the country. • Guidelines and guidance for M&E to subnational districts, regions and provinces • Guidelines for linking M&E to other sectors such as education, labour, and the military • A budget for M&E that is between 5% and 10% of the national HIV/AIDS budget from all sources. On average, 7% should be used as the reference. • A significant national contribution to the national M&E budget (not total reliance on external funding resources) • A formalized M&E link, particularly with appropriate line ministries, nongovernmental organizations (NGOs) and donors, and national research institutions aimed at enhancing operations research efforts • A multisectoral working group to provide input and achieve consensus on indicator selection and various aspects of M&E design and implementation • Expertise in the M&E or an affiliated unit to cover: epidemiology, behavioural/social sciences, data processing and statistics, data dissemination, resource-tracking (both commodity and financial resources)
Clear goals	<ul style="list-style-type: none"> • Well-defined national programme or project plans with clear goals, targets and operational plans. National M&E plans should be revised every 3–5 years, and M&E operational plans updated yearly. • Regular reviews/evaluations of the progress of implementation of the national programme or project plans against targets • Coordination of national and donor M&E needs

Indicators	<ul style="list-style-type: none"> • A set of priority indicators and additional indicators at different levels of M&E • Consistent indicators that are comparable over time and have clear targets • Selection of a number of key indicators that are comparable with those of other countries
Data collection and analysis	<ul style="list-style-type: none"> • An overall national-level data collection and analysis plan, including data quality assurance • A plan to collect data and periodically analyse indicators and associated datasets at different jurisdictional levels of M&E (including geographical) • Second-generation surveillance, where behavioural data are linked to disease-surveillance data
Data dissemination	<ul style="list-style-type: none"> • An overall national-level data dissemination plan, with basic data sets freely and transparently available in a timely manner. Transparency is essential for real accountability. • A well-disseminated, informative annual report • Annual meetings to disseminate and discuss M&E and research with policy-makers, planners and implementers • A clearinghouse for generation and dissemination of findings • A centralized database or library for all HIV/AIDS data collection, including ongoing research which is transparently and publicly available • Coordination of national and donor M&E needs
Special studies	<ul style="list-style-type: none"> • Select priority outcome/evaluation studies • Include qualitative studies as needed • Include operational research studies

ESTABLISHING AN M&E FRAMEWORK

The “input–activities–output–outcome–impact” framework is generally used to select indicators for inclusion in M&E. The following framework provides a logical order for collecting and analysing information.



KEY STRATEGIES IN M&E

This section highlights some of the key strategies used in M&E, setting out the range of methods available under each strategy and the main questions that can be answered using these strategies.

PROCESS M&E

Process monitoring involves gathering data on how implementation is progressing. It provides important information on the sequence of events, the factors that assisted or prevented implementation and important feedback from recipients of services about what they found effective. Many of the activities of a programme are captured in process monitoring. Data for process M&E can be collected from project records, service activity records, client feedback questionnaires or focus group discussions, interviews with project or service staff, observation of services, facility audits, interviews with referral agencies and interviews with people from target populations who did not access or use the offered services.

Uptake and coverage monitoring

Monitoring the coverage and use of services and programmes provides vital information on reach into target populations. This can be done by monitoring geographical coverage (using mapping techniques) and by keeping a track of the coverage of individuals over time. Project or service records can provide the data for this monitoring, along with surveys of at-risk populations to ascertain that they have used the services and programmes.

Outcome evaluation for discrete interventions

It is important to be able to measure the outcomes of a particular intervention to monitor effectiveness, tailor the intervention better to the needs of the recipients and also determine how the intervention model can be replicated for other populations or areas. This generally involves the design of a study that combines qualitative and quantitative research methods. It is important to conduct outcome evaluation after the inception of an intervention. It is important, however, to start the evaluation only after the intervention has had sufficient time to have an effect.

Some key steps for outcome evaluation involve:

- establishing common goals and evaluation questions
- developing a methodology that suits the population being evaluated
- establishing a collaborative relationship with key stakeholders
- establishing regular feedback mechanisms to assist in programme modification
- ensuring that the evaluation is used to strengthen the programme.

Choosing indicators for M&E of the national programme

A vast array of indicators is available for monitoring and evaluating national programmes. These are summarized in the resources at the end of the module.

The following guiding principles can be used in the selection of indicators.

- Keep the number of indicators to the minimum needed, with specific reference to the level of the system that requires and will use indicators to make programming and management decisions.
- Use a conceptual framework for M&E for proper interpretation of the results.
- Ensure that the indicators are linked to the goals and objectives, and that they are able to measure changes over the time period of the programme.
- Ensure that the standard indicators are used to the extent possible for comparability over time or between population groups.
- Ensure that indicators relate to defined services which are delivered by the programme. Attempt to define the standard package of services provided by the programme and the groups targeted.
- Consider the cost and feasibility of data collection and analysis.
- Take into account the stage of the AIDS epidemic.

EXERCISE B***(Country group work followed by intercountry group discussion)***

A separate handout contains a summary of indicators for national HIV prevention and care.

In country groups, select key programme indicators with attention to your priority populations. Identify whether these are input, activity, output, outcome or impact indicators. Remember to reflect on the main aims of the programme: reducing HIV transmission and reducing the impact of HIV on people living with HIV/AIDS (PLHA) and people affected by HIV.

When you have made your selection, discuss whether your current information management system collects information that would allow you to accurately report on these indicators.

Discuss the reasons for your selection of indicators with the intercountry group.

OBJECTIVE 4: To describe the role of the national programme in setting and coordinating a national research agenda for guiding the programme

Surveillance and M&E systems provide only part of the information necessary to shape a national AIDS programme. Biological and behavioural data can indicate the extent of the epidemic and the risk behaviours present, but these give little information about the context of risk. Service use data can record only the number of people accessing services, but is not indicative of the people ignoring services and the reasons for this.

Social, cultural and operational research provides important details about exactly what shapes people's behaviour and what affects their ability to access services and programmes.

While the national AIDS programme may not be in a position to carry out research, it has a key role to play in ensuring that the research carried out answers the questions of main concern to the programme. This can be done by:

- setting up a research subcommittee of the national AIDS committee, which develops a proactive research agenda, priority questions for research and a plan for encouraging institutions to take on these research questions;
- ensuring that donors include research that is of interest to the programme in any bilateral projects;
- facilitating communication and collaboration between researchers and practitioners, particularly in the area of community and nongovernmental organization interventions, to ensure that research is practice-based and that practitioners develop their capacity to contribute to the research;
- establishing an AIDS research policy that includes national ethical principles and guidelines for AIDS research;
- facilitating meetings and conferences to bring researchers, practitioners and policy-makers together;
- encouraging key social and cultural researchers, and research institutions in the country to contribute to the design and implementation of AIDS research.

RESOURCES

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