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<td>Submitted by</td>
<td>HIV/AIDS EG ITA in coordination with the HIV/AIDS EG Chair</td>
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**Working Program/Strategy for the collaboration in the prevention of HIV (within the context of Northern Dimension Partnership programme)**

Draft Update October 1, 2007
(Pauli Leinikki, chairman of the HIV Expert Group for the Northern Dimension Partnership programme)

**Summary**

This strategy update is intended to complement the previous strategy describing the epidemiological situation, main concerns and priority areas for common actions for the HIV expert group working within the Northern Dimension Partnership Programme that has previously been approved by the CSR (www.npdhs.org). Details about the epidemiological developments are not reiterated and the background texts for the recommendations are only briefly updated where significant changes have taken place during the last two years.

Annex 1 contains a list of objectives and possible output criteria.

The HIV epidemic continues to spread mainly through injecting drug use but increasingly the infection is also spreading to other parts of the population. Significant change has taken place through the possibility to widely implement highly active antiretroviral treatment (HAART) not only improving the situation of those infected but also by enhancing prevention efforts and reducing the stigma and discrimination known to drive the epidemic further. The future of the epidemic in the region is markedly shaped by the ability to use HAART so that all vulnerable groups, injecting drug users (IDU) in particular, can be reached.
Recommendations for priorities are categorized under five headings: surveillance, general awareness and policy development, legislation, prevention and treatment, care and support. International recommendations for the organization at country level (i.e. “Three Ones” principle launched by WHO) are recognized as well as the role of major funding mechanisms at country level such as the Global Fund.

Most partners in the NDP are now members of the European Union which through its financing and political instruments is able to shape and direct HIV-related activities within member states. New financing instruments to cover the costs of projects that involve countries within and outside EU have not yet been fully developed and projects covering the NDP geographical area must be compiled by including bilateral projects involving Russia and network projects covering the EU member states.

Background

Defining the target geographical area for NDP HIV activities.

The NDP programme involves partners with equal rights and obligations. Both sovereign states and international organizations participate in the work. The NDP should bring social and economic well being through enhancing collaboration between the partners and developing common best practices for regional collaboration. The HIV expert group should in particular take into consideration the severity of the HIV epidemic in NW Russia and the Baltic countries. Resources of the other partners should be networked so that they help these countries to overcome the threat.

Recent epidemiological development

NW Russia
The number of reported cases continues to increase rapidly although not as fast as 5 years ago. The epidemic is still driven by infections among injecting drug users (IDUs) although increasingly infections are also reported from people (often women) who report heterosexual transmission. The number of children born to HIV-infected mothers is quite high and not all women have been counselled or treated during their pregnancy. The most affected areas are St. Petersburg and Leningrad Region, Murmansk show a clearly rising trend while in the other regions the situation is still stable or satisfactory.

Kaliningrad
The rate of new cases reported annually has remained high after the peak in the 1990:s with a prevalence among the highest in the region (400/million at the end of the year 2005).
Number of people living with HIV/AIDS (PLWHA) in North-West Russia by year

Source: National AIDS Centres

The Baltic Countries

Reported HIV cases by transmission mode in Nordic countries and Baltic States, 2005

Nordic Countries

- MTCT: 2%
- Hetero: 54%
- MSM: 36%
- IDU: 8%
- Transfusion: 0.3%

Baltic States

- MTCT: 0.6%
- Hetero: 35%
- MSM: 9%
- IDU: 59%
- Transfusion: 6%

Cases with unknown transmission mode excluded

Estonia

New cases appear still quite rapidly although the rate is declining. Regional differences are considerable. The disease burden is among the highest in Europe, in Narva region up to 4 per cent of adult population may carry the infection. Practical arrangements for the provision of HAART to
everybody who need it have proceeded rapidly but the epidemiological impact is yet to be seen. A common cross-border prevention project is under development with Russia. A larger proportion of those infected belong to younger age groups (less than 30 years) than in other Baltic countries.

Latvia
Latvia has also a heavy burden of infections, injecting drug use being the most common vehicle for transmission. Low-threshold services have been organised as well as universal provision of HAART.

Lithuania
Lithuania has the lowest prevalence and incidence of infections among the three Baltic countries. Drug use is an important vehicle for transmissions.

Western Europe
In most western European countries the numbers of newly detected HIV infections have recently grown. The two categories with greatest increase are heterosexually acquired infections among people from high-endemic areas and, among men who have sex with men (MSM). The latter category has potentially more impact on the development of the epidemiology since it is a reflection of increased risky behaviour while in the former category the risk may have mostly been linked with the circumstances in their native countries and environments.

Social and political impact, future

In most European countries the situation has stabilized after initially large and sudden outbreaks in the late 1980s and early 1990s concomitant with a considerable reduction in risk behaviour like unprotected sex and needle sharing. Targeted prevention approaches, such as provision of easy-access medical and social support together with counselling and provision of free condoms and exchange of needles and syringes into clean ones are being implemented successfully in many cities and countries. New resources have become available to provide HAART to all who need it and case management practices are being streamlined to ensure nondiscriminating access based on medical criteria only. Aside of such success, the incidence of new infections in some countries is still very high and both drug users and sex partners of ex-drug users seem to be the most vulnerable groups. A significant outbreak among men who have sex with men has not yet been discovered in Russia or the Baltic countries although signs of increasing risk behaviour among these men have been observed in many countries.

Compared to most Western European or Nordic countries, the social and economic impact of HIV will be much more severe particularly in Estonia, Latvia and NW Russia. With the introduction of HAART treatment, the not only the quality of life but also life expectancy of those infected will improve dramatically. In order to achieve this, a system to provide life-long drug therapy along with strong social support must be set up. In order to adjust to this, the national health policies may need to be revisited frequently and social and health care will consume much more resources than what used to be the case only 5-10 years ago. Also, approaches that are used in other countries may not be appropriate. All this is a challenge not only to the health policies but to the entire political structure. Providing equal opportunities to infected people and avoiding discrimination will need political courage and advocacy.
**Recommendations**

1. **Surveillance**

Surveillance is a key for adequate response. Information to politicians and lay people about the dynamics of the epidemic as well as the dynamics of the underlying risk factors and impact of interventions are necessary for making correct decisions. Good surveillance needs access to groups at high risk of infection that are often difficult to reach through traditional surveillance methods. Ideally, surveillance should be linked to preventive interventions that are targeted to drug users, commercial sex workers, migrant populations etc. Signs of suboptimal coverage of populations include the rapidly increasing rate of HIV-positive women giving birth to children in Russia without having had contact with the health care during pregnancy. Underreporting may also become more prevalent as many patients seek treatment in private clinics. Monitoring changes in the risk behaviour patterns that are associated with HIV spread will become more and more important indicators for the development of the epidemic. Significant improvements in the surveillance of sexually transmitted infections are also needed in almost all of the countries. In many instances, legal obstacles and discrimination is posing challenges to good surveillance. More extensive use of sentinel surveillance could in many instances provide the missing data and indicate trends.

Availability of effective treatment for HIV infection as well as for drug dependence will probably increase the willingness of people to seek for testing and other contacts with health care providers. This will improve the sensitivity of surveillance. Voluntary Counselling and Testing (VCT) is an important instrument whose utilization should be enhanced by applying approaches that promotes reaching of vulnerable groups. One way to do this is through low-threshold service centres (LTSC) for drug users and for commercial sex workers. Use of rapid tests also help, repeated visits will not be needed to learn the result and waiting for the result is optimal time for counselling and advice.

Wide use of HAART will bring along the problem of monitoring the efficacy and compliance among people receiving medication. This should become part of the basic surveillance of the epidemic. Data collection linked to outreach programs is feasible for second-generation surveillance. All these elements could be brought together under the concept of “extended case management” that includes early detection of cases, targeted counselling and secondary prevention and follow-up of treatment and patient’s compliance in addition to the elements traditionally associated with case management.

**Recommendations for actions/priorities (1, surveillance):**

- Promote effective VCT with special emphasis on reaching the vulnerable groups. (low threshold centres, outreach approaches, anonymous testing, use of rapid tests)
- Easy access to (anonymous) VCT should be ensured for IDUs, CSWs and their clients, ethnic minorities, foreign students, migrant populations, adolescents etc.
- Second generation surveillance according to standards set by UNAIDS and WHO should be promoted to receive information about changes in risk behaviour and other, societal exposing factors.

2. **General awareness, policy development**

The World Bank projects that the cumulative number of HIV cases in Russia in 2020 to be 5.4 million as an “optimistic scenario” and 14.5 million as a “pessimistic scenario”. The
corresponding increase in mortality and possible net population loss are projected to be 5 to 13 million by 2020. The impact will be hardest in Russia’s most affected regions, some of which border EU and the Northern countries. The possible outcomes to the Baltic countries have not yet been analysed in detail. Modelling of the outcome of HIV-epidemic in the Baltic region could be a fruitful field of international collaboration including ND.

National policies should recognize the severity of the threat and raise the general political awareness of the situation. Measures to eliminate discrimination must be implemented, be it people living with the infection or people who need help because their behavioural patterns puts them at particular risk for the infection. National policies should also ensure that all people at risk get adequate information about the risks and access to means to avoid it. HIV should also become an issue in all policies in order to create the necessary human and financial resources that are needed to change the course of the epidemic.

**Recommendations for actions/priorities (2. Policies):**

- General awareness about the impact of the emerging threat and measures to control the situation on individual and societal level should be promoted. Political leadership at all levels is needed.
- HIV/AIDS cannot be considered just a health issue. Input and support from other sectors should be promoted for effective planning and implementation of the response.
- Human and financial resources for the fight against HIV should be created both within the national health and other sectors of administration (economy, security, industry etc.), localities and the entire civil society.
- The human rights of people living with HIV/AIDS should be equal to those of non-infected people. People are more vulnerable to the effects of HIV infection when they do not have the respect and support of their community. Discrimination due to sexual orientation, drug abuse, ethnic background etc. make people also vulnerable to infection.

**3. Development of legislation and policies**

Legislation should promote the participation of the entire society in the fight against HIV. Preventive work is much more effective if the authorities get full support from civil organisations (NGOs) and self help groups including people with the infection. Private business might have a significant role by reaching their employees in situations useful for preventive interventions. Employers also bear important responsibility in preventing discrimination in workplaces.

Modelling studies demonstrate that focusing preventive measures to IDUs in an epidemiological situation like present day NW Russia is the most effective way to prevent the infections at the entire population level also. Scientific studies show that harm reduction is an essential element in effective HIV prevention among IDUs. Legislation should not prevent effective, evidence-based prevention strategies. It should ensure access to free, voluntary, anonymous or confidential HIV/AIDS counselling and testing, and nondiscriminatory access to treatment and care. It should promote the rights of prisoners to receive the same quality health care as the rest of the population. Legislation should also ensure necessary education concerning prevention of sexually transmitted diseases and infections linked with drug use at all levels of education.
**Recommendations for actions/priorities (3. Legislation and policies):**

- Develop legislation to promote partnership between NGOs, civil societies, private business and governmental agencies in their fight against HIV. This process could be assisted by common, international projects, training etc.
- Develop policies to ensure universal, non-discriminating access to anti-retroviral drug treatment to all infected people, using medically justified criteria.
- Develop legislation to allow implementation of evidence-based prevention strategies among vulnerable groups such as drug users, other socially excluded groups, sexual minorities etc. The policies should combine harm reduction programs with medical and social rehabilitation.

**4. Prevention**

HIV-prevention must be a joint effort shared by various sectors of administration such as education, health, justice, economy, defense and internal security. Administration is responsible for successful recruitment of NGO:s and the civil society to work side by side with public bodies. Most affected countries need to scale-up their national HIV/AIDS prevention efforts to allow much broader coverage of at risk populations and other preventive measures to stop the epidemic.

Targeted interventions are necessary to initiate behavioural changes and diminish the risks for transmission. In vulnerable groups efforts should be focused as much to those already infected as those not yet infected. HAART should be seen as an integral part of prevention. Extended case management should include elements such as early case finding, appropriate primary and secondary prevention and monitoring of compliance and treatment outcome. Involvement of members from the target population is essential. The ability to reach the target populations should be monitored carefully; it may take some time before an intervention becomes sufficiently accepted by the target population to achieve its goal.

Basic education at schools should give sufficient information and life skills to average children to be able to avoid HIV-infection. This means that the curricula at schools should be re-evaluated and restructured, also teachers need training to be able to communicate the necessary messages effectively. HIV must be integrated into a broader sexual health agenda. Young people themselves should participate in designing and delivering educational activities. A big challenge is to reach young people who are particularly vulnerable to HIV for various reasons.

Prevention of other sexually and parenterally transmissible diseases should be closely linked to HIV prevention. STI control projects should be able to reduce the rate of new infections in particular among young people.

Several minority groups are often left outside proper information concerning HIV. This may be due to language problems but also to social marginalization. The status and needs should be investigated and appropriate intervention programs developed. Representatives of target populations should participate in the planning and deliverance of interventions.

Reduction of mother-to child transmission (MTCT) to very low levels is possible today with the help of HAART. All infected pregnant women should have the possibility to get proper treatment free of charge. This should be integrated into comprehensive and non-discriminating antenatal services linked with necessary social and economic support. HIV infected women should have the
same right to take reproductive choices as uninfected women. Projects to develop best practices and proper surveillance of this particular problem should be encouraged.

Overcrowded prisons pose a significant threat for the spread of communicable diseases in the region. Both behavioural risks (sexual and parenteral infections) and risks due to crowding (tuberculosis, other respiratory infections) contribute. At the same time prisons should also be seen as potential sites for successful preventive work both for HIV and for drug abuse. HIV testing should be made readily accessible to inmates of all prisons, discretely and at their own request; it should always be voluntary and accompanied by counselling also in the case of negative test results. Needle exchange programs can be useful and integral parts of a general approach to drug and health services in prisons. They should be integrated into other health promotion measures, counselling and social rehabilitation. Continuation of preventive work and support after the inmates return to the civil society must be properly organised.

**Recommendations for actions/priorities (4. prevention):**

- Promote networks of “low-threshold centres” (easy access sites for medical and support) and outreach activities for hard-to-reach target groups. Established networks should continue and develop best practice documents. Links with medical and social rehabilitation should be strengthened.
- “Youth clinics” supporting the development of important life skills to lessen the vulnerability of young people to HIV should be established.
- Work towards the acceptance of school education programs, with the main aim to increase knowledge, encourage healthy attitudes, develop essential life skills and support non-risk-taking behavior. Create networks to improve life skills of young people.
- In prisons harm reduction strategies should be implemented, including support and rehabilitation programmes for those having completed their sentence. Pilot projects for needle/syringe distribution/ exchange should be established.
- Prevent mother-to-child transmissions. Health services that serve women of reproductive age should be strengthened and reshaped to enhance non-discriminating detection and treatment of HIV-infection during pregnancy. Specific approaches are needed to reach socially marginalised pregnant women with drug dependence.
- Promote frequent and interactive evaluations of current interventions. Peer reviewing using international experts could be applied through the NDP.

**5. Treatment, care and support**

Anti-retroviral treatment has the promise to significantly enhance HIV prevention but it may also fail. Widespread unregulated access to anti-retroviral drugs could lead to rapid emergence and spread of resistant virus strains. To be successful, a universal and non-discriminating access to treatment based only to objective medical criteria is essential. Lowering the price for medicines, technical improvements for simpler dosage and development of new antiviral drugs through research are all necessary ingredients for future success.

Delivery of HAART should be linked with proper medical and social support organised in such a way that normal life is possible (“one-door delivery”). Since the need is life-long, it may become necessary to arrange the service outside the normal health services. When necessary, the services should also include harm reduction measures to keep the patients attached to the treatment. Monitoring should include among other things compliance and possible emergence of drug resistance.
Education of health care workers (HCW) in counselling and care of HIV infected people and AIDS patients become even more important in the future. Well-informed HCW will also help disseminate information and an anti-discriminatory attitude into the society.

**Recommendations for actions/priorities (5. Treatment and care):**

- Create national case management guidelines based on scientific evidence. These guidelines should be harmonised as much as possible in the region. The case management should include elements from early case detection and primary prevention to secondary prevention, harm reduction, medical and social care and support to home care and compliance monitoring.
- Develop a network of diagnostic laboratories to enable monitoring of disease progression, evaluation of treatment success and resistance testing in case of treatment failure.
- Strengthen NGOs and communities in their role in supporting home-based care and clinical management of infected persons.
- Establish and develop effective education of HCW in counselling and care of HIV-infected people and AIDS patients.
Annex 1

Objectives and output criteria for the implementation of the HIV policy of the NDP  
(Draft 1.10.2007; Pauli Leinikki)

<table>
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<th>Objectives</th>
<th>Indicators (P = programmatic, (Op=output, OC = outcome)</th>
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<tr>
<td><strong>1. Surveillance</strong></td>
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<tr>
<td>Promote effective VCT with special emphasis on reaching the vulnerable groups. (low-threshold centres, outreach activities, anonymous testing, technical improvements)</td>
<td>How many VTC sites have special activities/programmes (define!) for vulnerable groups? (P) Which groups are included (IDU, CSW, MSM, young people, migrants, prisoners, other?) (P) To what extent rapid testing or comparable services are provided for clients? (Op)</td>
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<td>Access to (anonymous) VCT should be easy and nondiscriminating and coverage should be monitored on a regular basis.</td>
<td>How big proportion of IDUs and CSWs are covered by the easy access activities? (Op) Are there agreements with law-enforcing officials to get undisturbed function? (P)</td>
</tr>
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<td>Surveillance should cover the entire country/region with equal efficacy</td>
<td>How many regions/municipalities have VTC-sites with special programmes towards vulnerable groups? (Oc)</td>
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<tr>
<td>Second generation surveillance should be promoted to receive information about changes in risk behaviour and other, societal exposing factors.</td>
<td>How many VTC sites collect information within the frame of second generation surveillance? (Oc)</td>
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<tr>
<td>Surveillance does not violate confidentiality but its results are open</td>
<td>Describe methods for data collection, analysis and reporting. (Op)</td>
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<td><strong>2. General awareness, policy development</strong></td>
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<td>General awareness about the impact of the emerging threat and measures to control the situation on individual and societal level should be promoted.</td>
<td>Are there studies about the level of knowledge and importance of HIV as a public policy issue? (P) Number of (published) studies about the impact of the epidemic on national and regional economy, health care delivery etc? (Op) Number of communications concerning the priorities in the national policy? (Op) Number of initiatives/motions in the parliament on HIV/AIDS issues? (Oc) Annual public budget allocations? (Oc) Articles published or in press? (Oc)</td>
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<td>Governmental advocacy and leadership should be evident</td>
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<td>Other sectors (than health) should be adequately involved in the national response</td>
<td>Activities (VTC, ARV) implemented for military, prisoners, labour force, law-enforcing personnel, etc? (Op) Inputs from industry, commerce, education, homeland security, into national HIV-policy? (Oc)</td>
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<td>Sharing of responsibilities between federal, regional and local administration should be clear and support even and just distribution of activities towards all citizens</td>
<td>How well the “Three Ones” –principle (of WHO) has been implemented? (Description) (Oc)</td>
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<td>The human rights of people living with HIV/AIDS should be equal to those of non-infected people.</td>
<td>No and title of special activities to alleviate the impact of discrimination? (Op) No and title of special activities to remove/diminish discrimination? (Op) Is treatment including HAART free of charge? (Oc) Do PLHWA get support for housing? (Oc) Do PLHWA get support for employment? (Oc)</td>
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### 3. Legislation and policies

| Remove legal obstacles to ensure universal, nondiscriminating access to anti-retroviral drug treatment to all infected people. | National guidelines for HAART for various groups formulated and implemented. (Oc) Procurement and licensing of generic drugs under special programmes. (Op) |
| Develop policies to promote partnership between NGOs, civil societies, private business and governmental agencies in their fight against HIV. | Changes in the status of NGOs in the common HIV-policy over the last 5 years (Oc) No of projects related to HIV involving NGOs, civil societies and private business? (Op) |
| Remove legal obstacles for using evidence based interventions such as health promotion including needle exchange and maintenance therapy for injecting drug users. | Harm reduction programs implemented? (Oc) Rehabilitation programmes in place for drug users, for prisoners? (P) |
| Ensure linkage of these activities with medical and social rehabilitation. | Describe links and arrangements (P) |

### 4. Prevention

<p>| Promote networks of “low-threshold centres” and/or outreach programmes for hard-to-reach target groups. | Participation in the networks (Oc) Reporting of activities (Oc) |
| Established networks should continue and develop best practice documents. | Best practice documents output (Oc) |</p>
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<th>Links with medical and social rehabilitation should be strengthened.</th>
<th>Describe links (P)</th>
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<td>“Youth clinics” supporting the development of important life skills to lessen the vulnerability of young people to HIV should be established.</td>
<td>Number, activities etc of Youth skills clinics (P, Op)</td>
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<td>School education programs should be revisited, with special emphasis on objective and evidence-based knowledge, support to healthy attitudes, development of essential life skills and support to non-risk-taking behaviour. Networks to improve life skills of young people should be promoted and involve young people.</td>
<td>New programmes should be produced, distributed and also discussed by the general public. (P, Op, Oc) Programmes for school drop-outs? (Oc)</td>
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<td>To support HIV-prevention in prisons, harm reduction strategies need to be implemented, involving all relevant individuals and groups in their design, planning and implementation. Pilot projects for needle/syringe distribution/exchange should be established.</td>
<td>Surveillance activities (P) Harm reduction activities (P) Rehabilitation activities within the prison (P) Post sentence rehabilitation and empowerment (P)</td>
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<td>Prevent mother-to-child transmissions. Health services that serve women of reproductive age should be strengthened and reshaped to enhance non-discriminating detection and treatment of HIV-infection during pregnancy. Specific approaches are needed to reach pregnant women with drug dependence.</td>
<td>Antenatal clinics: Number and function. (P) Surveillance etc (P)</td>
</tr>
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<td>Promote frequent and interactive evaluations of current interventions. Peer reviewing with an international expert base could be an important tool to be applied within the ND. This process would also facilitate networking process.</td>
<td>Number of evaluations (Op) Structure for evaluation activities (P)</td>
</tr>
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<td>Promote HIV-prevention in all sectors of the society</td>
<td>HIV prevention in the working place? (Oc) Guidelines for post-exposure prophylaxis exist? (Oc) Role of municipal administration in HIV-prevention (P, Oc)</td>
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5. Treatment care and support:

| Develop national guidelines for extended case management. (See annex 2) | Effective early case finding? (Oc)  
Equal and nondiscriminating access to treatment for all infected people? (Oc)  
Affordability of drugs? (Oc)  
Procurement and Supply Stability and Sustainability of ARV? (Oc)  
Integration to health care in general? (Oc)  
Reduction of the number of referrals necessary? (Oc)  
Scaling up to meet the needs? (P, Op) |
|---|---|
| Develop a network of diagnostic laboratories to enable monitoring of decease progression, evaluation of treatment success and resistance testing in case of treatment failure. | List and describe diagnostic laboratories.(P)  
Common EQA established? (Op)  
Activities and training programmes linked to them? (Op, Oc) |
| Strengthen NGOs and communities in their role in supporting home-based care and clinical management of infected persons | Support to self-help groups? (P)  
Support to home-based care? (P)  
Need for DOTS-type arrangement? (Oc) |
| Establish and develop effective education of HCW in counselling and care of HIV-infected people and AIDS patients | Education and training of professionals (Op, P) |

Acronyms:

LTC  Low-threshold centres. (Easy-access sites delivering health promotion including medical and social counselling and help, harm reduction activities, preventive education etc)
HAART: Highly active antiretroviral treatment
ECM: Extended case management. Case management scheme including guidelines for early case detection, primary prevention, secondary prevention, medical and social support including harm reduction if necessary, HAART, prevention and treatment of opportunistic and concomitant infections, home care, etc.
NDP: Northern Dimension Partnership
HCW: Health Care Worker
MTCT: Mother-to-child transmission
NGO: Non-governmental organisation
VTC: Voluntary counselling and testing
CSW: Commercial sex workers
Annex 2

Components of extended case management:
1. Early identification of the cases: Use of low-treshold approaches, enhancing of VCT activities, technical applications (flexible use of rapid tests, self collection of samples etc etc.
2. Counseling related to the early phases of possible/probable infections.
3. Psychosocial support
4. Medical follow-up
5. Medical management of early stages of infection
6. Prophylaxis for opportunistic infections etc
7. TB care and management
8. HCV, care and management
9. Substitution therapy
10. Treatment and rehabilitation of drug dependency
11. Implementation of HAART
12. Prevention of MTCT
13. Other secondary prevention
14. Social rehabilitation and support
15. Home-care
16. HIV-infected IDU:s. Special issues on medical and social problems and their management.
17. Terminal care