

Maximizing opportunities for integrated HIV prevention

A guidance document on rapid acceleration of HIV prevention in the health sector in the WHO African Region

Draft

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Acronyms

AFRO	Africa Regional Office
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance System
CBO	Community-based Organization
CDC	United States Centres of Disease Control
FBO	Faith-based Organization
G8	Group of Eight Nations (Canada, France, Germany, Italy, Japan, Russia, the United Kingdom and the United States.
HCW	Healthcare worker
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IMAI	Integrated Management of Acute Illness
MCH	Maternal and Child Health
NGO	Non-government Organization
PITC	Provider-initiated HIV Testing and Counselling
PMTCT	Prevention of Mother to Child Transmission of HIV
RCH	Reproductive and Child Health
STI	Sexually Transmissible Infections
T&C	Testing and Counselling
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNAIDS	United Nations Joint Program on AIDS
WHO	World Health Organization

Introduction:

At the end of 2007, of the estimated 33.2 million people living with HIV/AIDS, 22.5 million (68%) were in sub-Saharan Africa. Of the 2.5 million new infections worldwide in 2007, 1.7 million (68%) occurred in sub-Saharan Africa, with an estimated overall adult prevalence of 5%. During the same year, an estimated 2.1 million adults and children died globally - 76% of these deaths occurring in sub-Saharan Africa.¹ Now the leading cause of death for both children and adults, AIDS has reduced average life expectancy from 62 years to 47 years in the African Region. Prevention, like treatment, remains concentrated in urban areas. Vulnerable groups are inadequately targeted, fuelling the epidemic. Prevention in the health sector would be more effective if closely coordinated with treatment, care and support interventions. The scale-up of access to HIV treatment, care and support over recent years, and the energy and commitment it has generated among health workers, provides an excellent opportunity to strengthen prevention outcomes and to bring them in line with the successes in treatment, care and support.

It has been shown that HIV prevention is cost-effective and that implementation of a comprehensive HIV prevention package (linked to treatment, care and referral using HBC as an entry point) could avert 29 million (63%) of the 45 million new infections expected to occur in the Region by 2010.²

Current global initiatives and commitments provide an enabling environment to scale up prevention efforts in the African Region, while ensuring linkages to treatment, care and support interventions. In June 2005, UNAIDS approved a policy position paper aimed at intensifying HIV prevention.³ The Gleneagles G8 Summit of July 2005 made a commitment to provide support to countries for achieving universal access to prevention, care and treatment for all those who need it by 2010.

The G8 call was backed up by the World Health Assembly that called for the development and implementation of a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it.⁴

The 55th Session of the Regional Committee for Africa held in August 2005 in Maputo, Mozambique adopted Resolution AFR/RC55/R6 calling upon Member

¹ UNAIDS AIDS Epidemic Update, December 2007

² HIV prevention in the African Region: a strategy for renewal and acceleration, AFR/RC56/8 17 June 2006

³ Intensifying HIV Prevention: UNAIDS Policy Position Paper (2005)

⁴ United Nations General Assembly, 2005 World Health Summit Outcome, A60/L1

States to intensify HIV prevention efforts and to declare 2006 a year for Accelerating HIV Prevention in the African Region.

The adoption of this resolution led to the development by WHO/AFRO of a set of guidelines for acceleration of HIV prevention in the health sector. This guidance document builds on those guidelines, and seeks to focus and reinvigorate efforts to make best use of opportunities that contact between community members and health services offers to support and encourage HIV prevention.

It is intended that the Ministry of Health and the National AIDS Program in each country will take this guidance, adapt it to local conditions and use it as the centrepiece of a concerted effort at national, district, facility and community level to increase the knowledge and skills of health and community workers to incorporate HIV prevention more consistently into their daily work and to re-organise services so that they are more able to support HIV prevention efforts.

Section 1: The health sector's contribution to HIV prevention

The health sector has a key role in HIV prevention. It provides direct HIV prevention services and is a key contact point for people at risk of HIV and for PLHIV. It provides technical assistance to other sectors for the development of content of campaigns and community initiatives to reduce HIV transmission. It backs up these initiatives by providing a range of entry points for the people targeted in these campaigns and initiatives to find their way into prevention, treatment and care services and programs.

The broad definition of health sector includes public and private health services and NGOs, FBOs and CBOs that are delivering health services or working in collaboration with health services. This includes clinics and hospitals as well as community outreach workers, traditional birth attendants, traditional healers and community health workers. The guidance is focussed on the health sector contribution to prevention and therefore does not specifically focus on community mobilization, mass media campaigns, social marketing, education, social welfare and the myriad of other multisectoral contributions to an overall HIV prevention programme. Obviously, coordination and consistency across this multisectoral response is crucial to the overall success of prevention efforts.

The health sector's contribution to HIV prevention is summarized in the table below.

HIV prevention in the health sector	
<p>Direct contributions:</p> <ul style="list-style-type: none"> ▪ HIV testing & counselling ▪ STI prevention and control ▪ Reproductive choice and family planning for PLHIV ▪ PMTCT ▪ Safer infant feeding advice, ANC care and safer labour and delivery practices ▪ HIV prevention incorporated in the clinical care of PLHIV, including active support for disclosure, partner testing, risk reduction counselling, especially for sero-discordant couples ▪ Basic HIV prevention messages provided in all clinical care settings ▪ Provision of condoms in health care settings ▪ Access to clean injecting equipment and to drug treatment services for drug users ▪ Male circumcision ▪ Prevention of unsafe injections in the medical settings ▪ PEP following sexual assault/or exposure to contaminated products/instruments ▪ Community outreach ▪ Blood transfusion safety ▪ Standard infection prevention precautions ▪ Safe management of medical waste ▪ Workplace interventions in the health sector ▪ Referral to community-based prevention services 	<p>Indirect contributions:</p> <p>Technical assistance for</p> <ul style="list-style-type: none"> ▪ Campaigns ▪ NGOs/CBO/FBO community mobilisation/awareness raising ▪ Condom social marketing ▪ Behaviour change communication IEC ▪ Structural initiatives – e.g. education of girls ▪ Workplace initiatives

These efforts are supported by a range of intermediaries who work between the health services and the community – community health workers, health motivators, treatment supporters, lay counsellors and traditional birth attendants. They are also supported by including PLHIV as paid members of the clinical team, to act as expert patients and peer educators.

Different approaches to HIV prevention and care produce different results. In the early years of the global response to HIV, many prevention and care programs were delivered separately. Prevention focussed on primarily

awareness-raising through mass media, broad condom promotion and the promotion of VCT. Treatment care and support programs often focussed primarily on treating the sick, expanding to primary health care for PLHA once treatments became more available.

There is ample evidence now, using modelling techniques, to demonstrate the relative impact of different approaches to HIV. The graphs below illustrate that a combined approach (the integration of HIV prevention, treatment and care) is likely to have a far greater impact on new HIV infections and AIDS deaths.

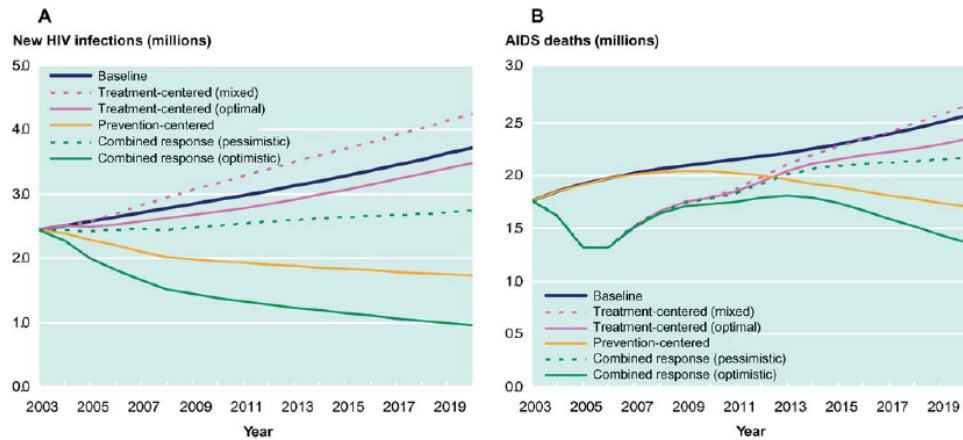


Figure 1. HIV Incidence and AIDS Mortality among Adults in Sub-Saharan Africa, 2003–2020, under Different Intervention Scenarios
 (A) HIV incidence.
 (B) AIDS mortality.
 DOI: 10.1371/journal.pmed.0020016.g001

Section 2: Missed opportunities in the health sector’s contribution to HIV prevention

Despite the efforts that have been made to train health workers and to integrate HIV prevention into health services, there are still many missed opportunities for HIV prevention in the day to day contact between health workers and members of communities. Effective HIV prevention requires the development of a long-term prevention and care relationship with people with HIV, assisting them to manage their chronic illness and supporting them to develop the strategies they need to protect themselves and others in the long-term. It also involves the continual reinforcement of HIV protection messages for people who do not have HIV, to assist them to maintain protective behaviours. This has provided a challenge for health services in resource-constrained settings, where the demand for services is high and staff numbers are inadequate. There has been little opportunity to take a proactive approach to following up people living with HIV and people at risk

and little time to incorporate HIV prevention counselling into daily health practice.

Programs such as TB, STI and MCH have at times focussed only on the immediate problem at hand and have missed the opportunity to integrate HIV testing and counselling and HIV prevention support into their range of services. Acute care for sick adolescents and adults also often neglects opportunities for HIV prevention.

Integration of HIV prevention into care involves the inclusion of components of HIV prevention (HIV testing and counselling, HIV prevention support, access to male and female condoms and lubricant, to clean injecting equipment and HIV prevention services such as PMTCT) into existing health services such as acute care services, primary health care clinics, community health services and other speciality clinics such as STI, TB, maternal and child health and reproductive health. It also involves the inclusion of prevention within integrated approaches to scaling up acute and chronic HIV care and treatment (using IMAI and other locally-tailored planning processes) at district and primary care level. It also involves mobilizing and supporting PLHIV to play a role in HIV prevention with their peers.

Scaling up of PMTCT is moving ahead well in many parts of Africa, especially for the third prong of the WHO comprehensive PMTCT strategy that relates to provision of ARV prophylaxis to pregnant women with HIV. There are still significant gaps relating to prongs one and two of the strategy, which are related to primary prevention of HIV infection and routine offer of family planning services to women with HIV.

Integration of HIV testing, counselling and referral into TB and STI services means that people with TB and STIs are more likely to be offered HIV testing and counselling, and on-going HIV treatment, care and support if diagnosed with HIV, and counselling if diagnosed HIV negative. Integration of PITC into acute care of children, adolescents and adults will identify many PLHIV and provides an opportunity for risk reduction counselling. Growing attention to identifying and providing brief interventions to reduce hazardous alcohol use may also contribute to reducing HIV transmission related to unsafe sex while intoxicated.

Despite these advances, there are still many gaps in the consistency of prevention efforts and many ways in which people can fall through the cracks. Some of these include:

- A specific focus on using HIV testing and counselling as a diagnostic tool and a channel to treatment and care for PLHIV, resulting in the under-servicing of people diagnosed HIV negative, who often receive a one-off piece of information or a one-off counselling session that is insufficient to support their ongoing protection and safety.

- An emphasis in health services on getting PLHIV into treatment regimes, neglecting a broad public health focus that puts equal weight on prevention. This emphasis is also reflected in many training packages and programs.
- A focus on HIV clinical care for PLHIV without clear follow through strategies in those services to help the person disclose safely to others (to assure partner counselling and testing) and to incorporate safer sex and other protections fully into their lives.
- A narrow focus on PMTCT in services (aimed primarily at one-off testing of pregnant women) without a clear plan to bring men into testing and counselling services through supported disclosure or through other means like home or workplace-based testing. Placing a focus on couple counselling and testing, and on HIV testing of men, aims to increase knowledge of HIV status without placing women with HIV at additional risk of violence or rejection.
- Production-line design of service delivery that supports a quick throughput of patients, but does not create space or time for staff to work with patients on HIV prevention for themselves and others.
- A weakness in follow-up or case management and patient tracking systems that could alert staff to people who have dropped out and allow staff to follow these people up in community.
- Referral of people from one service to another without strategies to ensure that they make it to the other service and get what they need from it.
- Missed opportunities in general healthcare that mean HIV and AIDS is not raised by health workers when dealing with other issues and HIV prevention messages are not reinforced across all health services.
- Incorrect assumptions that all HCWs have basic HIV and AIDS knowledge, resulting in a lack of attention to basic HIV and AIDS information in pre- and in-service training.
- A reluctance among HCWs to discuss HIV prevention services if the client is HIV negative, or to discuss condom use and safe sexual practices in any detail with HIV positive clients.
- Inadequate attention to the role that stigma and discrimination among the HCWs plays in preventing people from accessing effective HIV prevention messages and services.

- Inadequate functional linkages between health sector and community resources that support prevention, minimizing opportunities to working collaboratively to achieve more consistent outcomes

Section 3: Maximising opportunities for HIV prevention in the health sector

In broad terms, the solutions to the problems outlined above fall into the following broad categories:

Healthcare worker knowledge and skills: Do healthcare workers feel confident to raise HIV prevention issues in a meaningful way with their patients? Is HIV content included in pre and in-service training? Are healthcare workers regularly assessed, mentored and supported in their role as prevention supporters? Do all staff recognize that they need to make a contribution to prevention? Will all staff feel committed to offer HIV prevention information?

Structural issues: Is there a structure in the programme to allocate funds for community preparedness activities? Does the way that patients move through the service, the way patient records are kept and used and the way that staff are allocated to tasks allow HIV prevention interventions to be carried out effectively? Is there time, personnel and space allocated to provide on-going confidential counselling?

Continuity of care issues: Are services and service providers connected well enough, so that people are not lost when they are referred from one service to another? Are people falling through the cracks? Do healthcare workers have tools or procedures in place to track how their patients are progressing with issues like disclosure and sustaining safer behaviour? Is there an overall plan and adequate coordination to ensure that wherever a person presents for health services, they get consistent prevention messages and services?

Availability of healthcare workers: Are there adequate numbers of healthcare workers to meet the ever-increasing demand for HIV prevention and care services? Given the chronic shortage of health workers, are there strategies in place to involve other sectors (civil society, PLHA groups, private sector) to increase the HIV prevention workforce?

Taking a four-pronged approach:

National program managers, district health management teams, facility managers and care teams all need to examine the way that they are currently providing programs and services, and use the four-pronged

approach outlined below to integrate HIV prevention into a much wider range of programs and services. Attention to each of these four areas will contribute to the health sector's capacity to carry out the following interventions that will dramatically increase the reach of HIV prevention messages and services into the communities that need them.

1. Promoting HIV prevention for all:

Even without knowing their HIV status, people can take steps to protect themselves and others against HIV. Health workers are key people of influence in their communities and with their patients. They need to be able to reinforce safer sex messages with their patients and in their lives in communities. They need to continually create opportunities in their health service delivery to raise HIV as an issue, provide access to male and female condoms and take an ongoing interest in whether their patients understand HIV risk and have been able to reduce their risk and vulnerability. This requires the development of skills and time to talk to patients about HIV prevention, particularly about sex and other challenging topics.

2. Helping people to access HIV testing and counselling:

All health workers need to have the capacity to assist people who have not been tested for HIV to understand the need for them to know their HIV status and to access efficient testing and effective counselling services.

Making a referral is not enough. Health services need to bring testing and counselling to the places where people access other health services, and where they live - "Door to Door" and have services that offer HIV testing and counselling outside normal working hours, to attract people who work. HIV testing and counselling needs to be built in as part of normal service delivery in primary health clinics, STI services, TB clinics, MCH services and through outreach to communities. It needs to be normalized and offered to all, so that stigma and discrimination, isolation and sexual abuse is reduced and so that when people are offered HIV testing, they do not feel that they are being singled out as being at particular risk or belonging to a particular risk group.

PMTCT provides a good HIV testing and counselling entry point for women of child-bearing age, but only reach women who are pregnant or planning a pregnancy. Other user-friendly entry points for women are required, so that women who are not informed by their husbands or male partners that they are HIV positive can access HIV testing, prevention and early treatment.

HIV testing and counselling user-friendly entry points for men also need to be expanded, to reduce the burden of disclosure on their wives and sexual partners diagnosed through PMTCT and other services for women. STI clinics, men's health days in general clinics, workplace clinics and community HIV

testing and couple or family-centred services counselling can expand these entry points for men.

3. Providing HIV prevention support for people who test HIV negative:

HIV testing is not just a diagnostic tool or a pathway to treatment, care and support. People who test HIV negative have just as much need for information and counselling as those who are diagnosed HIV positive. Health workers need to be trained and empowered to go beyond simple statements like 'You must use condoms' or 'You need to reduce the number of your sex partners' and find out from their patients what exactly puts them at risk and what prevents them from protecting themselves and others.

Despite the high workloads and staff shortages experienced in many health services in resource-limited settings, there is a need to think laterally and find creative ways for health workers to spend time talking to people who test HIV negative, helping them to identify realistic strategies that they can use to reduce their risk. There are many factors that contribute to risk – like not having the power to insist on condom use in relationships or having your judgement impaired by the use of alcohol and other drugs.

4. Providing HIV prevention support for people who test HIV positive:

People who test HIV positive often receive one-off post-test counselling at the time of testing that informs them of the need for safer sex and other forms of protection, encourages them to disclose their status to others who may have been at risk, refers them for treatment and care and tells them how they can protect their family by accessing PMTCT. A one-off post-test counselling session has limited effect, particularly as the patient is often shocked and stressed by his or her diagnosis and not in a position to absorb the information provided. The aim of post-test counselling for people diagnosed with HIV is to develop a supportive relationship that lasts over time, or to ensure that they find their way into services that can provide that on-going support and counselling.

People who are diagnosed with HIV, but not yet requiring ART, need to be provided with ongoing care and support. This is a key time when people are lost to follow-up. These people emerge some time later with an opportunistic infection or for PMTCT services when they become pregnant. This gap in time between a diagnosis of HIV and the need for HIV clinical services is a key period for reinforcement and support for HIV prevention. Services need strategies that support the development of a long-term relationship with these PLHIV, using community intermediaries like lay counsellors, other PLHIV, expert patients and other community workers with emphasis on bringing services to the door or closer to home.

Couple testing and counselling provides an opportunity to work with families to reduce risk and needs to be available in all sites that conduct HIV testing. However, relying on disclosure as the only means of getting the person's sexual partners to access HIV testing, counselling and on-going support may not be the most effective HIV prevention strategy. This places the burden solely on the PLHIV who has been diagnosed and this person may not have the skills or power to carry out this disclosure safely. They also may be overwhelmed by fear of what will result from the disclosure – violence, rejection by family and community.

Working with sero-discordant couples is particularly important. Disclosure from the person with HIV to their HIV negative partner, and sustained safe behaviour to prevent the negative partner from sero-converting, requires long-term counselling and support.

HIV prevention needs to become a much more integrated part of the on-going clinical care of PLHIV. This would involve:

- A discussion about HIV prevention at each clinical visit – with clear guidance and training about what sorts of issues should be raised in a range of clinical encounters
- Clinical staff developing an HIV prevention plan for each patient that sits alongside their treatment and care plan and is regularly monitored – in the form of an IMAI job aid.
- Ongoing assistance with disclosure, which is often very complicated for men who do not want to admit unsafe extra-marital sex to their wives, and for women who fear abandonment or violence from their husbands or partners if they disclose
- Access to the male and female condoms in HIV treatment clinics and staff skilled in demonstrating condom use
- The involvement of HIV expert patients in HIV prevention support
- Access to HIV support groups where on-going HIV prevention issues can be discussed, and assistance to these groups to incorporate HIV prevention into their discussion and support
- Wallcharts, job aids and other resource materials to prompt patients and health workers to discuss HIV prevention

Concrete examples of acceleration strategies for a range of health services:

All parts of the health sector can make a contribution to HIV prevention. Strategies need to be tailored to the particular setting. The table below provides examples of practical things that each service can do to integrate greater attention to HIV prevention in the care they provide.

Site	Actions to assist in integration of HIV prevention
All health services	<ul style="list-style-type: none"> ▪ Ensure basic level information training for all HCWs, administrators, managers and ancillary staff to reinforce BCC messages ▪ Offer provider-initiating testing and counselling (or referral to HIV testing and counselling with follow-up) ▪ Have male and female condoms readily available and promote and demonstrate their correct use ▪ Have BCC materials available and on display (incl. wallcharts) ▪ Promote and hold men’s health clinic days with HIV testing and counselling integrated ▪ Strengthen blood transfusion safety practices ▪ Promote prevention of unsafe injections ▪ Ensure skills and equipment are in place for standard infection prevention precautions ▪ Support safe practices to manage medical waste ▪ Provide PEP for occupational and non-occupational exposure
PMTCT services	<ul style="list-style-type: none"> ▪ Offer HIV testing and counselling on site and recommend it for all pregnant patients ▪ Follow up pregnant women diagnosed HIV negative early in pregnancy to assist them to remain HIV negative ▪ Introduce HIV prevention plans for patients, noting progress in specific key areas – disclosure, pregnancy planning, safer sex ▪ Ensure that all staff are trained in HIV prevention counselling ▪ Promote mother to mother community support for accessing PMTCT services and partner disclosure and testing ▪ Provide follow-up by community health workers of women who do not attend ▪ Provide men’s spaces/days to encourage men’s HIV testing and counselling ▪ Have male and female condoms readily available and promote and demonstrate their correct use ▪ Have BCC materials available and on display (incl. wallcharts)

Site	Actions to assist in integration of HIV prevention
STI clinics	<ul style="list-style-type: none"> ▪ Offer HIV testing and counselling on site and recommend it for all patients at risk ▪ Provide specific counselling and follow up for HIV negative patients ▪ Hold and promote regular, well-promoted men's clinics to relieve burden of disclosure on wives/female partners ▪ Have BCC materials distributed and on display (incl. wallcharts) ▪ Have male and female condoms readily available and promote and demonstrate their correct use
HIV treatment and care clinics	<ul style="list-style-type: none"> ▪ Ensure inclusion of HIV prevention information, counselling and support in care plans and clinical practice ▪ Provide active and on-going support for partner disclosure, testing & counselling ▪ Prioritise counselling for sero-discordant couples ▪ Pay specific regular attention with patients to issues of disclosure and safer sex - integrate prevention as a standard of care, using every clinic encounter as an opportunity to address safer sex, alcohol use, and other risks ▪ Refer drug users with HIV to prevention and drug treatment services, and get to know how these services work to improve communication and collaboration ▪ Have male and female condoms readily available and promote and demonstrate their correct use ▪ Ensure that BCC materials are distributed and on display (inc. wallcharts) ▪ Prepare health workers and PLHIV lay counsellors to provide integrated prevention, care and treatment services (using IMAI or comparable integrated approach) ▪ Track prevention interventions on the patient summary HIV care/ART card or an additional counselling summary card ▪ Promote safe surgical and emergency services
TB programs and clinics	<ul style="list-style-type: none"> ▪ Provide HIV testing and counselling on site and recommended for all TB patients ▪ Refer TB patients who test HIV positive to care and treatment services and follow-up with these services to ensure patient access ▪ Provide specific counselling and follow up for HIV negative patients ▪ Have male and female condoms readily available and promote and demonstrate their correct use ▪ Have BCC materials available and on display (incl. wallcharts)
Adult medical, other acute care services	<ul style="list-style-type: none"> ▪ Provide HIV testing and counselling on site and recommended for all patients or all patients at risk ▪ Provide specific counselling and follow up for HIV

Site	Actions to assist in integration of HIV prevention
	<p>negative patients</p> <ul style="list-style-type: none"> ▪ Ask all patients about genital ulcers and all men about urethral discharge ▪ Provide on site provision of STI diagnosis and management ▪ Provide regular, well-promoted men's clinics to relieve burden of disclosure on wives/female partners ▪ Have BCC materials available and on display (incl. wallcharts) ▪ Have male and female condoms readily available and promote and demonstrate their correct use ▪ Provide youth-friendly services that pay particular attention to flexible opening hours, non-judgemental staff, availability of peers for support and information, attention to privacy issues, youth-generated health messages, innovative health promotion strategies and so on
<p>Non-facility services and community outreach. Door to Door services.</p>	<ul style="list-style-type: none"> ▪ Provide training for community workers/expert patients/lay counsellors/TBAs/health motivators/church/faith-based service providers in HIV prevention counselling ▪ Support the involvement of these community workers in prevention case management – follow-up of patients in community and at home ▪ Have male and female condoms readily available and promote and demonstrate their correct use ▪ Have BCC materials available and on display (incl. wallcharts) ▪ Promote functional referral networks with standardized referral procedures and tools to optimize access to prevention services in both health facilities and the community.

Section 4: Steps to be taken

Actions required at national level:

The process begins with the development of ownership at national level for a concerted effort to accelerate HIV prevention in the health sector. This would involve holding a series of meetings of relevant people at national level to promote the concept and get their support and ownership. It would be particularly important to seek the support of the Health Minister, senior health bureaucrats, the head of the national AIDS Program and the heads of other national programs such as TB, STI and MCH.

This would be followed by adaptation of this national guidance at national level. This would include:

- An analysis of the progress of health sector HIV prevention efforts to date, drawn from:
 - surveillance and BSS data
 - social research
 - program evaluations, national strategies, GFATM and donor submissions and reports
 - data on reach and coverage of prevention services (HIV T&C, PMTCT, STI prevention and control)
- An analysis of health sector HIV workforce development, looking at:
 - Existence of national guidelines and training in HIV prevention and care (IMAI or equivalent)
 - Progress of rolling out HCW training and mentoring capacity to support provision of prevention services as a standard of care within health facilities
 - Extent of incorporation of HIV prevention and care training in pre-service training for HCWs
 - Establishment of workplace programmes.
- Identification of key priorities for acceleration of HIV prevention in the health sector and allocation of task and responsibilities – particularly the allocation of responsibility for coordination of this strategy to an individual or section within the national AIDS program
- Cultural adaptation of wall charts and other BCC materials to support the acceleration of HIV prevention in the health sector
- Examination and adaptation of the IMAI and FHI training materials for use at district and facility levels

This would be followed by a briefing and planning workshop for all relevant health sector national program areas to assist them in identifying how their program plans and training curricula can be modified to assist in this acceleration effort. This would include, but not be limited to, the national TB, STI, PMTCT, MCH programs as well as representatives from pre-service health training institutions. In addition to modification of training curricula, attention would be paid to providing guidance through these national programs to coordinators at district level to gain their support in district level acceleration strategies.

Actions required at district level:

The national adaptation and planning would be followed by workshops bringing together health sector district management teams to develop

strategies, based on the national guidance, to be implemented at district level.

This would ideally be done in an integrated manner, through an IMAI District Management Team Workshop that integrates prevention and care. If this is not possible then a separate workshop on the acceleration of HIV prevention in the health sector would be held. This would bring together District Management Teams from a group of neighbouring districts and take them through a process of examining the current contribution of health sector in their district to HIV prevention, identification of gaps and strategies of acceleration.

District coordinators from national programs such as TB, MCH, PMTCT and STI would also participate in this workshop.

Whilst this guidance document focuses primarily on what needs to happen to better integrate HIV prevention into the health sector, a set of tools will be made available to District health managers to provide guidance on how to achieve this at district, facility and community level. These will be backed up by the following IMAI and FHI materials and other materials that are already available:

- The IMAI District Management Team workshop curriculum that includes integration of HIV prevention into health services
- The Health Managers' Guide to Integrating HIV Prevention in the Healthcare Setting, developed by FHI in Africa and released in 2007
- The WHO/IFRC/SAFAIDS training package for community health workers/volunteers on HIV prevention, treatment, care and support focuses on training C&HBC workers to perform specific tasks in HIV Community preparedness, HIV Community Counselling and HIV testing, ART adherence, Provision of basic medicines and nursing care for AIDS patients, Positive living and nutrition. The package is available in English, French and Portuguese.

Actions required at facility and community levels:

District management teams would then convene workshops of health facility managers and community program managers within their District to identify strategies at facility and community level for the acceleration. These would include strategies to:

- Increase the reach and coverage of key health sector HIV prevention services – condom education, demonstration and distribution, HIV T&C, PMTCT STI, TB treatment and care
- Simplify the way that these services provide HIV prevention information, counselling and support
- Establish youth-friendly services to increase privacy and confidentiality in counselling and support, reducing alienation of youth and young men in particular

- Concentrate on addressing the cultural and religious context which remains the single most important gap and challenge to scaling-up condom use as an HIV prevention method
- Train households in HIV prevention with linkages for referral and support by health care teams
- Improve supervision of HCWs and provide funding for transport and other safety supplies so that supervisors and HCWs are motivated.
- Broaden the workforce involved in HIV prevention through task shifting and the greater use of lay counsellors, expert patients and community health intermediaries
- Identify training needs for HCWs in the District and plan to build HCW capacity, including ongoing mentoring and support over time
- Systematize linkages between health facilities and community services to create referral mechanisms that optimize patient access to prevention services

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The workforce training needs assessment would also include attention to the training needs of all health workers in basic HIV information and counselling.

Following this workshop, facility managers would be encouraged to return to their facility and work with their staff to identify (and develop an action plan to address) the structural changes that could be made to contribute to HIV prevention outcomes in their facility:

- The time and space for counselling of PLHIV and people who test HIV negative
- How prevention can be incorporated into each clinic encounter as a standard practice and in a manner that does not further burden HCWs
- How patients are tracked and followed-up
- How patient's progress in areas of HIV prevention is monitored and enhanced
- How disclosure is supported and whether this is balanced by broader strategies to provide service entry points for partners
- How HCWs work with people who refuse to disclose to their partners
- What tools and job aids are needed to support HCWs in incorporating prevention in clinical practices

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The Operations Manual for Delivery of HIV Prevention, Care and Treatment at Primary Health Centers in High-Prevalence, Resource-Constrained Settings would be used as a key resource to assist in this assessment and modification. This WHO/CDC manual sets out the training and infrastructure requirements for delivering HIV prevention, treatment and care through primary health centres. The FHI materials summarized in the Appendix also include a physical facility checklist.

Managers and coordinators of community programs would also be encouraged to meet with the intermediaries they support to identify strategies for bringing more people into contact with health sector HIV prevention services and for backing-up HIV prevention efforts in the community. One key part of this is increased collaboration between facility and community services. Facility and community program managers would identify ways that community workers could become a more integrated part of the facility health care team, so that they could assist more effectively with HIV prevention and care follow up in community.

Training resources such as the IMAI training course for ART treatment supporters, the WHO/IFRC training package for community health workers/volunteers and the FHI facilitators' guide for 'Prevention for Positives' provide useful additional guidance.

Monitoring progress:

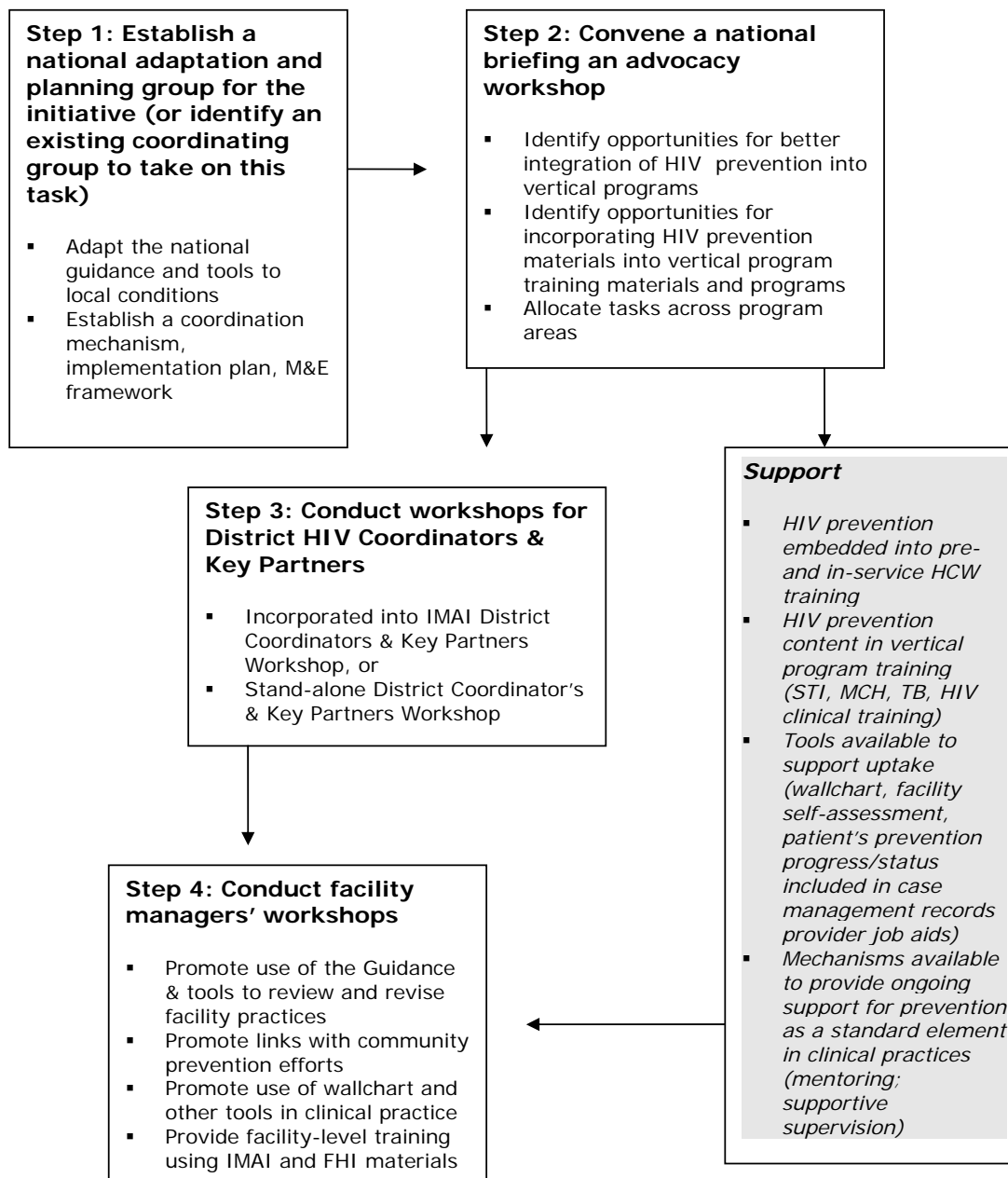
The health sector contributes to HIV prevention but is not solely responsible for it. It will be difficult to measure the impact of the acceleration of the health sector's contribution to HIV prevention in the short term on HIV transmission rates.

This guidance document, and IMAI more broadly, sets out an approach to accelerate the provision of HIV prevention in health facilities. Monitoring and mentoring visits could be used to identify the degree to which facilities have incorporated and met these standards, and the proportion of facilities across a district that meet the standards.

Indicators for the integration process could include:

- Percentage of national training curricula with HIV prevention content integrated
- Percentage of pre-service training institutions with HIV prevention content in their curricula
- Percentage of facilities which have put in place measures to integrate HIV prevention into treatment and care services (measured against an agreed national set of standards based on this guidance)

Appendix 1: Flowchart of steps to be taken



Appendix 2: IMAI as an integrated HIV prevention, treatment and care strengthening tool

IMAI Acute Care and Prevention

IMAI is not only a package aimed at HIV services. The IMAI Acute Care guideline module (and its several short training courses) is targeted at all adolescents and adults, both HIV negative, HIV positive and unknown HIV status.

Preparing health workers to treat the common, less severe opportunistic infections allows them to stabilize many clinical stage 3 and 4 patients prior to ARV therapy without referral to hospital. This and the management of acute problems that occur during chronic HIV care and ART were emphasized during the initial scale-up training using IMAI. This is only one component of what is available in IMAI Acute Care.

With the exception of pregnancy, most adolescents and adults come to health facilities for acute medical problems. Syndromic management of the common problems of adolescents and adults can contribute significantly to the prevention of HIV transmission because it integrates detection and management of genital ulcers and other common sexually transmitted infections (screening for these on all encounters); supports the recommendation of an HIV test to everyone presenting with a medical problem; and prepares health workers and lay counsellors to convey the key HIV prevention messages for those who test positive and negative.

Prevention is also served more broadly in the specific section on prevention which includes not only safer sex counselling but also important messages for adolescents (delaying sexual intercourse, exploring alternative forms of sexual pleasure, how to say no to sex, drugs and alcohol) and brief interventions for harmful or hazardous alcohol use.

During scale up training, the Acute Care guideline module is usually introduced using a two-day short course which emphasizes when to suspect HIV and TB and the management of common opportunistic infections. This is followed by a one-day course for clinicians on provider-initiated testing and counselling (PITC), based on a guidance in Acute Care. It is important to also use the IMAI Acute Care guideline module and the several harmonized short training courses to prepare those responsible for outpatient adult medical care, even if they are not on clinical teams providing chronic HIV care. In addition to the short OI and PITC training courses, several compatible short courses are available on STI and other genitourinary problems and the

management of mental health and neurological problems. A short course on the management of fever/malaria will be released soon.

The third revision of the Acute Care materials includes special attention to presumptive treatment for STIs in sex workers, guidance on speculum exams and tolerant care for sex workers. This revision will also include the management of proctitis and guidance on water-soluble lubricants and guidance on tolerant care for MSM. To emphasize the importance of the integrated prevention content, the next version will be called IMAI Acute Care and Prevention.

Prevention within IMAI patient education materials

The HIV prevention wallchart (in preparation) will be consistent with the updated IMAI flipchart and other IMAI materials. Support for the socio-cultural adaptation of the flipchart and wallchart, and key explanations within the IMAI materials, is important for an effective combined prevention approach.

Prevention integrated with acute and chronic HIV care and ARV therapy and prevention

IMAI Acute Care training materials contain information on HIV pre and post-test counselling, STI counselling and on teaching about correct condom use. Chronic HIV Care and ARV therapy and prevention materials contain sections on Positive Prevention by PLHIV and on HCW HIV prevention support for PLHIV. They also contain a section on HIV prevention for healthcare workers themselves, including avoiding HIV transmission in the workplace, support for healthcare workers with HIV, addressing stigma and issues of burnout.

Follow-up after training

The IMAI clinical mentoring training materials include a section on prevention, to enable clinical mentors to focus on prevention when reviewing cases on site. The quality assurance tools, such as the structured provider-patient observation and exit interview, pay attention to whether key prevention messages and interventions were delivered. Mentoring and supportive supervision are key opportunities to promote accelerated prevention.

CHW training

The ART Aid training materials cover pre- and post-test counselling and on-going prevention and care support. There are also sections on facilitating peer support groups, including attention to HIV prevention in peer support, and on mobilizing communities to contribute to prevention and care.