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Developing programmes and delivering services

Although HIV programmes have dramatically scaled up over the past decades, many challenges remain. Access to care for everyone eligible for antiretroviral therapy (ART), especially those disproportionately affected by HIV, has still not been achieved. Overall, we need to make the shift from a primarily biomedical approach to a holistic response that meets the needs of people living with HIV, their families and caregivers in their communities. Healthcare programmes need to be adapted to more efficiently use resources, promote an enabling environment that will reduce the likelihood of new HIV infections, and ensure better health and social outcomes for people living with HIV and their families. In particular, the many systemic barriers that communities face in accessing and taking up the best possible healthcare services must be addressed.

The 2013 Guidelines provide operational guidance to help countries develop programmes and services that support the new clinical recommendations, such as earlier treatment and provision of better drugs. The key new operational recommendations are around **integration and decentralisation of health services and task shifting**. These inter-linked strategies, adapted to local contexts, could directly address some of the most common barriers to care, such as the distance and cost of travel to health facilities and long waiting times at clinics.

Integrating and linking HIV services with other health services (including sexual and reproductive health, maternal and child health, tuberculosis (TB) and drug dependence) aims to provide more comprehensive care. It can take the form of providing related services in a single health facility, sharing information or making referrals across facilities. Integration of services is critical in different settings, including in concentrated epidemics and for key populations.

Decentralisation, a particularly important strategy in generalised epidemics, means moving HIV care and treatment from a limited number of specialised ART sites (often in urban areas) to sites in the community closer to where people live.

Task shifting refers to trained nurses, midwives and community healthcare workers taking on tasks that were traditionally carried out by doctors. In many countries there are not enough doctors to provide HIV treatment to all who need it, especially at primary care sites. With training and support, other healthcare workers can initiate or maintain people on ART.

The 2013 Guidelines call for people living with HIV, key populations and community-based organisations to be actively engaged in the development and delivery of many services. This is due to a growing recognition that

Message

People who inject drugs accounted for 62% of reported HIV cases in 19 countries in Europe and central Asia in 2010, but represented only 22% of the people receiving ART.

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Link

This module links to Chapter 9: Guidance on operations and service delivery, in the 2013 WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. Available at: www.who.int/hiv/pub/guidelines/arv2013/download/en/index.html

people living with and affected by HIV play a key role in delivery of HIV services at the community level, including acting as role models to others in need of treatment, providing peer support and reducing stigma associated with seeking and using HIV services. These interventions are often critical to providing non-discriminatory and responsive care, particularly for population groups who are marginalised or even criminalised.

What do the 2013 Guidelines say?

Integrating and linking services

- In generalised epidemic settings, ART should be initiated and maintained for eligible pregnant and postpartum women and for infants at maternal and child healthcare settings, with linkage and referral to ongoing HIV care and ART where appropriate.
- In settings with a high burden of HIV and TB, ART should be initiated for an individual living with HIV in TB treatment settings, with linkage to ongoing HIV care and ART. TB treatment may be provided for an individual living with HIV in HIV care settings where a TB diagnosis has also been made.
- ART should be initiated and maintained in eligible people living with HIV in care settings where opioid substitution therapy is provided.

Decentralisation of HIV treatment and care

The following options for decentralisation of ART initiation and maintenance should be considered:

- Initiation of ART in hospitals, with maintenance of ART in peripheral health facilities.
- Initiation and maintenance of ART in peripheral health facilities.
- Initiation of ART in peripheral health facilities, with maintenance at the community level (that is, outside of health facilities in settings such as outreach sites, mobile and fixed syringe exchange sites, health posts, home-based services or community-based organisations) between regular clinical visits.

Task shifting

- Trained non-physician clinicians, midwives and nurses can initiate first-line ART and maintain ART.
- Trained and supervised community health workers can dispense ART between regular clinical visits.

What does this mean for my country?

Task shifting, decentralisation and integration of HIV care, support and treatment will require better understanding of local context – epidemiological, political, legal, socio-cultural, economic and best practices. A well-coordinated and appropriately funded multi-sector effort involving a wide range of organisations and stakeholders is also required to sustain and scale up services. Innovative strategies may need to be developed to overcome barriers, and careful planning, implementation, monitoring and evaluation are essential. If task shifting, decentralisation and integration are to achieve better health outcomes, they must be integrated into the existing national plan of action.

The aim of linkages and referrals must be to make it easier for individuals living with HIV to navigate the system and support them to remain engaged in care. As long as the legal environment supports cross-sector collaboration, multi-disciplinary disease and client management approaches can bridge gaps between sectors and disciplines (e.g. through the use of unique identifier codes protecting client confidentiality while allowing tracing of referrals and service uptake).

Linkages and referral systems must exist between community-based and other healthcare services in order to provide holistic care. Care should be rights-

Advocate!

People living with HIV and key populations must be actively involved in developing, delivering and monitoring services. We, as communities, make varied and critical contributions to health systems. These need to be better recognised and invested in.

Message

In sub-Saharan Africa, 32% of people living with HIV who were eligible for ART were lost before initiating treatment.

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based, non-judgmental, and responsive to gender, age, sexual orientation, and individual risks and vulnerabilities. Communities must ensure that integration of services in one facility, for example, does not lead to further stigma or denial of choice to people living with HIV.

While the 2013 Guidelines focus on the integration of health services within healthcare facilities, integration can also be important within the framework of community-based services. Integration could occur, for instance, between HIV and sexual and reproductive health services in a drop-in centre for a key population run by a community-based organisation, with bidirectional referrals to public and private healthcare providers for additional health services. Another example would be the integration of peer-driven psychosocial and economic support services into healthcare facilities.

The 2013 Guidelines highlight some key implementation considerations:

- *Programme managers and communities should jointly consider options for decentralisation to see which are feasible and best fit local needs.*
- *Programme managers should consider human resources capacities and task shifting, and develop policies to recruit and retain staff particularly in remote rural settings. Adequate training and supervision, including for community health workers, is important to ensure high quality care.*
- *Programme managers and communities should strengthen linkages and referral systems.*
- *Programme managers should agree on the division of labour and responsibilities among levels of the health system (national, provincial or regional) and with community-based service providers, including networks of people living with HIV.*

Programme managers and communities need to communicate the new guidelines and their implications to build trust in the new service delivery models and standards of care. Communities must strengthen their treatment literacy and human rights programmes, thus empowering people living with HIV to make informed decisions regarding lifelong prevention, treatment and care.

It is widely recognised that people living with HIV have been at the forefront of efforts to ensure that *all* people living with HIV get the services they need. The Positive Health, Dignity and Prevention (PHDP) operational guidelines[1] offer further guidance on meaningfully involving people living with HIV and ensuring that HIV programmes meet their needs. For instance, assessment checklists can guide communities and programme managers in planning, implementing and evaluating the recommended service delivery models. Communities can also ensure that the comprehensive package of services and support for people living with HIV, described in the PHDP guidelines, is integrated into the national strategic plan and other national-level strategies (e.g. health system strengthening). National networks of people living with HIV need the support of donors and United Nations agencies to use the PHDP guidelines to improve national HIV programmes.

In order to achieve rapid scale up and acceptance of new standards of care and service delivery in affected communities, it is crucial to ensure the leadership and engagement of communities and people living with HIV in all their diversities.

Community-led services[2] need to continue to support and complement the health system. There is increasing evidence of the benefits of community-based ART delivery models to offer treatment, support adherence, maintain people in high-quality care, and improve the quality of life of people living with HIV. More research is needed on how community models can support underserved populations who often have difficulties accessing ART. Depending on context, these may include vulnerable men, women, children, adolescents, people in rural areas, prisoners, refugees, mobile populations, sex workers, men who have sex with men, transgender people and people who use drugs. Communities need to be clear about the costs of these models so they can advocate for them to be included in national budgets.

Advocate!

Governments and other stakeholders should use the Positive Health, Dignity and Prevention framework to ensure that national HIV programmes are responsive to and meet the needs of people living with HIV.

Research!

Further studies are needed on how community models can better serve populations who are often last to benefit from HIV services, and promote their human rights.

1. See Module G. PHDP operational guidelines are available at: www.gnpplus.net/assets/positive_health_dignity_and_prevention_operational_guidelines_-_unaids_gnp_2013.pdf

2. See examples of models of community ART delivery in Annex 11.1. of the March 2014 supplement to the 2013 WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.* Available at: www.who.int/hiv/pub/guidelines/arv2013/arvs2013upplement_march2014/en/

Simple, integrated systems to monitor and evaluate community-based models of care are necessary to ensure reliable drug supply, support programme efficiency and effectiveness, and ensure programme transparency and accountability. Similarly, services delivered by communities need to be regularly monitored and evaluated using an agreed set of indicators, and integrated into national monitoring and evaluation (M&E) systems. The PHDP framework provides guidelines for measuring the impact of national programmes and references to other useful M&E resources. Community-based organisations delivering services and advocating for change also need to feed back to the communities they serve, and put in place ongoing consultation and feedback mechanisms.

Take stock! Take action!

- [ ] Has there been an assessment of the strengths and weaknesses of current programmes and delivery of services, including identification of gaps? Have there been discussions in your country on how to adapt and improve both health and community systems and the linkages between them to better support adoption of the 2013 Guidelines?
- [ ] Is your community engaged in plans to help deliver ART (e.g. via home-based care or adherence clubs for stable patients)? Have the different models of community-based services been evaluated to determine which should be scaled up to support the 2013 Guidelines?
- [ ] Do national laws and policies need to be updated to allow for community-based models of prevention, care and support?
- [ ] Are networks of people living with HIV, community-based organisations, healthcare workers and programme managers aware of and using PHDP operational guidelines?
- [ ] Have the new recommendations been discussed with other relevant programmes, such as maternal and child health, TB and drug dependence, to ensure delivery of integrated services? Are current linkage/referral systems adequate and functioning, including between health facilities and community-based services? What are the changes needed to support the new recommendations?
- [ ] Where and what services need to be decentralised to better support the 2013 Guidelines? Have different options or models of decentralisation of services been analysed?
- [ ] Are nurses and community health workers engaged in discussions around the adoption of the 2013 Guidelines and prepared to take on additional roles recommended for task shifting?
- [ ] Has there been an assessment of how many additional healthcare workers are needed to implement the new recommendations? What cadres (doctors, nurses, midwives, community health workers, laboratory assistants) are needed, and how can they be recruited and retained?
- [ ] Is there a plan to update training curricula for healthcare workers and provide ongoing and systematic training, including for community health workers? Will there be an established system to ensure ongoing organisational support and quality assurance of services provided at periphery and community levels?
- [ ] Are targeted communication strategies, along with updated treatment and rights literacy initiatives, in place to ensure that people living with HIV, their families, caregivers and communities are adequately informed about the new recommendations?
- [ ] Have the health system costs of implementing the new recommendations been estimated and budgeted for? Are there adequate national resources or have donor funds been mobilised, including for community models?

This is one in a series of modules supporting a community response to the 2013 WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.*

Produced by the International HIV/AIDS Alliance, Global Network of People Living with HIV (GNP+) and STOP AIDS NOW!

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